**REGISTER TODAY!**

**WVOS ANNUAL FALL MEMBERSHIP MEETING**

in conjunction with the **WVU FALL CANCER CONFERENCE**

**OCTOBER 28 & 29, 2010**

_Erickson Alumni Center_  
_Morgantown, WV_

Visit [www.wvos.info](http://www.wvos.info) for registration information as well as a detailed agenda.

**NOTE:** Separate registration required for both the WVOS Annual Fall Membership Meeting and the WVU Fall Cancer Conference.

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**WVOS**  
**Mission Statement**

To engender and promote improvements in patient care, education, clinical trial accrual and pertinent economic and legislative issues as they affect all elements of oncology in the State of West Virginia.
WVOS has confirmed that Humana is reimbursing our members incorrectly for services rendered to PEIA retirees. According to the Medicare PEIA Medicare Advantage Regional Preferred Provider Organization (RPPO) plan, “Humana Medicare Advantage RPPO” Agreement, all providers who have not signed a contract directly related to this plan should be reimbursed at the MEDICARE fee schedule for services and drugs.

WVOS has confirmed that Humana has been erroneously processing non-network providers at 95% of the Medicare rates for both services and drugs! Receiving 95% of Medicare ASP rates for drugs puts virtually every drug an oncologist gives underwater!

**IMPORTANT:** EVERY provider of PEIA retirees should check their Humana reimbursement and make sure the reimbursement is correct! If errors are found, please notify WVOS immediately and we will add your name to our growing list and have your claims corrected ASAP! You can email WVOS at reimbursement@wvos.info. To read more about the PEIA Humana RPPO plan. Link provided below.

http://www.westvirginia.com/peiademo/content/Medicare_Advantage_Flyer.pdf

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**STATEWIDE CANCER CLINICAL TRIALS NETWORK DEVELOPMENT CONTINUES**

Reducing the overall burden of cancer related mortality in the State of West Virginia by increasing accruals to clinical trials is the primary goal of the WVOS development of a WV Cancer Clinical Trials Network.

WVOS, Mary Babb Randolph Cancer Center of West Virginia University, David Lee Cancer Center of Charleston Area Medical Center, United Hospital Center, Clarksburg, Schiffler Cancer Center of Wheeling Hospital, City Hospital of West Virginia University Hospital-East, Martinsburg as well as several other oncology and healthcare partners throughout West Virginia are working together to address this major cancer care issue in our state.

In recent planning meeting it was decided to engage the assistance of Oncology Solutions, LLC to collaborate with WVOS in the development of the Network.

You will hear more about our exciting undertaking in the next issue of the **WVOS Oncology Review**. This initiative was also highlighted in ASCO Post, “CLICK HERE” to read more about our Statewide Clinical Trial Network!

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(1)
The West Virginia Oncology Society is excited to announce the launch of our

**Patient Advocacy Initiative!**

Our goal is to ensure that all patients in West Virginia are able to receive care and are never turned away for inability to pay. In support of this initiative, we have created an **easy to use** listing of patient assistance opportunities for our members now available on our website. When searching for patient support you are able to search by drug, diagnosis, or even look for assistance specific to patients in West Virginia!

Please visit our website, click on the patient assistance tab and begin utilizing this tool **TODAY!!**

www.wvos.info
ASH Submits Comments on Inclusion of Clinical Trials Coverage Provision Among Health Reform Benefits Deemed Not Applicable to “Grandfathered” Health Plans

ASH has joined with a number of organizations to submit comments in response to a proposed regulation that includes coverage of routine patient costs associated with clinical trial participation among the benefits deemed to be not applicable to certain health plans in existence prior to enactment of the health reform law.

Read the complete article HERE

ASCO Urges CMS to Withdraw National Coverage Analysis for FDA-Approved Cancer Drug

Recently, ASCO submitted comprehensive comments to the Centers for Medicare & Medicaid Services (CMS) expressing concern regarding its decision to open a national coverage analysis (NCA) for an FDA-approved cancer treatment. DETAILS

AHRQ Releases Technology Assessment on Antiemetic Drugs and Chemotherapy or Radiation Therapy in Adults

The Agency for Healthcare Research and Quality (AHRQ) has released a technology assessment titled “Consideration of Evidence on Antiemetic Drugs for Nausea and Vomiting Associated with Chemotherapy or Radiation Therapy in Adults.” This AHRQ technology assessment can assist physicians by providing a review of current literature on the following questions:

Read the complete article HERE

HHS Announces Medicare Expands Coverage of Tobacco Cessation

The U.S. Department of Health and Human Services expanded Medicare coverage of evidence-based tobacco cessation counseling, removing a barrier to treatment for all tobacco users covered by Medicare. Before Wednesday, August 25th's decision, Medicare had covered tobacco counseling only

Continued on next page...
for individuals diagnosed with a recognized tobacco-related disease or showed signs or symptoms of such a disease. Under the new coverage, any smoker covered by Medicare will be able to receive tobacco cessation counseling from a qualified physician or other Medicare-recognized practitioner who can work with them to help them stop using tobacco. All Medicare beneficiaries will continue to have access to smoking-cessation prescription medication through the Medicare Prescription Drug Program (Part D).

**September/October Issue of The Hematologist**

**ONLINE EDITION AVAILABLE HERE**

**New Section Page added to the Physician Quality Reporting Initiative (PQRI) Webpage**

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new section on “How to Get Started” in participating with the Electronic Prescribing Incentive (eRx) program, is available on eRx webpage. The new section page can be found on eRx webpage at [http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp](http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp) on the CMS website.

**Recent Drug News and FDA Approvals**

**FDA Drug Shortages**

- **NEW** Etoposide Injection [DETAILS]
- Cisplatin for Injection [DETAILS]
- Mitomycin for Injection [DETAILS]
- Furosemide Injection 10 mg/ml [DETAILS]
- Leucovorin Calcium Lyophilized Powder or Injection [DETAILS]

Another good resource which provides detailed information about the various drug shortages please visit: [http://www.ashp.org/DrugShortages/Current](http://www.ashp.org/DrugShortages/Current)

**WVOS Underwater Drug Reimbursement Initiative**

Does your practice have any drug being reimbursed at less than the purchase price?

WVOS is launched an Underwater Drug Reimbursement Initiative to support our members by working with payers to cover the costs of our patients’ drugs.

