WVOS Fall Membership Meeting Summary

On Thursday, October 28, 2010, the WVOS convened its Fall Meeting at the Erickson Alumni Center in Morgantown. John Azar, M.D., WVOS President, provided opening remarks and an update on the society followed by a clinical session on “Multiple Myeloma Clinical Forum: Navigating the Path to Achieve Disease Control”, sponsored by Celgene. The meeting continued with Jame Abraham, M.D. who gave an overview on the status of the clinical trial network. Dr. Abraham, along with Dr. Azar, and Jim Frame, M.D., WVOS Vice President, signed the ‘Agreement’ to contract with Oncology Solutions, LLC to collaborate with WVOS in the development of the Network.

Continued on next page...
The evening also included a society financial report by Dr. Azar as well as an Oncology Nursing update from Debbie Falconi, RN, MSN, OCN. She presented an update on her ONS Chapter which has been active for over 20 years. Chapter goals included the promotion of high professional standards of nursing, improved oncology nursing, encouragement of nurses to specialize in oncology nursing and the development and fostering of a culturally diverse membership. WVOS recognized the critical importance of Oncology Nursing in the delivery of high quality cancer care and the need to foster ONS Membership throughout West Virginia. To wrap up the day, Dr. Frame reviewed the goals of WVOS for 2011 as he takes over the presidency of WVOS.

The WVOS Fall meeting continued the next day with a joint meeting with the WVU School of Medicine, Mary Babb Randolph Cancer Center, and WVU Office of Continuing Education. Many WVOS Board Members and members at large served as session moderators including Dr. Maria Tirona, Edwards Comprehensive Cancer Center, Huntington, Dr. Jondavid Pollack, Schfiller Cancer Center, Wheeling and Dr. Gerrit Kimmey, Huntington Internal Medicine Group, Huntington.

The morning topics included emerging targeted therapies for breast cancer, an update on breast cancer surgery and reconstruction, the challenges and opportunities of cancer survivorship, an overview of cyberknife stereotatic radiosurgery, therapeutic advances in renal cell carcinoma, and systemic therapy for metastatic colon cancer. Dr. Azar and Dr. Frame launched the afternoon session with a summary of the WVOS accomplishments and future initiatives. Dr. Jame Abraham followed with an overview of the statewide clinical trial network. The afternoon consisted of a lung cancer update, an update on the management of prostate cancer and finally a review of blood and marrow transplantation for follicular lymphoma. The meeting had record attendance with approximately 200 attendees present.

Congratulations to our prize winners
Maria Tirona, M.D., Edwards Comprehensive Cancer Center
and
Melinda Perdue, CTR, Princeton Community Hospital
WE WOULD LIKE TO THANK THE ENTIRE AUDIENCE FOR OUR RECORD BREAKING ATTENDANCE!
November 2nd, 2010

Late this afternoon, the Centers for Medicare and Medicaid Services (CMS) posted the final version of the Physician Fee Schedule and Revisions to Payment Policies for 2011. The final rule, which is titled “Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011,” became available today, November 2, 2010 at around 4:15 p.m. The final notice will be published in the Federal Register on November 29, 2010. In the interim, the final rule can be viewed at [http://www.ofr.gov/OFRUpload/OFRData/2010-27969_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-27969_PI.pdf).

Our very quick read of the impact table in the final rule indicates that hematology/oncology will not face any reduction in reimbursement during 2011. This is an improvement over the proposed 1% reduction for 2011 in the proposed version of this rule that CMS released last summer. Recall that last year CMS announced that hematology/oncology would sustain a 6% reduction to be phased in over four years (2010 through 2013). It appears that much if not all of the portion of this anticipated reduction for 2011 has been mitigated by the rebasing of the Medical Economic Index and other changes.

We will be analyzing the full impact of the final rule and be back with more information. Please also note that the issues addressed in this final notice are separate from the looming expiration date for the latest SGR patch at the end of this month. The overarching SGR issue remains in the hands of Congress and is outside of the scope of CMS’ final rule.

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**McKesson to Purchase US Oncology in a Transaction Valued at $2.16 Billion Combined**

Organization will focus on delivering a robust portfolio of leading-edge solutions to community oncology practices

SAN FRANCISCO and THE WOODLANDS, TX, November 1, 2010—McKesson Corporation (NYSE: MCK), a leading healthcare services and information technology company, and US Oncology, a leading integrated oncology company, announced today that the two companies have signed a definitive agreement under which McKesson will purchase all outstanding shares of US Oncology for cash. Read more.......

New Guideline From ASH and ASCO Recommends Caution Regarding ESA Use in Cancer Patients

An updated joint guideline by the American Society of Hematology (ASH) and the American Society of Clinical Oncology (ASCO) advises physicians about the appropriate use of erythropoiesis-stimulating agents (ESAs), a class of drugs that stimulate the bone marrow to produce more red blood cells, to treat cancer patients with chemotherapy-induced anemia. Read more. (1)

FDA Grants Accelerated Approval for New Dasatinib Indication

On October 28, 2010, the U. S. Food and Drug Administration granted accelerated approval to dasatinib (Sprycel®, Bristol-Myers Squibb), an orally administered kinase inhibitor, for the treatment of newly diagnosed adult patients with Philadelphia chromosome positive chronic myeloid leukemia in chronic phase (CP-CML). The recommended dasatinib dose for this indication is 100 mg orally once daily. Sprycel was originally approved in June 2006 for the treatment of adult patients with CP-CML resistant or intolerant to prior therapy that included imatinib. Read more. (1)

Major Insurer Announces Plans for New Payment Model for Cancer Care

United Healthcare, one of the nation’s largest health insurers, has announced plans to advance a new cancer-care payment model designed to "focus on best treatment practices and better health outcomes." In a first-of-its-kind pilot program that marks a shift away from the current "fee-for-service" payment approach, United Healthcare will begin working with five medical oncology groups around the country to reimburse participating oncologists upfront for an entire cancer treatment program. Read more. (1)

Labeling Changes Regarding Safety Information (fatal fetal pulmonary hypoplasia) for Herceptin®

Trastuzumab is indicated for the adjuvant treatment of HER2-overexpressing breast cancer and for the treatment of HER2-overexpressing metastatic gastric cancers and HER2-overexpressing metastatic breast cancer.

The FDA issued a notice to inform practitioners of important new safety information regarding the already labeled adverse reaction of oligohydramnios (decreased amniotic fluid). Based on post-marketing adverse event reports, cases of oligohydramnios sequence manifesting as pulmonary hypoplasia, skeletal abnormalities, and neonatal death have been reported in the offspring of mothers exposed to trastuzumab during pregnancy.

Full prescribing information, including clinical trial information, safety, dosing, drug-drug interaction, contraindications is available at the FDA website. (1)
ASCO Encourages HHS to Adopt Value-Based, Patient-Centered National Health Care Quality Plan

ASCO’s comments to the Department of Health and Human Services (HHS) regarding the proposed National Health Care Quality Strategy and Plan encourage the adoption of a value-based, patient-focused system that will deliver better health care and quality of life for both patients and communities. ASCO already has established systems for promoting high quality care including the Quality Oncology Practice Initiative® (QOPI) and the ASCO Breast Cancer Registry Pilot Program, funded by Susan G. Komen for the Cure®.