**WE NEED YOUR HELP**......Please report any Underwater Drug Reimbursement to reimbursement@wvos.info.
**Pending Reimbursement Issue**

**West Virginia Medicaid**  
Paclitaxel, J9255, NDC 61703-0342-50  
Problem: Medicaid rejecting claims stating the NDC is no loaded or incorrect.  
Reported: 9/2/2010  
**Update 9/3/2010:** WVOS confirmed that this NDC is correct however, not on the rebate list and therefore is rejecting. The issue was reported to WV Medicaid has reported this issue and said the correction should be processed by 9/15.

Many thanks to Mary Blevins, Assistant Business Office Supervisor Beckley Oncology Associates, Inc., for bringing these issues to our attention!

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**Great tidbit from one of our members...**

When you are having trouble with drug reimbursement, don't forget to enlist the help of the drug company, they not only provide excellent advice but they assist with claims status, help track your claim and if you just can't get reimbursed, can often provide drug replacement on a case by case basis. I use them frequently with excellent results!!

*Tonia Flohr, CPC, CHONC - Primary Oncology Network, PLLC*
JNM: PET/CT, SPECT/CT Integral in Cancer Treatment Planning


ASTROgram: ASTRO to host 2011 Final Rules Webinar in December

ASTRO understands how staying in step with Medicare payment and coding changes can be challenging for practicing physicians. Prepare for 2011 and join us for a webinar to discuss the 2011 Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective System (OPPS) Final Rules, which will be released from the Centers for Medicare and Medicaid Services this November. Learn how these payment updates will affect your practice firsthand from ASTRO physician leaders and reimbursement and coding experts, David Beyer, M.D., FASTRO, and Najeeb Mohideen, M.D. CPT code changes for 2011 relevant to radiation oncology will also be reviewed. Space is limited so register soon.

To register CLICK HERE
**ASTROgram: ASTRO Submits Comments on Proposed Medicare Physician Fee Schedule**

ASTRO submitted comments on the CY 2011 Medicare Physician Fee Schedule to the Centers for Medicare and Medicaid Services (CMS) by the August 24, 2010, deadline. ASTRO also submitted separate comments with a coalition of organizations concerned about abuses of the physician self-referral law. More information and the complete letter are available on the [ASTRO Medicare News page](#).

**Press Release: ASTRO Publishes Whole Breast Irradiation Guidelines**

Fairfax, Va., August 4, 2010 - The American Society for Radiation Oncology (ASTRO) has released evidence-based guidelines to define appropriate fractionation of whole breast irradiation (WBI), finding that hypofractionated (HF) WBI is effective for many patients with early-stage breast cancer. These guidelines are published in the *International Journal of Radiation Oncology•Biology•Physics*, the official journal of ASTRO.

[Read the complete article HERE](#).

**18F-FDG PET/CT-based gross tumor volume definition for radiotherapy in head and neck Cancer: a correlation study between suitable uptake value threshold and tumor parameters**

To define a suitable threshold setting for gross tumor volume (GTV) when using 18Fluorodeoxyglucose positron emission tomography and computed tomogram (PET/CT) for radiotherapy planning in head and neck cancer (HNC).

[Read the complete article HERE](#).

**The role of adjuvant pelvic radiotherapy in rectal cancer with synchronous liver metastasis: a retrospective study**

Synchronous liver metastases are detected in approximately 25% of colorectal cancer patients at diagnosis. The rates of local failure and distant metastasis are substantial in these patients, even after undergoing aggressive treatments including resection of primary and metastatic liver tumors. The purpose of this study was to determine whether adjuvant pelvic radiotherapy is beneficial for pelvic control and overall survival in rectal cancer patients with synchronous liver metastasis after primary tumor resection.

[Read the complete article HERE](#).
With a focus on the Medicaid program, CMS has rolled out the Medicaid Integrity Program (MIP) and Medicaid integrity contractors (MICs) gradually over the last year. The Deficit Reduction Act of 2005 required the program be implemented statewide by 2010. The independent contractors or MICs hired by CMS will perform the following tasks as part of the MIP:

- Review provider actions to detect fraud, waste, or abuse.
- Audit provider claims.
- Identify overpayments.
- Educate providers and state and local employees involved in Medicaid administration on payment integrity.

There are three types of MICs. The types and roles they play are listed below.

- **Review of Provider MIC**: Work with CMS to analyze data and identify potential leads for prospective audits.
- **Audit MIC**: Perform audit on-site or “desk” audits of providers’ records depending on what CMS and the review of provider MIC identifies.
- **Education MIC**: Provide educational services to providers and Medicaid employees based on payment issues relevant to their region. CMS has just started awarding contracts in this area.

Although their purpose parallels the Medicare RACs, audit MICs differ in a number of important ways.

**RACs versus MICs**

In general, MIC audits have fewer statutory checks on record review compared with RAC audits. Under Medicare, RACs have a three-year limit on the period for which they can review records. There is no such limit for MICs, which have the legal authority to look back as far as records exist. Note, however, that CMS has adopted a general policy of mirroring the look-back period that the state employs. Similarly, there is no limit to the number of records that an auditor can request under the MIP, while RAC audits are capped. CMS also defers to state policy when it comes to the number of days providers have to produce records under a MIP audit. With a RAC audit, providers have a mandatory 45-day period to collect records. In summary, providers have a lot less certainty concerning the details of a MIC audit. On the positive side, MICs are not reimbursed on a contingency basis like RACs, which receive compensation based on the amount of overpayments they find. MICs simply receive a fee for their services.

CMS has divided the country into distinct regions, each with its own MIC, in order to streamline the process. The West Virginia region is:

- **Regions III/IV**: Alabama, Washington, D.C., Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, N. Carolina, Pennsylvania, S. Carolina, Tennessee, Virginia, and West Virginia. The MIC for this region is Thomson Reuters.

Any Medicaid provider can expect an audit, including fee-for-service, institutional, and non-institutional providers, and managed care organizations. This summer, of the approximately 500 audits underway, 44 percent occurred on hospital records, 29 percent on long-term-care facilities, and 21 percent on pharmacies.

There are many questions related to MIC’s and CMS promises more information, including answers to frequently asked questions, soon on its MIP Web page (www.cms.hhs.gov/medicaidintegrityprogram).

**Additional Information Sources**

- CMS Medicaid Integrity Program Website http://www.cms.gov/MedicaidIntegrityProgram/
- MIP A to Z http://www.cms.gov/ProviderAudits/Downloads/mipatoz.pdf (1)
J11 MAC CONTRACT AWARDED TO PALMETTO GBA

On May 25, 2010, Palmetto GBA was awarded the A/B Medicare Administrative Contractor (MAC) contract for Jurisdiction 11 and Home Health and Hospice MAC Jurisdiction C.