Because over 80 percent of cancer care occurs in the community-based setting, ASCO has established the QOPI system for measuring and promoting quality of care in community-based oncology practices as well as academic medical centers. ASCO urges policymakers to ensure that the National Health Care Quality Strategy and Plan fosters the use of ASCO's QOPI performance measures in oncology to ensure the use of relevant, actionable performance measures for cancer care that are evidence-based and directly linked to improved patient outcomes and quality of life.

The use and adoption of clinical registries that include data from community-based settings are hoped to provide critical insights regarding the cause of health care disparities, and may also point to possible strategies for addressing barriers related to care. In addition, ASCO urges policymakers to support a quality initiative using data from various cancer tumor and clinical registries to pursue a coordinated effort to promote quality of care. Such an effort would result in a system in which rapid learning and discovery could take place on a wide range of issues, including meaningful examinations of the underlying factors resulting in disparities in health care.

To learn more about ASCO’s efforts in the area of quality, visit www.asco.org/quality.

ASH Urges Congress to Prevent Medicare Physician Payment Cuts, Yet Long-Term Medicare Fix Faces Fiscal, Political Hurdles

Congress will reconvene for a "lame duck" session following the November mid-term elections. One of the most pressing issues it will face is the need to pass legislation to prevent a 23 percent Medicare physician payment cut from going into effect December 1. ASH has joined with a number of other medical organizations in sending a letter to congressional leaders urging Congress to take action quickly and provide long-term stability and predictability in Medicare physician payment rates. DETAILS

ASCO to Co-Convene Drug Shortage Summit

ASCO is one of four organizations convening a meeting this week to develop a coordinated effort to address the critical issue of drug shortages. The Drug Shortages Summit, co-convened by the American Society of Anesthesiologists (ASA), the American Society of Health-System Pharmacists (ASHP), and the Institute for Safe Medication Practices (ISMP) will be held on Friday, November 5, 2010 in Bethesda, MD. The invitation only summit will focus on determining the scope and causes of drug shortages, their potential harm to patients, and potential policy changes that could prevent them. Participants in the meeting will then develop an assertive action plan that focuses on ending disruptions in patient care caused by drug shortages.
**Recent Drug News and FDA Approvals**

### New FDA Approval for Afinitor®

On October 29, 2010, the U.S. Food and Drug Administration granted accelerated approval to everolimus (Afinitor®, Novartis), an mTOR inhibitor, for patients with subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS) who require therapy but are not candidates for surgical resection. Afinitor was originally approved in March 2009 for the treatment of adult patients with advanced renal cell carcinoma (RCC) whose disease was resistant to sunitinib or sorafenib. [DETAILS](1)

### Changes in the Measurement of Serum Creatinine which may have an Impact on Carboplatin Dosing

This communication is to inform members of the oncology community of recent changes in the measurement of serum creatinine which may have an impact on carboplatin dosing. Based on preliminary communications with the National Cancer Institute/Cancer Therapy Evaluation Program, a potential safety issue with carboplatin dosing has been identified. (October 10, 2010). [DETAILS](1)

### FDA Drug Shortages

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Formulation</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW</strong> Adriamycin (doxorubicin)</td>
<td>lyophilized powder</td>
<td>DETAILS</td>
</tr>
<tr>
<td>Procrit (epoetin alfa)</td>
<td></td>
<td>DETAILS</td>
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<tr>
<td>Desmopressin Injection</td>
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<td>DETAILS</td>
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<tr>
<td>Etoposide Injection</td>
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<td>DETAILS</td>
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<tr>
<td>Cisplatin for Injection</td>
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<td>DETAILS</td>
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<tr>
<td>Mitomycin for Injection</td>
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<td>DETAILS</td>
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<tr>
<td>Furosemide Injection 10 mg/ml</td>
<td></td>
<td>DETAILS</td>
</tr>
<tr>
<td>Leucovorin Calcium Lyophilized Powder or Injection</td>
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</tbody>
</table>

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)

### FDA Approves Trastuzumab for HER2-Positive Gastric Cancer

On October 20, 2010, the U. S. Food and Drug Administration granted approval for trastuzumab (Herceptin), Genentech, Inc.), in combination with cisplatin and a fluoropyrimidine (capecitabine or 5-fluorouracil), for the treatment of patients with HER2 overexpressing metastatic gastric or gastroesophageal (GE) junction adenocarcinoma, who have not received prior treatment for metastatic disease. [DETAILS](1)

### The Great American Smokeout

Make a plan to quit tobacco **November 18**. Read about resources to help quit smoking. Learn how to break the chain of tobacco addiction.
**Corrected 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.
Corrected 9/15/2010

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

Please report any reimbursement issues you may have to reimbursement@wvos.info and we will help to resolve the issue for the entire state.

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**The Health-PAS Web Portal has been developed to allow WV Medicaid Providers to submit, reverse, and replace claims; verify member eligibility; download forms, manuals, publications, and remittance advices; check the status of claims; and to allow easy access to a provider directory.**

Health PAS Web Portal Provider User Guide **REVISION OCTOBER 2010**

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**Re: Recovery Audit Contractors (RACs) for Medicaid**

October 1, 2010 - Dear State Medicaid Director:
This letter is part of a series of letters intended to provide preliminary guidance on the implementation of the Affordable Care Act (P. L. 111-148). Specifically, this letter provides initial guidance on section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program, which amends section 1902(a)(42) of the Social Security Act (the Act) requiring States to establish programs to contract with RACs to audit payments to Medicaid providers by December 31, 2010.......


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**Some articles of interest:**
- NDC Billing Instructions (p4)
- Multiple NDCs (p4)
- No More Consultation Codes (p5)
- Errors that result in Denied Claims (p6)
- Timely Filing Policy (p8)
- Provider Relations Territory Map (p10)
Radiation with Hormone Therapy for Prostate Cancer Ups Survival

Prostate cancer patients treated with a combination of hormone therapy and radiation have a substantially improved chance of survival compared to patients who do not receive radiation, according to interim results of the largest randomized study of its kind to be presented at the plenary session, Nov. 1, at the 52nd Annual Meeting of the American Society for Radiation Oncology (ASTRO).

From 1995 to 2005, 1,205 men with high-risk prostate cancer in the U.S., the United Kingdom and Canada were randomly selected to receive hormone therapy alone or a combination of hormone therapy and radiation treatment and were followed for at least six years on average. The study was jointly conducted by the National Cancer Institute of Canada, the United Kingdom Medical Research Council and the Southwest Oncology Group in the U.S.

Read the complete article HERE

Annual 7% Increase in Radiation Therapy Patients

According to a recent study published by IMV Medical Information Division, an estimated 1.1 million patients were treated in 2009 with radiation at 2,170 radiation therapy locations in the U.S. Compared to 2007, this represents a 15 percent jump from just over 954,000 patients, for an annual average increase of about 7 percent. The top three cancer site types treated with radiation are breast, prostate and lung cancer, which account for 24 percent, 20 percent and 12 percent, respectively.

Read the complete article HERE

HIFU Offers Promising Outcomes as Prostate Cancer Treatment

With more than 20,000 patients currently being treated in Europe and the results of a recent multicenter study in France offering promising results, researchers are hopeful that high-intensity focused ultrasound (HIFU) will emerge as a primary therapy for selected patients with localized prostate cancer.

Along with impressive cancer survival rates, HIFU delivered outcomes similar to those expected with conformal external beam radiation therapy (EBRT), said Sebastian Crouzet, M.D., an associate professor in the Therapeutic Ultrasound Research Laboratory at the University of Lyon in France. Research by Dr. Crouzet and colleagues was published in the July 2010 online edition of the European Urology journal and presented at the 2010 American Urological Association annual meeting.

Read the complete article HERE

Proton Therapy Safe, Effective for Early-Stage Lung Cancer Patients

Fairfax, Va., October 19, 2010 - Proton beam therapy is safe and effective and may be superior to other conventional treatments for Stage I inoperable non-small cell lung cancer (NSCLC) patients, according to a study in the October issue of the International Journal of Radiation Oncology•Biology•Physics, the official journal of the American Society for Radiation Oncology (ASTRO).

Lung cancer is the number one cause of cancer death for men and women, according to the American Cancer Society. The standard treatment for early-stage lung cancer is surgery to remove all or part of the lung, but for patients with inoperable lung cancer, radiation is commonly used for treatment.

Read the complete article HERE
Introduction Adjuvant local-regional radiotherapy (LRRT) is routinely recommended for breast cancer patients. It is well known to be related to pulmonary side-effects. We studied post-RT radiological changes on X-ray and CT, and correlated the findings with Quality of Life (QoL), common dosimetric factors and co-variates. The results were compared with a previously reported cohort of 137 irradiated women.

Read the complete abstract HERE

Demand for Radiation Therapy Projected to Outpace Supply of Radiation Oncologists

SOURCE: UT MD Anderson Cancer Center

UT MD Anderson research shows tenfold difference between supply and demand over next decade. Between 2010 and 2020, the demand for radiation therapy will exceed the number of radiation oncologists practicing in the U.S. tenfold, which could profoundly affect the ability to provide patients with sufficient access to treatment, according to new research from The University of Texas MD Anderson Cancer Center.

The study, published in the October 18, 2010 issue of The Journal of Clinical Oncology, estimates that over the next decade, the number of cancer patients requiring radiation therapy will increase by 22 percent, while the number of full-time equivalent radiation oncologists entering the workforce will increase by just two percent. Researchers based their calculations on projections that in 2010, 3,943 radiation oncologists will treat an estimated 470,000 patients in the U.S.

Read the complete article HERE

VETERANS DAY
NOVEMBER 11, 2010

WVOS would like to send out a sincere THANK YOU to all our veterans.
News Updates

Providers currently have two options when it comes to the use of HCPCS modifier JW.

OPTION 1: Use HCPCS modifier JW. The directions we have on the use of this modifier differ from those received from CMS. We ask that providers submit using only ONE line with the total dosage, indicating the discarded portion in the documentation field of electronic claims or Item 19 of paper claims.

OPTION 2: Continue submitting drugs with the combined amounts administered and discarded. Document the patient’s medical record with the actual amount administered and the amount discarded.

Juan Lumpkin - Provider Outreach & Education - Palmetto GBA - OH/WV Part B

Read more HERE

Medical Review Results of Widespread Review Chemotherapy Administration Codes

The Palmetto GBA (Ohio/West Virginia) Medical Review Department completed a widespread probe review initiated in April 2010 on chemotherapy administration codes. Please check out the findings and share with appropriate staff.

Read more HERE

Denials: Top Reasons and Procedures

Find denial reasons in plain language and tips for resolving them in the Palmetto GBA Denial Resolution tool. Top denial reasons include services for hospice patients; bundled services; Medicare is the secondary payer; and bundled payment for pre- and post-operative visits.

Read more HERE

Medicare Improves Access to Preventive Services for 2011

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period that will implement key provisions in the Affordable Care Act of 2010. These provisions expand preventive services for Medicare beneficiaries, improve payments for primary care services and promote access to health care services in rural areas. The new policies will apply to payments under the Medicare Physician Fee Schedule (MPFS) for services furnished on or after January 1, 2011.

Read more HERE

Medical Review Findings 4th Quarter

The goal of the medical review program is to reduce payment errors by identifying and addressing documentation and billing errors concerning coverage and coding. The Palmetto GBA Medical Review Department has identified the problem areas listed in this article for the fourth quarter of 2010. Please note this is not an all-inclusive list and is in no specific order. This list reflects the majority of documentation issues discovered during the review process.

Read more HERE
New Remark Codes for Ordering/Referring Providers

If you order durable medical equipment (DME) or other supplies from a DME supplier, ensure that you are providing the supplier with the individual (ordering or referring) provider’s National Provider Identifier (NPI), not the provider group’s NPI. Refer to the instructions in this article regarding remark code N265 for additional information.

Read more HERE

Definition of a 'New Patient' for E/M Services

A ‘new patient’ is a patient who has not received any professional services, such as evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

Read more HERE

Evaluation and Management (E/M) Coding Reminders

This article provides guidance and helpful reminders about submitting Evaluation and Management services.

Read more HERE

Incentive Payment Update for 2009 Physician Quality Reporting Initiative

Incentive payments for the 2009 Physician Quality Reporting Initiative (PQRI) are available this fall for eligible professionals who met the criteria for successful reporting. Carriers and Medicare Administrative Contractors (MACs) will begin processing and distributing 2009 PQRI incentive payments on October 25, 2010. Distribution of 2009 PQRI incentive payments is scheduled to be completed by November 12, 2010.

Read more HERE

Notice of New Interest Rate for Medicare Overpayments & Underpayments: 1st

The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 10.75 percent effective October 22, 2010, for Medicare overpayments and underpayments.

Read more HERE

2011 Medicare Participation Enrollment & Fee Schedule Information

We are again excited to provide you with a CD-ROM packed full of useful information, which will include the 2011 Medicare Participation Enrollment form and other valuable information. We anticipate that the CD-ROM will be mailed in November 2010 and will contain the following: Announcement, Resource and contact listing, and CY 2011 Medicare Participation Enrollment announcement and agreement.

Read more HERE
Counseling to Prevent Tobacco Use

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations. (1) Read more HERE

Part B Redetermination Requests Can Be Accepted Via Fax: Ohio & West Virginia

Effective October 1, 2010, Palmetto GBA will begin accepting Part B redetermination requests via fax. No special preparation is necessary for redetermination requests submitted this way. The redetermination form can serve as the fax cover sheet. All current required elements remain in effect for any requests sent via fax. (1) Read more HERE

ARE YOU LOOKING FOR INFORMATION ON ANY OF THE FOLLOWING?