On June 1, 2010, the Centers for Medicare & Medicaid Services (CMS) notified us that the U.S. Government Accountability Office (GAO) had received a protest of CMS’ award to Palmetto GBA. The GAO denied the protest on September 9, 2010. Accordingly, we will be working closely with CMS in the coming days to begin work on implementation of the Jurisdiction 11 workload.

Read the complete article HERE

Palmetto GBA Listserv - A MUST to stay informed

There is no time like the present to ensure that you are receiving the latest news. Sign up now for the Palmetto GBA listserv. We also ask that you encourage your coworkers and associates to register too.

Register HERE

Palmetto GBA Laboratory and Molecular Diagnostic Services Program

As a CMS contractor, Palmetto GBA must determine reasonable and necessary services and apply fair reimbursement to services that are not listed in the current CMS laboratory fee schedule. For a wide range of laboratory and molecular diagnostic services, this responsibility is complicated...

Read more HERE

MEDICARE ADVISORY

The Palmetto GBA “Medicare Advisory” contains the information above and much more. This is a MUST READ for every practice.

Download the September edition of the Medicare Advisory in PDF format HERE

ARE YOU LOOKING FOR INFORMATION ON ANY OF THE FOLLOWING?

- Alternative Process for Individual Eligible Professionals to Access PQRI and E-Prescribing Feedback Reports (Pg 7)
- Timely Claims Filing: Additional Instructions (Pg 13)
- Roster Billing Guide for Influenza and Pneumonia Immunizations to Medicare Part B (Pg 31)
- Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (Pg 32)
- Oral Anticancer Drugs: Coverage Issue (Pg 40)
- Medical Director's Desk – Regarding LCD’s (Pg 46)
CMS News & Updates

END STAGE RENAL DISEASE PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED BILLING FOR LIMITED PART B SERVICES

This article is based on Change Request (CR) 7064 which announces the implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. (1)

**COMPLETE DETAILS**

***MEDICARE TIP***

Do you ever wonder why a claim did not crossover to the supplemental insurance company (Trading Partner)? There are different reasons why a claim might not crossover. Supplemental insurers contract with Medicare to supply them with the information to process the supplemental benefits. A Supplemental payer generally has no liability for additional payment when claims are paid at 100% of Medicare's approved amount or claims that are denied in full. Therefore, most companies choose not to receive claims for which they have no liability. (1)

IMPLEMENTATION OF NEW STATUTORY PROVISION PERTAINING TO MEDICARE 3-DAY PAYMENT WINDOW - OUTPATIENT SERVICES TREATED AS INPATIENT

On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010,” Pub. L. 111-192. Section 102 of the law pertains to Medicare’s policy for payment of outpatient services. (1)

For more information, please read full article

WHAT’S NEW WITH THE ELECTRONIC PRESCRIBING INCENTIVE (eRx) PROGRAM!

New Section Page added to the Physician Quality Reporting Initiative (PQRI) Web Page The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new section on "How to Get Started" in participating with the Electronic Prescribing Incentive (eRx) program, is available on eRx web page. The new section page can be found on eRx web page at http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp on the CMS website. (1)

INITIAL ELECTRONIC HEALTH RECORD CERTIFICATION BODIES NAMED

Key Step in National Initiative toward Adoption of Electronic Health Records (EHRs)
The Certification Commission for Health Information Technology (CCHIT), Chicago, Ill. and the Drummond Group Inc. (DGI), Austin, Texas, were named today by the Office of the National Coordinator for Health Information Technology (ONC) as the first technology review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health and Human Services earlier this year.

For the complete press release, go to Initial EHR Certification Bodies Named. (1)
CMS CREATES TIP SHEETS ON MEDICARE & MEDICAID EHR INCENTIVE PROGRAM

CMS has created tip sheets for Professionals and Hospitals on the Medicare and Medicaid EHR Incentive Programs. Professionals can find information on how the EHR Incentive Program works and a comparison of the EHR Incentive Program versus PQRI and E-Prescribing. Hospitals can find information on eligibility and factors that impact incentives. These tip sheets are located on CMS website at http://www.cms.gov/EHRIncentiveprograms/.

WHAT’S NEW WITH PHYSICIAN QUALITY REPORTING INITIATIVE

New Section Page added to the Physician Quality Reporting Initiative (PQRI) Webpage
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new section on "How to Get Started" in participating with the PQRI program, is available on PQRI webpage. The new section page can be found on PQRI webpage at http://www.cms.gov/PQRI/03_How_To_Get_Started.asp on the CMS website.

2010 PQRI 1st Quarter Data Codes Submission Error Report by Specialty
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2010 PQRI 1st Quarter Data Codes Submission Error Report by Specialty for January 1, 2010 - March 31, 2010 is available on the PQRI web page on the CMS website. To access this downloadable report, visit http://www.cms.gov/PQRI/Downloads/1Q_2010QDCSubErrorRptbySpecialty07272010_08122010.pdf.

Payment Adjustment for Newly Incentive Eligible Professionals for the 2008 PQRI
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce information on payment adjustments for newly incentive eligible professionals for the 2008 Physician Quality Reporting Initiative (PQRI) program is posted on the Spotlight page of the PQRI webpage at http://www.cms.gov/PQRI on the CMS website.

Upcoming incentive payment distributions-payment adjustment for newly incentive eligible professionals for the 2008 PQRI after incorporation of the allowed charges requirement:

- Distribution of this additional 2008 incentive, for those newly incentive eligible, begins August 25, 2010 and ends September 17, 2010 (late August through mid September).

There is a total of 889 TIN/NPIs who were not incentive eligible in the 2008 PQRI program but who are newly incentive eligible after incorporation of the allowed charges requirement.