- Claim Rejections for Beneficiaries Enrolled in Medicare Advantage (MA) Plans (Pg 3)
- Notice of New Interest Rate for Medicare Overpayments and Underpayments – 1st Notification for FY 2011 (Pg 3)
- 2011 Medicare Participation Enrollment & Fee Schedule Information (Pg 4)
- Part B Redetermination Requests Can Be Accepted Via Fax (Pg 5)
- Eligible Physicians and Non-Physician Practitioners who need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries (Pg 14)
- Dot Matrix Printers (Ohio and West Virginia Only) (Pg 19)
- Unprocessable/Rejected Claims (Pg 36)
- October 1, 2010 Maximum Allowed Units Update (Pg 45)
- Counseling to Prevent Tobacco Use (Pg 65)
- Positron Emission Tomography (FDG PET) for Initial Treatment Strategy (PI) in Solid Tumors and Myeloma (Pg 83)
- Medical Director’s Desk – LCD (Pg 85)

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

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

CONFUSION ABOUT COPAYS

(Taken from the October 13, 2010 issue of the WVSMA Westgram)

We’ve had some calls from physician offices about patients complaining to them that they shouldn’t have a copay/coinsurance, etc. due on preventive medicine visits. Apparently, there was a piece on MSNBC that patients saw, which stated that there were to be no more copays for preventive services. This is only partially correct. Per the government website, that only applies to certain plans. Here is the information posted on the healthcare reform website: http://www.healthcare.gov/law/provisions/preventive/index.html

The advice from the WVSMA and AMA has been to verify benefits online when possible and if the health plan website is still showing a copay, the patient will have to address the issue directly with his/her plan. (1)
**WILL YOUR PAYMENTS STOP JANUARY 3, 2011?**

Do you order laboratory tests, radiology services, other types of diagnostic tests, diabetes self management training, medical nutrition therapy or durable medical equipment or supplies? If the answer is yes, your National Provider Identifier (NPI) is entered on claims sent to Medicare as an ordering/referring physician. Beginning January 3, 2011, when those claims reach your Medicare contractor and the NPI entered as the ordering/referring is not in the Provider Enrollment, Chain and Ownership System (PECOS), those claims will reject and not be paid.

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare.

The fastest, easiest way to enroll is through the Internet-based PECOS. To learn more about the January 3, 2011 deadline, review the Centers for Medicare & Medicaid Services Medicare Learning Network (MLN) Matters Special Edition article SE1011.

Please visit the UK CECentral Website at [http://www.cecentral.com/](http://www.cecentral.com/) and type PECOS in the search field to locate a 45-minute course that will help you prepare for secure, online enrollment. This activity has been approved for AMA PRA Category 1 Credits™.

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**CMS RELEASES INCENTIVE PAYMENT UPDATE FOR 2009 PHYSICIAN QUALITY REPORTING INITIATIVE**

Incentive payments for the 2009 Physician Quality Reporting Initiative (PQRI) are available this fall for eligible professionals who met the criteria for successful reporting. Carriers and Medicare Administrative Contractors began processing and distributing 2009 PQRI incentive payments on October 25, 2010. Distribution of 2009 PQRI incentive payments is scheduled to be completed by November 12, 2010. 2009 PQRI feedback reports will be available on the Physician and Other Health Care Professionals Quality Reporting Portal starting the second week of November.

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**NEW – MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL**

Section 6409(a) of the Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, to establish a Medicare self-referral disclosure protocol ("SRDP") that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act).

The SRDP requires health care providers of services or suppliers to submit all information necessary for CMS, on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located on the CMS website at [http://www.cms.gov/PhysicianSelfReferral/](http://www.cms.gov/PhysicianSelfReferral/).
MEDICARE LEARNING NETWORK FACT SHEETS AVAILABLE

The Medicare Learning Network® has several new Fact Sheets available this month. The topics range from E-Prescribing to the Medicare enrollment process. You can access these Fact Sheets and other educational products on the MLN website.

2010 PQRI & ELECTRONIC PRESCRIBING INCENTIVE PROGRAM NATIONAL PROVIDER CALL WITH QUESTION & ANSWER SESSION

The CMS Provider Communications Group is hosting a national provider conference call on the 2010 Physician Quality Reporting Initiative & Electronic Prescribing Incentive Program on Wednesday, November 10, 2010, from 1:30 - 3:00 p.m. EDT. Visit the CMS website to register for the call. Call participants can access a transcript one week after the call on the CMS website.

2010 - 2011 SEASONAL INFLUENZA (FLU) RESOURCES FOR HEALTH CARE PROFESSIONALS

- Keep this Special Edition MLN Matters article and refer to it throughout the 2010 - 2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don’t forget to immunize yourself and your staff.

HEADS UP...PREPAYMENT EDITS ON NEW PATIENT VISITS

As a result of incorrect billing 73% of the time, another Medicare carrier is implementing a prepayment edit on procedure codes 99204 and 99205 for physicians and non-physician practitioners (NPP) of all specialties. While this is NOT Palmetto GBA it is a good idea to audit your own records to make sure this doesn’t happen to us. Please refer to the URL for the article https://www.highmarkmedicareservices.com/bulletins/partb/news09202010.html

CMS MLN MATTERS & LEARNSOURCE ARTICLES

- Clarification of Payment Window for Outpatient Services Treated as Inpatient Services http://www.cms.gov/MLNMattersArticles/downloads/MM7142.pdf
- Twelfth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0: Coordination of Benefits (COB) http://www.cms.gov/Version5010andD0/30_CMS_Communications.asp
- Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season

Continued on next page...
Oncology REVIEW

Newsletter Title

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

October 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

WVOS Underwater Drug Reimbursement Initiative

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

WVOS 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.
PRIVATE PAYER UPDATES

WEST VIRGINIA HEALTH PLANS
The most frequently visited plans are listed below. Click on the links to access the websites.

AETNA
Home Provider

CARELINK HEALTH PLANS
Home Provider

CIGNA
Home Provider

HEALTH PLAN OF OHIO
Home Provider

HUMANA
Home Provider

MOUNTAIN STATE BLUE CROSS BLUE SHIELD
Home Provider

OPTIMUM CHOICE
Home Provider

PALMETTO GBA
Home Provider

UMWA HEALTH & RETIREMENT
Home Provider

UNITED HEALTHCARE
Home Provider

FALL ISSUE AVAILABLE HERE

A FEW ARTICLES YOU WON’T WANT TO MISS:

Precert required for sipuleucel-T (Provenge®) cancer treatments…..pg 2
How to submit the names of your mid-level practitioners…..pg 5
Order free “Navigating Your Health Benefits for Dummies” guides….pg 10
AND MUCH MORE…..

#1 Did You Know….Humana and Walmart have announced an innovative Medicare Part D Prescription Drug Plan with the lowest national monthly premium offered in all 50 States and D.C. Read the complete article

#2 Did You Know….Humana offers Providers with a quarterly publication “Your Practice” which is focused on innovative strategies for practice efficiency. Take a look

#3 Did You Know….Humana is phasing in a process in which all checks that are cut to a provider on a single day will be sent out in one envelope. This new practice is being phased in, so it may take a few months to start seeing any change in the mailings. Humana is aiming to have the transition completed by early 2011.

#4 Did You Know…. The Humana Medicare Advantage Preauthorization and Notification List has been revised as of November 1, 2010. Added to the list are: Azerra; Folotyn; Istdox; Jevtana; Nplate; Provenge; and Sandostatin Lar.

The complete list is available at: http://www.humana.com/providers/claims/pre_authorization.aspx.

Some of the drugs in the list: Aloxi; Aranesp; Avastin; Dacogen; Emend IV; EpoGen; Erbitux; Fusilev; Herceptin; Immune Globulin; Ixempra; Neulasta; Procrit; Reclast; Torisel; Treanda; Vectibix; Velcade; Vidaza; and Zometa.

Preauthorization is required for Humana MA HMO and Humana MA PPO. Notification is requested, but not required for Humana MA PFFS.

Each drug in the list has its own precertification request form that must be filled out. At the bottom of the above list is a link to the individual forms. (1)
Due to the increasing number of oral oncology medications being developed, the potential for expanded off-label use of oncology medications and the associated toxicity and cost of these medications has led UnitedHealthcare to require notification and coverage review for certain oral oncology drugs.

As previously communicated in the UnitedHealthcare Network Bulletin, beginning September 1, 2010, UnitedHealthcare will require notification and coverage review to determine eligibility for coverage for 13 oral oncology medications under the member’s pharmacy benefit plan. Notification applies to the following medications:

- Afinitor®
- Hycamtin®
- Sprycel®
- Tarceva®
- Tykerb®
- Votrient™
- Nexavar®
- Sutent®
- Temodar®
- Thalomid®
- Gleevec®
- Revlimid®
- Tasigna®

Patients who are currently on any of these medications will continue to have coverage as long as they are insured under their current plans. New prescriptions written on or after September 1, 2010 will require notification and coverage review.

Our Notification Program will utilize the National Comprehensive Cancer Network (NCCN) Compendium to help determine coverage of oral oncology medications. This is consistent with our approach for medical coverage of physician administered oncology medications.

We have reviewed a number of cases where cancer patients enrolled in specialty pharmacy programs improves compliance. Accordingly, most UnitedHealthcare benefit plans require that these medications be provided by specialty pharmacies (Prescription Solutions and IVP/Walgreens Specialty Pharmacy) participating in our Specialty Designated Network, which provide clinical management programs and resources that help our members achieve optimal outcomes with their drug therapy. The specialty pharmacy program applies to most of the fully insured commercial population and more than 55 percent of the self-funded commercial population currently.

If physicians wish to begin a review process for a patient, or have questions regarding the oral oncology notification process, they should call Medco, the pharmacy benefit administrator that is providing services for the Notification Program at 800-417-1764.

We understand the urgency and will notify the physician and her/his patient of the coverage determination within two business days of receiving the clinical information for the request. If there is disagreement with the coverage determination, both will be provided with information on how to appeal.

Sincerely,

Lee N. Newcomer, MD
SVP, Oncology
**RECENT BULLETINS & NOTICES**

**Preparing for the Transition to HIPAA Version 5010**  
**Receiving HIPAA Version 5010 Electronic Claim-Related Transactions**  
**Modifier Required for Procedures Reported More Than Once Per Day Effective 1-24-2011**  
**Mountain State to Update List of Procedures Requiring Authorization 92 Additions Effective 2-1-2011; 308 Deletions Effective 12-1-2010**  
**Register Now to attend a National Imaging Association (NIA) Educational and MSBCBS General Updates Webinar.**  
**Mountain State Blue Cross Blue Shield to Delete 242 Codes from Its List of Procedures Requiring Authorization Effective 9-27-2010**  
**Mountain State Prescription Drug Benefit Management Moving to Highmark Effective 1-1-2011**

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**WVOS Private Practice Reimbursement Q & A’s**

**Question:** We gave hydration before and after chemotherapy for 30 minutes. We combined the time and billed for 1 hour of hydration using 96361. Is this correct?

**Answer:** No, the CPT guidelines state, “report 96361 for hydration intervals of greater than 30 minutes”. Since each interval was only 30 minutes you would be outside the AMA CPT guidelines. Please refer to the beginning of the administration section of the 2010 AMA CPT for further information.

**Question:** Our nurses gave a chemo injection – Lupron and billing with the administration code 96402. Additionally the patient was nauseous and we gave an antiemetic using 96367. We were rejected for the 96367 code, why?

**Answer:** CPT 96367 is an add-on code and must be combined with an initial code. Since 96402 is not an initial code, this combination would deny. Most recommend billing the therapeutic infusion as the initial code along with the injection.

**Question:** What Is the Reporting Period for Eligible Professionals Participating in EHR Incentive Programs?

**Answer:** For demonstrating meaningful use through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP’s first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year.  

**Question:** I received payment on a brand new drug (it didn’t have a NOC code yet) but only received the invoice amount. I thought we were supposed to be reimbursed WAC +6% when the ASP isn’t established!

**Answer:** According to the CMS Claims Processing Manual, Chapter 17, Drugs and Biologics: “The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP.”

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**REIMBURSEMENT QUESTIONS?**  
reimbursement@wvos.info
Recent Oncology Nursing News

Most Young Breast Cancer Patients Find Support Groups Good Source of Information, Advice

Source: The Oncology Nurse-APN/PA

After coping with the initial shock of a cancer diagnosis, many women decide to take a proactive approach and seek sound information and advice so that they can make informed decisions about their healthcare. The Oncology Nurse recently spoke with two young women who found that support groups were a valuable resource for obtaining information and forming bonds with other patients and survivors. One went on to create her own group to help women with specific needs she felt were not being met based on her own experience. (1)

Read the entire article HERE

Doctor of Nursing Practice: An Oncology Nurse Practitioner's Journey

Source: The Oncology Nurse-APN/PA

The Doctor of Nursing Practice (DNP) degree has been designated by the American Association of Colleges of Nursing (AACN) as the graduate degree for advanced practice nurses (APNs). Currently, obtaining this degree remains an option; pursuit of a doctoral degree in nursing is a personal and professional decision made by some APNs. The trend toward doctoral preparation appears to be gaining momentum, however, and after the year 2015 it may be difficult to find a nurse practitioner program that awards a Master of Science in Nursing (MSN). (1)

Read the entire article HERE

Drug Slows Advanced Lung Cancer Progression in Women

[By Deborah McBride, RN, MSN, CPON®, Contributing Editor]

Early trial results showed that erlotinib can extend the life of women with advanced lung cancer who are too sick for conventional chemotherapy, according to a new study. In the trial, 15% of women were alive and had no progression of their cancer 12 months after taking the drug compared with only 5% of those on a placebo. Men had no benefit in overall survival or progression-free survival with the drug.

The study involved 670 chemotherapy-naïve men and women with stage III and IV non-small cell lung cancer, most of whom were too ill to have standard platinum chemotherapy. According to the researchers, more than half of patients with lung cancer fall into the category of being too ill for conventional chemotherapy, for which there is little effective treatment. It is not known why the drug was most effective in women. (1)

Read the entire article HERE

Early palliative care: A focus on enhancing quality of life that begins at diagnosis

Early access to palliative care can significantly improve the lives of patients with metastatic non-small-cell lung cancer (NSCLC), according to a new study. Globally, metastatic NSCLC causes more cancer deaths than any other type of cancer.1 It is estimated that patients live less than 1 year after diagnosis, and that limited survival time is fraught with difficult symptoms and reduced quality of life.2,3 Could the introduction of early palliative care along with standard oncologic care have a positive effect on patients, as well as their utilization of health services, during that difficult time? (1)

Read the entire article HERE
Soy intake linked to lower recurrence of breast cancer in some cancers

Patients with hormone-sensitive cancers may lower their risk of breast cancer recurrence by increasing their soy intake, according to a study published in the Canadian Medical Association Journal (2010 Oct 18. [Epub ahead of print]).