CMS MLN MATTERS & LEARNSOURCE ARTICLES

- 2010 Physician Quality Reporting Initiative & Electronic Prescribing Incentive Program National Provider Call with Question & Answer Session (1)

- Closing in on 120 Days and Counting Until January 2011 Target Testing for Version 5010 (1)
  http://www.wpsmedicare.com/part_b/publications/2010_0830_120days.shtml

- CMS to Host Listening Session Regarding Confidential Feedback Reports and the Implementation of a Value-
Current 2010 Medicare Fee Schedule


LCD’s and NCD’s

http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~West%20Virginia%20Part%20B%20Carrier~Medical%20Policies~LCDs%20and%20NCDs?open&expand=1

Patient Eligibility / Claim Status Information / C-Snap


July 2010 Average Sales Price (ASP) Files Are Now Available

www.cms.hhs.gov/McrPartBDrugAvgSalesPrice

Quarterly Update to Correct Coding Initiative (CCI) Edits

Version 16.3, Effective October 1, 2010


Informative articles on "Proposed Rule for 2011 Physician Fee Schedule"

Centers for Medicare & Medicaid Services – SUMMARY

American Society of Clinical Oncology - SUMMARY

American Society of Hematology – SUMMARY

Association of Community Cancer Centers (article at bottom of page) – SUMMARY

Community Oncology Alliance – SUMMARY

(HOLD)
MOUNTAIN STATE BCBS PROVIDER WORKSHOPS

Mountain State Blue Cross Blue Shield has announced the dates for their 2010 Provider Workshops. For those unable to attend the workshops, the company plans to offer webinars. These workshops are an excellent means of obtaining the latest news about the plan.

Here are the locations for the fall conferences. Each conference will run from 8:00 AM – 12:45 PM. More information about the workshops and the webinars, as well as registration forms, is available on Mountain State website, www.msbcbs.com.

Wednesday, September 15—Wheeling, WV—Oglebay Park
Wednesday, September 22—Beckley, WV—Tamarack
Wednesday, September 29—Parkersburg—Mountain State Corporate Office
Wednesday, October 13—Morgantown—Lakeview Resort
Wednesday, October 19—Charleston—Holiday Inn Charleston House

Mountain State BCBS Provider News August Issue AVAILABLE HERE

Articles of interest:

- Credentialing Information No Longer Required for Physician Assistants (p7)
- Influenza Vaccination News (p8)
- Cellular immunotherapy with sipuleucel-T for treating prostate cancer now covered. Effective: Aug. 16, 2010 (p21)
**Question:** I have been billing oncology claims for more than 10 years but sometimes I just need a refresher! When a patient comes to our office on Monday and we initiate a pump (96416) and then the patient returns on Tuesday and we take off the existing pump, flush the port, change the batteries, etc. My manager says we should bill another “Initiation of pump” 96416. Is this correct?

**Answer:** No, if a patient returns to your office to have a pump refilled, then you should bill the CPT code 96521, “refilling and maintenance of portable pump”.

**Question:** I keep hearing all kinds of stuff about ICD-10. Can you tell me when it is actually coming? I’ve been hearing about this the entire time I have been a biller!

**Answer:** While the threat of ICD-10 has been out there for years, CMS states that beginning October 1, 2013, all providers will be required to use the ICD-10 coding system. Currently you are hearing about the change to Version 5010 transitions occurring by January 1, 2010. This change is occurring to accommodate the new diagnosis coding system on the horizon. To read more about ICD-10, visit the following CMS website: [http://www.cms.gov/ICD10/](http://www.cms.gov/ICD10/).

**Question:** What is the difference between modifier 25 and 59, to me they are the same thing!

**Answer:** They both are similar and used for identifying a separately identifiable service. Modifier 25 is used with E & M visits while the 59 modifier is used with services, like our administration codes;

25 = Definition:
- Significant, separately identifiable evaluation and management (E/M) service by the same physician* on the day of a procedure

59 = Definition:
- Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances.

**Question:** Sometimes our PA is alone in the office seeing only Medicare patients. Can you tell me if we bill using her provider number, will our drug reimbursement be cut?

**Answer:** No, drug reimbursement will remain the same, ASP +6%, even when you are billing under the midlevel provider. All of the services, ie; office visits, administration codes, etc., will be reimbursed at the physician fee schedule minus 15%.

**Question:** Can you explain the difference between a deductible, co-pay(ment) and out of pocket?

**Answer:** The deductible is the amount you must pay for health care before insurance begins to pay. These amounts can change every year. A co-payment is the amount due after the insurance has paid. Out of pocket expenses would include both of these items or anything that is not covered by the insurance and appropriate to bill to the patient.
**Question:** What are the differences in HMO, PPO, PFFS, SNP and MSA plans?

**Answer:** Health Maintenance Organizations (HMO) - Just like the private sector, HMO is a group of doctors, hospitals and other care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You get your care from the provider in the plan.

Preferred Provider Organization (PPO) - Doctors, hospitals and providers that belong to the network and with most PPO plans, you can use doctors, hospitals and providers outside the network for an additional cost.

Private Fee for Service (PFFS) - These are sometimes referred to as regional PFFS since the doctor or hospital accepts payments from the insurance plan rather than Medicare. The insurance plan decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare covered benefits.

Special Needs Plan (SNP) - A type of plan for people with chronic illnesses or conditions with special needs.

Medical Savings Plans (MSA) - A type of savings plan for those people who do not go to the doctor often but need a savings plan to pay some of the costs of the deductibles and co-payments.

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**Question:** If we do a push of Adriamycin and it takes the nurse 25 minutes to do the push, can we bill for an infusion because the push took longer than 15 minutes?

**Answer:** A push is a push no matter how long it takes. The AMA CPT book does not have a code for a long push and therefore you must utilize a push code regardless of the time it takes.

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**Question:** With all the recent information about documentation and audits I am confused. Does a nurse have to write down the time of a push or can she just document that it was done?

**Answer:** Since the push is not a time based code, the time is not a factor. Infusions for example are time based and documentation of the time of the infusion is a requirement.
Recent Oncology Nursing News

The Nurse’s Role When a Patient Takes Medicinal Cannabis

Source: The Oncology Nurse-APN/PA

New literature review highlights the dilemmas faced by nurses caring for patients making therapeutic use of cannabis outside the law.

“Nurses are increasingly likely to deal with patients using medicinal cannabis and it is important that they put their personal views to one side and deal with the health consequences of that drug use,” said Anita J. Green, summarizing her research with Kay De-Vries in a press release accompanying the article September issue of Journal of Clinical Nursing.

This is particularly relevant to those nurses practicing in one of the 36 states without a medical marijuana law. To examine the pharmaceutical qualities of cannabis and the use of cannabis as a clinical intervention for palliative care, Green and De-Vries, both nurses practicing in the United Kingdom, reviewed more than 50 published papers along with professional guidelines and government guidance documents, official reports, and media coverage, from 1196 to 2009.