To investigate the effects of soy isoflavones on breast cancer patients receiving adjuvant endocrine therapy, researchers at the Cancer Hospital of Harbin Medical University in Harbin, China conducted a study involving 524 women who had surgery for breast cancer and were followed afterwards for between 5 to 6 years.

Read the entire article HERE

West Virginia Oncology Nursing Society Chapters

West Virginia Chapters Include….

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

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

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/
The information below pertains *strictly* to Outpatient Hospital only.

**CMS sets 2011 Hospital Outpatient, Ambulatory Surgical Center Rates**

*Final rule eliminates out-of-pocket costs for most preventive services*

Medicare beneficiaries will see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a final rule with comment period issued by the Centers for Medicare & Medicaid Services (CMS). The final rule with comment period updates payment rates and policies for services furnished in HOPDs and ambulatory surgical centers (ASCs), and implements changes required by the Affordable Care Act of 2010. READ MORE (1)

**Gateway Transition – Reduction of Capacity for Current National Government Services**

Part A and Part B EDI Gateway Dial-up Users

National Government Services previously announced the elimination of the direct dial-up options and is requiring the use of a Network Service Vendor (NSV) to access to the Electronic Data Interchange (EDI) Gateway. To facilitate this transition, on **Monday, November 1, 2010**, National Government Services will reduce the capacity of the EDI Gateway for direct dial-up and Point-to-Point Protocol (PPP) File Transfer Protocol (FTP) users by 50 percent. This reduction only applies to the National Government Services EDI Gateway for Part A and Part B trading partners.

TO READ THIS ARTICLE IN ITS ENTIRETY, 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 is dated 10/27/10. (1)

**NPI Crosswalk File Issue Requires Resubmission of Rejected Claims**

National Government Services has identified an issue with the daily National Provider Identifier (NPI) crosswalk file. The issue may have potentially caused claims to reject in error. It began on or around October 12, 2010 and impacted all Part B providers in Connecticut, New York, Indiana and Kentucky.

The problem has been corrected. Not all claims would have rejected during this timeframe. However, **if claims were incorrectly rejected as a result of this issue for claims on or around October 12 through October 25, 2010 they must be resubmitted by providers.** National Government Services is attempting to identify the rejected claims and will track the issue through next week to make sure it is completely resolved.

Incorrectly rejected claims can be identified via the following messages:

- N290 - Missing/incomplete/invalid rendering provider primary identifier
- N257 - Missing/incomplete/invalid billing provider/supplier primary identifier
- N433 - Resubmit this claim using only your National Provider Identifier (NPI)

(1)

**Article for Fulvestrant – Related to LCD L25820 (A46755)**

Article Published November 2010: The “Indications” section of the article has been revised to include the following language:

Continued on next page...
Fulvestrant injection is indicated as first-line (no prior endocrine therapy within one year) or subsequent-line (following prior endocrine therapy within one year or progression on another endocrine agent) endocrine therapy for postmenopausal women or for premenopausal women treated with ovarian ablation/suppression who have recurrent or metastatic disease characterized as:

- hormone receptor-positive
- hormone receptor-negative with asymptomatic visceral disease or involvement of bone or soft tissue only
- hormone receptor-positive and endocrine therapy refractory with asymptomatic visceral disease or involvement of bone or soft tissue only

Men with breast cancer should be treated similarly to postmenopausal women, except that use of an aromatase inhibitor is ineffective without concomitant suppression of testicular steroidogenesis.

(1)

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Table 2: Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2010

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 10/1/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9269*</td>
<td>Injection, C-1 esterase inhibitor (human), Berinert, 10 units</td>
<td>9269</td>
<td>G</td>
</tr>
<tr>
<td>C9270*</td>
<td>Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
<td>9270</td>
<td>G</td>
</tr>
<tr>
<td>C9271*</td>
<td>Injection, velaglucerase alfa, 100 units</td>
<td>9271</td>
<td>G</td>
</tr>
<tr>
<td>C9272*</td>
<td>Injection, denosumab, 1 mg</td>
<td>9272</td>
<td>G</td>
</tr>
<tr>
<td>C9273*</td>
<td>Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer’s, including leukapheresis and all other preparatory procedures, per infusion</td>
<td>9273</td>
<td>G</td>
</tr>
</tbody>
</table>

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Tobacco Cessation Benefit Expanded

Source: onPoint Oncology LLC

Patients with diagnoses or treatment that are affected by smoking have been covered for tobacco cessation since 2005. Effective for claims with dates of service on and after Aug. 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries:

1. Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease;

2. Who are competent and alert at the time that counseling is provided; and

3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations. For more information, please refer to all guidelines for smoking cessation on the CAN Web site.

Remember this newsletter is a summary of regulations for Medical Oncology. It is a preliminary reading of complex coding and billing material. There may be typos and misinterpretations. You are responsible for the information on every claim. Reading this newsletter does not substitute for understanding regulations and verifying the validity of every claim.

(1)
Important Information Regarding the Coverage of Sipuleucel-T (Provenge)—National Government Services Coverage Article A50060 as Related to Local Coverage Determination L25820

National Government Services has published a new coverage article for the use of Sipuleucel-T. Providers who report these services are responsible to follow all coding and coverage requirements defined in the coverage article A50060 and corresponding supplemental instruction article (SIA) A44930.

Provenge is covered for the treatment of asymptomatic or minimally symptomatic prostate cancer metastatic to bone and soft tissue in castrate-resistant (hormone-refractory) patients.

For claims submitted to the carrier or Part B Medicare administrative contractor (MAC), Sipuleucel-T (Provenge®) should be billed using Healthcare Common Procedure Coding System (HCPCS) code J3590 (Unclassified biologics). Include the name of the product and the dosage administered in Item 19 of the CMS-1500 claim form or the electronic equivalent.

For claims submitted to the fiscal intermediary or Part A MAC, Sipuleucel-T (Provenge) should be coded using HCPCS code C9399.

Sipuleucel-T (Provenge) is an autologous cellular immunotherapy and therefore the administration of this product may not be billed using a chemotherapy administration code. The administration of the product should be billed using current procedural terminology (CPT) code 96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour.

For complete instructions regarding coding, medical necessity, and documentation, please refer to the LCD for Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L25820). You can access coverage article A50060, Article for Sipuleucel-T (Provenge®) Related to LCD L25820 (A50060), on the CMS Web site.

End-Stage Renal Disease Eligibility/Entitlement Computer-Based Training Now Available in Medicare University at www.MedicareUniversity.com!

Attention Medicare Part A Providers
A computer-based training course (CBT) course for end-stage renal disease (ESRD) providers on Eligibility/Entitlement is now available in Medicare University (MU)! The CBT was developed to provide a basic understanding of the differences between eligibility and entitlement. Also, information will be included regarding ESRD with dual entitlement to Medicare.

Catalog ID  Catalog Entry (Name)
PTA-C-0028  ESRD Eligibility/ Entitlement

Go to www.NGSMedicare.com and accept the agreement on the Web site. On the home page, click on the MU logo and follow the instructions you, will be redirected to the Medicare University log on screen. If you are already a member, you may log in any time to take the course. If you wish to become a new subscriber (free of charge) to Medicare University simply follow the registration instructions!
Now Available from CMS: Written Transcript of the "ICD-10 Implementation in a 5010 Environment Follow-Up" Conference Call

It’s easy to use and offers a host of advantages over the paper-based enrollment process. Do you want to save money and time? The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) can help! Internet-based PECOS can be used in lieu of the paper Medicare enrollment application to:

- Submit an initial Medicare enrollment application
- Verify or change your enrollment information
- Track your enrollment application through the Web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate your Medicare enrollment
- Voluntarily withdraw from the Medicare Program

Use of this automated, online process results in less staff time and administrative costs to complete and submit enrollment information to Medicare.