Read the entire article HERE

Oncology Nursing Society Two Day Chemotherapy/Biotherapy Courses offered for 2010 at Fairmont General Hospital

Fairmont General Hospital is offering a series of five two day ONS courses to teach nurses about chemotherapy and biotherapy agents and their side effects. The course is not intended to be a certification course and nurses who take the course must still be observed at their own facility for competency in actual administration skills. There is a test at the end of the course and those participants who receive an 80% or higher receive a card that is good for 2 years stating that they have successfully completed the course. Additionally, 13.5 contact hours will be awarded for the course. All courses are taught by Tricia Julian, RN, BSN, OCN who has taught the course for the past 11 years. All classes are held at Fairmont General Hospital in Fairmont, WV. Both days of the course are from 8 AM to 4:30 PM. Cost of the course is $190.00 per participant.

Dates of courses with deadlines for registration are;

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<th>COURSE DATE</th>
<th>DEADLINE FOR REGISTRATION</th>
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<tr>
<td>September 21 &amp; 23, 2010</td>
<td>August 31, 2010</td>
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<tr>
<td>November 9 &amp; 11, 2010</td>
<td>October 19, 2010</td>
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For more information call Tricia Julian at 1-304-367-7247 or e-mail at julpa@fghi.com.
Cancer related fatigue (CRF) is still rated the most distressing side effect of all cancer therapies by patients and yet most of them do not receive any education or forewarning about fatigue. According to Ahlberg, et al., (2003), it is estimated that 70% -100% of all patients with cancer suffer from CRF which can be more distressing and disruptive to daily activities than pain. The National Comprehensive Cancer Network (NCCN) defines cancer related fatigue as an unusual, persistent, subjective sense of tiredness related to cancer or cancer treatment that interferes with usual functioning. Fatigue is not the same as tiredness. Tiredness happens to everyone, usually after activity or exercise and is relieved by sleep or rest. Fatigue, on the other hand, is a daily lack of energy that is not relieved from rest and not caused from activity or exercise. It can prevent a person from functioning normally and impacts their quality of life including mood, relationships, and job performance and is fairly constant. The specific mechanisms involved in the development of CRF are not completely known, but both physiologic and psychological factors seem to be involved.

Read the complete article HERE

One goal of the ongoing health care reform debate is to increase access to care through insurance reform. In contradistinction to these efforts, the future shortage of health care professionals will clearly limit such access. In cancer care, shortages of health care professionals will occur in conjunction with a growing older population, expanded treatment options, and increased cancer survivorship. Cancer care is distinguished by its interprofessional and multispecialty model. The ASCO Fall 2008 Workforce Statement urged development of the workforce to ensure continuous delivery of high-quality cancer care. Developing new strategies for oncology care delivery by increasing the numbers and expanding the roles of nonphysician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs), is critically important to meet the current and potential cancer care needs of the US population. There are differences that each discipline brings, and this article will present an overview of advanced practice registered nurses (APRNs) in oncology and demonstrate potential collaborative opportunities for the Oncology Nursing Society (ONS) and ASCO in closing the gap between demand and supply.

Read the entire article HERE
Disease-specific advance care planning: Conversations emphasize patient preferences and provide clarity

Advance care planning (ACP) discussions are not sufficiently incorporated into the care of oncology patients. Studies have consistently found that patients with late-stage cancer have a low rate of completing advance directives (ADs). Yet even the completion of ADs or appointment of proxies may be insufficient to address end-of-life decision making needs that may arise. Disease-specific advance care planning (DS-ACP) was developed to address many of the weaknesses of current end-of-life planning methods. Initial studies have suggested that DS-ACP can improve the experience of patients with chronic conditions. This article describes DS-ACP and how it can benefit oncology patients, their proxies, and providers.

Read the entire article HERE

West Virginia Oncology Nursing Society Chapters

North Central West Virginia ONS Chapter:
http://ncwv.vc.ons.org/

- Announcements
  - Click here to subscribe to the Chapter Announcements.

Ohio River Cities ONS Chapter:
http://ohioriver.vc.ons.org/

- Serving Northern WV, Fayette and Green Counties in Pennsylvania, and Western Maryland. The North Central West Virginia Chapter invites you to browse our site and participate in our events and other offerings.

The Ohio River Cities Chapter serves the counties of Boyd, Carter, Greenup, and Lawrence in KY; Gallia, Lawrence, Pike, and Scioto in OH; and Cabell and Wayne in WV.

The Ohio River Cities Chapter welcomes new members. Membership in the Ohio River Cities Chapter of the Oncology Nursing Society is open to all nurses who are members of the Oncology Nursing Society. Membership is open to pharmaceutical reps, as associate members, if they are national members of the Oncology Nursing Society and non-nurses.

Contact Kristie Meeker at MeekerK@somc.org if you are interested in becoming a member or know someone who might like more information about membership.

Visit ORC Chapter website for archived newsletters, minutes and photos of the 2009 Regional Cancer Nursing Symposium. http://ohioriver.vc.ons.org/
In the June and July NGS Medicare Monthly Review they announced updates to the following drugs:

- Avastin
- Carboplatin and Taxotere
- Etoposide and Oxaliplatin
- Paclitaxel
- Erythropoiesis Stimulating Agents
- Alteplase Recombinant and Epriubicin
- Floxuridine and Fulvestrant
- Ifosfamide and Irinotecan
- Paclitaxel and Panitumumab and Torisel
- Topotecan

Many of the updates now state: “Correct Coding requires the use of the secondary cancer code (196, 197, 198 and 199 series of ICD-9-CM codes) as the primary diagnosis and the original cancer site (V10 series of ICD-9-CM codes) as the secondary diagnosis”.

To read more about this [CLICK HERE](http://www.ngsmedicare.com/lcd/LCD_L25820.htm).

Here is the link to review all Drugs and Biologic LCD:

[http://www.ngsmedicare.com/lcd/LCD_L25820.htm](http://www.ngsmedicare.com/lcd/LCD_L25820.htm)

Local Coverage Determination and Article Revisions Effective September 2010

Below is a list of a few of the changes that can directly affect hematology oncology. For detailed information, please click on [www.NGSMedicare.com](http://www.NGSMedicare.com), select your Business Type and your Region and click “Go.” On the Provider Specific Portal Home Page, under News and Publications, click on What’s New from the drop down menu. This article was dated 9/1/2010.

- Article for Iron Sucrose, Iron Dextran and Ferumoxytol, (Intravenous Iron Therapy) – Related to LCD L25820 (A48420)
- Article for Paclitaxel (e.g., Taxol®/Abraxane™) – Related to LCD L25820 (A46758)
- Article for Sodium Ferric Gluconate, (Intravenous Iron Therapy) – Related to LCD L25820 (A46105)
- LCD for Stem Cell Transplantation (L30183)
- Article for Zoledronic Acid (e.g., Zometa®, Reclast®) – Related to LCD L25820 (A46096)

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1. Citations and links are omitted for brevity. For detailed information, please refer to the original source.
**How to Avoid the Top Hospice Claim Submission Errors**

*Attention Hospice Providers*

The National Government Services Provider Outreach and Education department will conduct the How to Avoid the Top Hospice Claim Submission Errors teleconference on September 14, 2010. This session will educate providers on how to review, resolve, and most importantly, prevent the top claim errors from being rejected or returned to your facility due to missing, invalid, or incorrect information.

**Date:** Tuesday, September 14, 2010  
**Time:** 1:00 p.m. ET

Registration for this session is now open. Visit our Web site for details at www.NGSMedicare.com. Choose Home Health and Hospice and your state (Region) and select “Go.” Select the Calendar of Events option under the Education and Support category (on dark blue navigation bar). Your registration is complete only when you receive a confirmation at your e-mail address immediately after submitting your registration.

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**Discarded Drugs and Biologicals Policy at Contractor Discretion**

This article is based on Change Request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the JW modifier (Drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

Change Request 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the JW modifier. [DETAILS](#)

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**Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window – Outpatient Services Treated as Inpatient**

On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010,” Pub. L. 111-192. Section 102 of the law pertains to Medicare’s policy for payment of outpatient services provided on either the date of a beneficiary’s admission or during the three calendar days immediately preceding the date of a beneficiary’s inpatient admission to a “subsection (d) hospital” subject to the inpatient prospective payment system, “IPPS” (or during the one calendar day immediately preceding the date of a beneficiary’s inpatient admission to a non-subsection (d) hospital). This policy is known as the “3-day (or 1-day) payment window.”

For more information, please click on [www.NGSMedicare.com](http://www.NGSMedicare.com), select your Business Type and your Region and click "Go." On the Provider Specific Portal Home Page, under News and Publications, click on What's New from the drop down menu. This article was dated 8/8/10
ACCC Efforts Pay Off: Drug Reimbursement in Hospital Outpatient Departments Set to Increase in 2011

The proposed **2011 Hospital Outpatient Prospective Payment System** rule has been put on public display by the Centers for Medicare & Medicaid Services (CMS). In the 2011 proposed rule, CMS announced that reimbursement for drugs and pharmacy services will increase to ASP+6 percent from the current level of ASP+4 percent. ACCC has advocated for this change for the past three years, ever since reimbursement began to decrease in 2007.

In meetings with CMS staff and in testimony before the APC Panel, ACCC has stated that hospitals should be reimbursed at least ASP+6 percent, if not higher, for drugs and their associated pharmacy costs. ACCC data have shown that pharmacy overhead costs are higher than CMS allows for, and, therefore, the ASP+ number should be higher. Each year, CMS listened, but continued to decrease the reimbursement. ACCC continued to push for its position, and it appears that all of that effort has finally paid off.

While ACCC does not agree with every aspect of the proposed rule and will be submitting comments to CMS about those issues, ACCC is pleased that CMS has finally recognized our efforts and our data.

The comment period for this rule closes on August 31. ACCC will submit comments during that period. We anticipate the final rule by Nov. 1, 2010.

**CLICK HERE** to read payment allowance limits for Medicare Part B drugs effective July 1.

(1) Source: ACCC

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**Timely Claims Filing: Additional Instructions**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7080 to expand the Medicare fee-for-service (FFS) reimbursement instructions outlined in CR 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

**Key Points to Change Request 7080:**

- For institutional claims that include span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 claim form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item “From” date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- Be Aware: If a line item “From” date is not timely, but the “To” date is timely, Medicare contractors will...
split the line item and deny untimely services as not timely filed.

- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

To read the complete article click on www.NGSMedicare.com, select your Business Type and your Region and click "Go." On the Provider Specific Portal Home Page, under News and Publications, click on What's New from the drop down menu.

(1) Medical Record Retention and Media Formats for Medical Records
For more information on this important topic:

(1) NGS SEPTEMBER MEDICARE MONTHLY REVIEW
Now Available…HERE

Articles of Note:
- CERT Alert: Observation Services Billing (pg3)
- Medical Policy Updates Effective September 2010 (pg 10)
- Signature Guidelines for Medical Review Purposes (pg 17)
- Timely Claims Filing: Additional Instructions (pg 28)
- Medical Record Retention and Media Formats for Medical Records (pg 30)
- 5010 Implementation-Processing Additional International Classification of Diseases, 9th Revision-Clinical Modification Diagnosis and Procedure Codes in Pricer, Grouper, and the Medicare Code Editor (pg 35)
- Version 5010 Implementation-Changes to Present on Admission Indicator ‘1’ and the K3 Segment (pg 43)
- Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative and Electronic Prescribing (E-Prescribing) Feedback Reports (pg 49)

(1) Informative articles on
"Proposed Rule for 2011 Hospital Outpatient Prospective Payment System Fee Schedule"

Centers for Medicare & Medicaid Services – SUMMARY
American Society of Hematology – SUMMARY
Association of Community Cancer Centers – SUMMARY

(HOLD)
**WVOS Oncology Outpatient Hospital Reimbursement Q & A's**

**Question:** What is the difference between "pass through" and "non pass through" when billing outpatient drugs?

**Answer:** Pass-through payments for specific drugs, biologicals, and devices used in the delivery of services that meet the criteria for pass-through status are generally items which are generally too new to be well represented in data used to set payment rates.

To read more about this please refer to Chapter 17, Section 10 - Payment Rules for Drugs and Biologicals (page 5) of the CMS Manual; [https://www.cms.gov/manuals/downloads/clm104c17.pdf](https://www.cms.gov/manuals/downloads/clm104c17.pdf)

**Question:** I heard that the UB-04 Revenue Codes have been revised. Where can I find them?

**Answer:** They are listed on the NGS site. Below is the link to the PDF list: [http://www.ngsmedicare.com/pdf/294_0810_UB_04_Revenue_Codes.pdf](http://www.ngsmedicare.com/pdf/294_0810_UB_04_Revenue_Codes.pdf)

**Question:** Where do I find a current outpatient hospital ASP 4% ASP file? It seems that the ones I have been able to find haven't been updated in a long time!

**Answer:** I do not know of a resource for CURRENT ASP +4% pricing. Most use the Part B pricing files which are set at ASP +6% and available on the CMS website in Excel format. They back off the 6% and then add in the additional 4% to have an accurate figure.