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. This article is dated 10/11/10.

Fiscal Intermediary Standard System/Direct Data Entry Computer-Based Training Now Available at www.NGSMedicare.com in Medicare University!

Attention Medicare Part A Providers
Computer-based training (CBT) courses for new providers or billers, as well as, staff looking for a Fiscal Intermediary Standard System/Direct Data Entry (FISS/DDE) refresher are now available in Medicare University (MU)! The series of five CBTs were developed to provide a comprehensive overview of FISS/DDE and includes modules on the following functions:

<table>
<thead>
<tr>
<th>Catalog ID</th>
<th>Catalog Entry (Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA-C-0018</td>
<td>FISS/DDE Inquiries Sub-Menu</td>
</tr>
<tr>
<td>PTA-C-0019</td>
<td>FISS/DDE Claims and Attachments Sub-Menu</td>
</tr>
<tr>
<td>PTA-C-0020</td>
<td>FISS/DDE Claim Corrections-Return to Provider</td>
</tr>
<tr>
<td>PTA-C-0021</td>
<td>FISS/DDE Claim Adjustments &amp; Cancels</td>
</tr>
<tr>
<td>PTA-C-0022</td>
<td>FISS/DDE Credit Balance Report Entry</td>
</tr>
</tbody>
</table>

Go to www.NGSMedicare.com and accept the agreement on the Web site. On the home page, click on the MU logo and follow the instructions to become a new member of MU, or take these courses anytime if you currently have access to MU!
**Oncology REVIEW Newsletter Title**

**WVOS Oncology Outpatient Hospital Reimbursement Q & A’s**

**Question:** Our facility gave a push of 5FU and then an infusion of Oxaliplatin (1hr). Since the chemo push was the first thing we did, it is my understanding that we are required to pick the “initial code” as the push. My biller is telling me that this is not correct and we can choose whatever we want. Who is correct?

**WVOS Oncology Outpatient Hospital Reimbursement Q & A’s**

**Question:** Our facility gave a push of 5FU and then an infusion of Oxaliplatin (1hr). Since the chemo push was the first thing we did, it is my understanding that we are required to pick the “initial code” as the push. My biller is telling me that this is not correct and we can choose whatever we want. Who is correct?

**LCD for Erythropoiesis Stimulating Agents (ESA) - L25211 R13 (effective 10/1/2010)**

LCD revised for annual ICD-9-CM code updates for 2010. The “ICD-9-CM Codes That Support Medical Necessity” section of the policy is expanded with the addition of code 237.79 to section for anemia related to chemotherapy.

Added clarification that either Hgb or Hct levels may be used to demonstrate that the therapeutic criteria are met. This clarification of existing instructions does not change coverage, therefore no notice period was required and none was given.

CMS Web references were changed to [http://www.cms.gov/center/coverage.asp](http://www.cms.gov/center/coverage.asp). Complete LCD reviewed. Removed listing of transmittals that have been manualized. Minor changes related to template language.

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**NGS NOVEMBER MEDICARE MONTHLY REVIEW**

**Now Available….HERE**

**Articles of Note:**

- Local Coverage Determination and Article Revisions Effective November 2010
  - Including; Fulvestrant, IVIG, Denosumab, & Intravenous Iron Therapy (pg3)
- CERT Alert: Observation Services Billing (pg11)
- Will Your Payments Stop January 3, 2011? (pg14)
- Healthcare Provider Taxonomy Codes October 2010 Update (pg14)
- Influenza Vaccine Payment Allowance – Annual Update for 2010-2011 Season (pg21)
- Counseling to Prevent Tobacco Use (pg24)
- Allogeneic Hematopoietic Stem Cell Transplantation for Myelodysplastic Syndrome (pg28)
- Positron Emission Tomography for Initial Treatment Strategy in Solid Tumors and Myeloma (pg32)
- 2010–2011 Seasonal Influenza (Flu) Resources for Health Care Professionals (pg37)
- October 2010 Update of the Hospital Outpatient Prospective Payment System
  - Billing for Drugs, Biologicals, and Radiopharmaceuticals (pg44)
  - Drugs and Biologicals with Payments Based on ASP Effective October 1, 2010 (pg45)
  - Payment Rates for Several HCPCS Codes Incorrect (pg46)
  - Correct Reporting of Biologicals When Used As Implantable Devices (pg47)
  - Correct Reporting of Units for Drugs (pg47)
  - Clarification on Billing for Observation Services on Condition Code 44 Claims (pg49)
- Recovery Audit Contractor Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted (pg62)

**AND MUCH MORE …**
**Answer:** Neither of you! For services in the facility setting the AMA has established a hierarchy related to the administration codes. Infusions are considered primary to pushes and pushes are primary to injections. Therefore, you would choose the initial code for the infusion (Oxaliplatin) and the sequential code (96411) for the 5FU push. Please refer to the beginning of the administration section of the 2010 AMA CPT for further information.

**Question:** Our patient presented to the center dehydrated. Our physician ordered fluids (hydration) for 2 hours and then decided to go ahead with chemotherapy. Should we use the hydration code as our initial code since that was the main problem with the patient on that day?

**Answer:** No, following the AMA CPT guidelines, chemotherapy infusions are primary to the therapeutic infusions which are primary to hydration. Therefore, you would use the chemo administration code as the initial and then the hydration (96361) code with a quantity of 2 for the 2 hours of hydration. Please refer to the beginning of the administration section of the 2010 AMA CPT for further information.

**Question:** We are an outpatient center. We gave chemotherapy using a membrane oxygenator perfusion pump. What chemo infusion code should we use, I can’t find anything in the administration section that related to this type of pump.

**Answer:** Most likely you want to consider using CPT 36823 as long as you performed the entire procedure as described in CPT including the insertion of the cannula. This code does include the reimbursement for the chemotherapy perfusion.

**Question:** I recently saw something from the FDA that stated that AMAG is in trouble for promoting Feraheme in oncology and that it is not indicated for use in oncology, the FDA document states, “Feraheme is not approved to treat iron deficiency anemia in women with abnormal uterine bleeding, or in patients with cancer and gastrointestinal diseases.” Is this a problem for our reimbursement???

**Answer:** The FDA did send a warning letter, [http://www.fda.gov/ICECI/EnforcementActions/WarningLetters/ucm230796.htm](http://www.fda.gov/ICECI/EnforcementActions/WarningLetters/ucm230796.htm), to AMAG in relation to wording on their website indicating that they were in violation of off label promotion because their website included promotion of unapproved uses including;

- “Feraheme is being developed to treat iron deficiency anemia associated with other conditions and disease states including women with abnormal uterine bleeding, and patients with cancer and gastrointestinal diseases.”