**Question:** I am new to the whole outpatient billing system, I come from a private practice. Do you know of any resource that gives an overview of the process?

**Answer:** Yes, CMS, through the Medicare Learning Network, published a Payment System Fact Sheet focused on the Hospital Outpatient Prospective Payment System (HOPPS). I have provided the link below: [https://www.cms.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf](https://www.cms.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf)

**Question:** What are the billing guidelines when the beneficiary is enrolled in a Medicare advantage plan during the home health episode, then switches to Medicare?

**Answer:** A new Outcome and Assessment Information Set (OASIS) assessment must be completed when a beneficiary is covered under a Medicare Advantage plan and subsequently switches to traditional Medicare during a home health episode. These guidelines can be found on the CMS Web site in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 10, Section 10.1.5.2
Overkill On Overfill?
Source: Roberta Buell, onPoint Oncology LLC

In Oncology, it is common that some of the vials that are distributed to the offices and hospitals have more drug in them than is advertised on the label. This is called the 'overfill'. Manufacturers sometimes put in small amounts of "overfill" in drug containers as a way to compensate for the portion of the product that may be lost when the drug is drawn up.

As we have reviewed previously, on July 13, 2010, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that would implicitly change Medicare Part B billing parameters for drugs and biologics.

The proposed rules amplify current CMS regulations to specify that payment under Medicare is unavailable for the portion of a drug or biologic in a container or vial that exceeds the amount specified on the product's approved label.

So, the proposed rule CLARIFIES that the amount of a drug or biologic that is reimbursable under Medicare is limited to the amount that the provider actually purchases, or the amount printed on the label. The PROPOSED RULE makes these points:

- Medicare average sales price (ASP) payment calculations depend upon the amount of a product in the vial or container as indicated on the product’s approved label.
- Payment for portions of a product in excess of the amount indicated on the product’s approved label will not be made by the Medicare program.

HOWEVER, CMS explains that the proposed rule is actually not a change in policy but rather as a clear statement of existing policy. CMS states that it is "longstanding Medicare policy" that allows providers to bill only for those services or supplies that represent an expense to the provider. CMS specifically notes that providers may not bill Medicare for overfill drawn out from vials and pooled from more than one container, because such overfill amounts do not represent a cost to the provider. According to CMS, if you bill for the overfill, this may subject such provider to "scrutiny and follow up action by CMS, its contractors, and OIG."

While this really is an old rule, who does the "clarification" benefit? Well, it may cost providers and, possibly, the Medicare program more because there is less extracted from each vial. Yet, it makes life easier for auditors, investigators, and others to enforce billing for overfill as a program overcharge. The deadline for comments to CMS regarding the proposed rule was 5:00 p.m. on August 24, 2010.
WVOS is keeping an eye on the West Virginia RAC Contractor - Connolly Healthcare

Connolly Healthcare recently posted multiple new CMS “Approved Issues” targeting OUTPATIENT HOSPITAL on their website. Some include:

- Darbepeotin alfa (ESRD) - Dose vs. Units Billed
- Irinotecan - Dose vs. Units Billed
- Docetaxel - Dose vs. Units Billed
- Carboplatin - Dose vs. Units Billed
- Bevacizumab - Dose vs. Units Billed
- Darbepeotin alfa (non-ESRD) - Dose vs. Units Billed

WVOS will continue to keep an eye on the site and provide an updates when available.


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**4th Annual Oncology Summit**

September 14-15, 2010 • Tysons Corner Marriott • Vienna, VA

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**CASE STUDY HIGHLIGHT**

Breakthrough Drugs — Challenges in Developing New Chemical Entities/New Chemical Classes/ New Mechanisms of Action Drugs — Clinical Research versus Clinical Development

Attend this session and have the opportunity to review a case study on CPI 613 as a single agent and in combination with gemcitabine for the treatment of patients with solid tumors in an escalating dose phase I clinical study. You don’t want to miss it — Register today!
Don’t Miss Out on the $350 Million UnitedHealth Group Settlement

Have you filed a claim yet in the $350 million UnitedHealth Group settlement? If you haven’t, time is running out to collect your share.

UnitedHealth agreed to the settlement to compensate physicians and their patients for 15 years of artificially low payments for out-of-network services. You’re eligible to file for damages if you provided covered out-of-network services or supplies between March 15, 1994, and Nov. 18, 2009, to a health plan insured or administered by UnitedHealth or its subsidiaries and have billed for those services.

Claim forms need to be completed and submitted by Oct. 5, so start the filing process today. Ask the settlement claims administrator for a copy of the defendant’s report, which indicates the covered out-of-network services and supplies you provided your patients from Jan. 1, 2002, to May 28, 2010. It may take several weeks before you receive the report, so the sooner you request your copy, the better.

The AMA offers various resources to help physicians file a claim, including an educational webinar, a comprehensive list of frequently asked questions and a step-by-step guide to help you maximize your recovery from the settlement. Visit www.ama-assn.org/go/ucrsettlement to view these resources.

CPT: The Gold Standard for Coding

Physicians know that three simple letters—CPT®—describe a code set and that Current Procedural Terminology (CPT®) makes it possible for physicians and insurance companies to communicate about services rendered. Using a CPT® code, physicians can file an insurance claim and identify that an appendectomy was performed or Strep pharyngitis was treated, and the insurance company knows what services to pay for.

The CPT® code is to the health care industry what a dictionary is to the publishing industry.

What is not known, and what is surrounded in mystery and sometimes misperception and falsehood, is where CPT® codes came from and how they are maintained.

In 1966 the AMA established CPT® codes, and they were subsequently and voluntarily adopted in the United States as the code set for choice for insurance claims filing. This meant that physicians could use one code set regardless of the insurance payer. In 1983, the AMA House of Delegates voted to have CPT® codes adopted as Medicare’s official terminology.

The association later finalized an agreement with the Health Care Financing Administration, now named the Centers for Medicare & Medicaid Services (CMS), to adopt CPT® for reporting physician services under Medicare and related programs. This agreement is not exclusive (CMS could sanction other code sets) and not binding on private insurance companies. And the AMA derives no income from the federal government for the agreement.
The CPT® codes are physician-developed and maintained. A CPT® Editorial Panel made up of physicians from different specialties guides the process, and an advisory panel that includes 90 physician specialty societies and 16 nonphysician health care societies assures that the codes are up to date and new codes are developed as needed.

Code change proposals are submitted by the physician and nonphysician societies and by individual physicians around the United States. Codes for the H1N1 influenza vaccine last year are an example of new codes and modifications of old codes that are made every year.

The financial resources invested in the development and maintenance of the CPT® codes has been provided solely by the AMA. The AMA in turn sells and licenses the CPT® codes for use in other publications, and uses the funds received to assist important programs in support of the medical profession. Physicians using CPT® codes are employing a tool that is essential for filing claims and supporting the work of the AMA in advocating for physicians.

CPT®—physician-developed, physician-owned, physician-maintained—is supporting physicians in their practices.

Cecil M. Wilson, MD, President

AMA pleased with Medicare Tobacco Cessation Counseling Expansion

The Centers for Medicare & Medicaid Services (CMS) this week expanded Medicare coverage of counseling to help patients stop smoking, a move that drew applause from the AMA. The AMA has long supported an expansion of coverage to all Medicare patients who smoke so all seniors can benefit from counseling that can help prevent life-threatening diseases associated with tobacco use.

"This expansion of coverage takes an important step toward helping Medicare patients lead healthier, tobacco-free lives," AMA President Cecil B. Wilson, MD, said.

Read more from Dr. Wilson.

View a CMS news release about the coverage expansion.

Genomic Index of Sensitivity to Endocrine Therapy for Breast Cancer

http://jco.ascopubs.org/content/early/2010/08/09/JCO.2010.28.4273.abstract
NCCN has published updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™) and NCCN Drugs & Biologics Compendium (NCCN Compendium™) for Acute Myeloid Leukemia. These NCCN Guidelines™ are currently available as Version 3.2010. The version change represents the removal of gemtuzumab ogozam due to its withdrawal from the U.S. market.

For the complete updated versions of the NCCN Guidelines™ and the NCCN Compendium™ please visit NCCN.org.

Commentary – Access to Cancer Care in the Era of Restricted Provider Networks

There is broad consensus that the United States’ current health care system is deeply flawed and that trends in health care spending are unsustainable. The recent health care reform bill (the Patient Protection and Affordable Care Act or PPACA) offers an opportunity to kick start changes that are badly needed. Where substantial disagreement exists, of course, is where it’s always found: in the details. We can all agree that it is essential to reduce ineffective care and costs; inefficient providers of care must be given reasons to become more efficient. But how?

New Addition to the Complete Library of NCCN Guidelines

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™) for Waldenström’s Macroglobulinemia/Lymphoplasmacytic Lymphoma were recently published as an addition to the Complete Library of NCCN Guidelines™. Previously, information for treating Waldenström’s Macroglobulinemia was included in the NCCN Guidelines for Multiple Myeloma.

Confirming a diagnosis of breast cancer in women with suspect lesions is possible to do in just 1 day, and improves patient access to treatment and clinical trials, research has shown.

A review of all clinical, pathological, biologic, and imaging data collected over the past 6 years at a specialist breast cancer diagnosis unit shows that three-quarters of women had a confirmed positive or negative result by the end of the day. The median wait time for an exact diagnosis was 15 days for the remaining 25% of patients.
When E&M coding patterns didn't match up with national benchmarks, one practice audited and overhauled its coding mentality.

At a time when the economy is straining the bottom line of medical practices, and rising healthcare costs are under scrutiny, evaluating how often your doctors undercode could mean thousands of dollars in revenue. The evaluation and management of patients represents a major portion of revenue generated by medical practices. When our practice compared our 15 physicians' E&M coding patterns with national benchmark data, we discovered evidence of "safe" coding practices – doctors selecting intermediate codes for E&M visits.

MGMA submitted comments on the proposed 2011 Medicare Physician Fee Schedule. Among other recommendations, MGMA commented on the following areas:

- Revision and rebasing of the Medicare Economic Index
- Multiple imaging procedure payment reductions
- Electronic prescribing incentive payments
- Reprocessing of claims for various 2010 physician services.

Read MGMA’s full comments.

"I see it all the time," says Doral Davis-Jacobsen, MBA, CMPE, MGMA member and manager of Dixon Hughes PLLC, Asheville, N.C. That is, a list of common collections oversights in medical practices, large and small, that cost organizations thousands – and sometimes millions – of dollars. Here are five from that list and how to solve them.

5 Common Collection Oversights – And How to Solve Them

How to Convince Physicians to Stop Undercoding

(1)
As advocated for by MGMA, the Centers for Medicare & Medicaid Services (CMS) recently published the latest PQRI report showing common reporting errors by measure for the first quarter of this year. This information is essential for practices participating in PQRI because it enables them to identify and correct their own potential reporting errors. Additionally, medical groups contemplating PQRI participation in 2011 should review the report to learn from other practices' reporting errors.

In addition, CMS officials recently indicated that the 2009 PQRI and 2009 electronic prescribing payments and feedback reports will be available around October 2010.

Get more PQRI information at mgma.com/pqri and cms.gov/pqri.

Medical experts have recommended the US Food and Drug Administration (FDA) withdraw approval of Roche’s best-selling cancer drug Avastin for the treatment of breast cancer.

Experts on the advisory panel voted 12 to one to recommend that the FDA remove the indication from Avastin’s label that the drug be used with chemotherapy to treat advanced breast cancer.

Read the complete article HERE

Brain Metastases in HER2-positive Breast Cancer: The Evolving Role of Lapatinib

Date: November 16, 2010
Time: 9:00am-4:00pm
Location: Days Hotel, Flatwoods, WV
RSVP: by October 30, 2010
With federal healthcare reform enacted and the cost of care escalating, community oncologists are challenged not only to remain up-to-date on clinical research but also to find new ways to cover their patients’ expenses and their own operating costs. In this discussion, editor-in-chief Mark Krasna, a surgical oncologist, asks the experts what community practices can expect in 2010. Although this is a politically charged area, our panel focuses on the practical aspects of delivering the highest quality of care.

Mark Krasna (MK): Besides those changes legislated at the national level through the Patient Protection and Affordable Care Act, are there trends of healthcare reform already taking hold in the private sector?

Michael Blau (MB): There are some common aspects between the legislative level and the private payer sector. The concepts of value purchasing, cost containment, a new value proposition dealing with medically unnecessary services, bundled pricing and episodes of care, and/or shared cost-savings with providers are all trends that are occurring in the private sector regardless of whether they are legislated or mandated as part of healthcare reform. Currently, there are demonstration projects, and pilot projects in these areas by private payers.
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Please feel free to submit articles, announcements, and other information for publication in the WVOS Oncology Review to Michelle Weiss, Associate Director, at admin@wvos.info

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