The FDA letter did require removal of this information from their website. The FDA did confirm that “Feraheme is indicated for the treatment of iron deficiency anemia in adult patients with chronic kidney disease.” Many oncology patients also suffer from chronic kidney disease. If you have more questions related to Feraheme reimbursement you can also contact their reimbursement assistance hotline at 877-411-2510.

**Question:** We have a couple patients that are now receiving an 11 mg dose of Velban. Velban comes in 10 mg vials and the nurse said there is an overflow in the vial of 1 mg. So, technically, we only use one vial! Is it ok to bill for the 2nd vial?

**Answer:** According to CMS, the overfill would be considered a "no cost item" and would fall under that provision (which I have attached). The provision simply states that you cannot bill for a "no cost item". Therefore you may document the exact dosage in the patient’s medical record, you would only bill for the 10 mg's. This was also addressed in the proposed Physician Fee Schedule Rule published this year.
CMS Issues Final 2011 HOPPS Rule and Physician Fee Schedule

Conference Call Scheduled for November 19

On November 2, the final 2011 Medicare rules, Hospital Outpatient Prospective Payment System (HOPPS) and CY 2011 Payment Rates and Payment Policies Under the Physician Fee Schedule, were released by the Centers for Medicare & Medicaid Services (CMS).

ACCC will sponsor a conference call on November 19, 2010, at 1:00 pm - 2:00 pm EDT to discuss both rules. Call in number: 888.283.6452. Passcode: 6106472.

The new HOPPS rule sets payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at average sales price (ASP) +5 percent (105 percent of the manufacturers' average sales prices). 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.

The new HOPPS rule modifies a number of the supervision requirements for outpatient therapeutic services, including redefining direct supervision for all hospital outpatient services to require "immediate availability" without reference to the boundaries of a physical location.

Record Retention Revealed
Source: onPoint Oncology LLC

Where you underwater for levoleucovorin in Third Quarter? The ASP plus 6% allowable for J0641 for Third Quarter has been increased from $.646 to $.732 for 0.5 mg. You must re-file to get the increase.

HHS Speeches: National Summit on Health Care Quality and Value

October 4, 2010-National Summit on Health Care Quality and Value-Washington, DC

"This August marked a turning point, as major insurance companies, provider groups, doctors, hospitals and patients all came together to announce that they would team up to support our “meaningful use” regulations - guidelines that doctors and hospitals will have to follow to earn incentives for moving from paper to electronic medical files. Dramatic change isn’t going to happen overnight. But it is underway." Read entire speech>>
According to their recent press release, UnitedHealthcare is working with five practices on a new payment model that seems to be more revolutionary than Pathways and other models out there.

This new approach, which reimburses participating medical oncologists upfront for an entire cancer treatment program for a certain diagnosis (the first one, according to our sources, was breast cancer), marks a shift away from the current "fee-for-service" approach, which rewards volume regardless of health outcomes. This new "bundled payment," or "episode payment," will be based on the expected cost of a standard treatment regimen for the specific condition, as predetermined by the doctor. Medicare is also testing episodes of care in other specialties, so get ready to hear more about this type of payment.

Here's how it works...The oncologist will be paid the same fee regardless of the drugs administered to the patient. Why? According to United, "in effect, separating the oncologist's income from drug sales while preserving the ability to maintain a regular visit schedule with the patient".

"By paying medical oncologists for a patient's total cycle of treatment, rather than the number of visits and the amount of chemotherapy drugs given, this program promotes better, more patient-centric, evidence-based care with no loss of revenue for the physician," said Lee N. Newcomer, M.D., UnitedHealthcare's senior vice president, oncology. "Everyone wins: as oncologists share best practices from the program about which treatment regimens are most effective, we expect to see consistently improved patient outcomes." Dr. Newcomer does not explain exactly how that communication will happen.

The five medical practices participating in the pilot have between 18 and 35 oncologists on staff and are based in Dayton, Ohio; Fort Worth, Texas; Kansas City, Mo.; Marietta, Ga.; and Memphis, Tenn.

In the pilot, each medical group chooses a standard chemotherapy regimen for each of 19 clinical presentations and participate in performance reviews of their data with other participating oncology groups to help identify best practices. Patient health information is protected and blinded in compliance with HIPAA privacy regulations (ummm..duh). The medical groups' participation in the program means they are willing to compare their results with peers.

Treatment regimens will be evaluated based on the number of emergency-room visits, incidence of complications, side effects and, most importantly, health outcomes - determining which treatment regimens do "the best job of helping to fight cancer".

UnitedHealthcare calculates the cancer care payment based on the amount of money the oncology group would make on drug profits using the difference between the group's current fee schedule and the drugs' costs. A case-management fee is also added to reflect the time and resources that the oncologist's office spends in managing the patient relationship. This new fee is paid by UnitedHealthcare on the first day the patient receives care from the medical oncology group. The upfront fee will cover the standard treatment period, which is typically six to 12 months. In cases of cancer recurrence, the bundled payments will be renewed every four months during the course of the disease, allowing the doctor to continue overseeing his or her patient's care even if drug therapy is no longer effective.

The medical group is free to change their drug regimens at any time, but the cancer care payment does not change. As part of the pilot, office visits, chemotherapy administration and other ancillary services like laboratory tests are paid based on fee-for-service rates.

In our view, it is imperative to know your costs for each diagnosis that you treat in your practice and understand how much you are currently reimbursed for that diagnosis throughout treatment. Otherwise, it will be impossible for you to participate in these initiatives.
Stark Law Series, Part II
Can You Spot a Stark Law Violation?

Last time, we discussed some popular misconceptions about the Physician Self-Referral Act, also known as the Stark Law which prohibits healthcare providers from submitting claims to Medicare/Medicaid for services rendered to a patient referred by a physician with whom that healthcare provider has financial ties such as a tenant-landlord relationship. The intent of Stark is to discourage patient referrals for financial compensation.

“Physicians should make decisions on sound professional judgment, not for financial reasons,” says John Claybrook, a partner with Nashville, Tenn.-based Waller Lansden Dortch & Davis, LLP.

Anytime a physician leases office space from a hospital, or vice versa, the lease arrangement is considered a financial arrangement triggering Stark. To avoid a violation, Walter Neilsen, also a partner with Waller Lansden Dortch & Davis, LLP, says that the lease must meet these requirements:

- All parties must sign a written lease;
- Lease must adequately describe the premises;
- Term of the lease has to be at least one year;
- The leased premises must be commercially reasonable and necessary for the legitimate business purpose;
- Leased space must be used exclusively by tenant.

Let’s test your knowledge of Stark Law. Below are six hypothetical scenarios that cover a wide range of issues. See if you can determine which of the scenarios violate Stark Law. The answers and a brief analysis of each scenario can be found by clicking the ANSWER link at the bottom of each scenario.

**LEASE SCENARIO 1**

A physician delivers her signed lease to the hospital’s leasing agent on Thursday, June 26th for a lease that will...
commence on Tuesday, July 1st. The leasing agent overnights the lease to the hospital’s corporate real estate department for signature. The physician calls the leasing agent on Friday, June 27th and advises the leasing agent that she must move in over the weekend.

*Can the physician move in over the weekend prior to the commencement date of the lease?* ANSWER

**LEASE SCENARIO 2**

A physician has been a tenant in a hospital’s medical office building for 15 years. The physician’s lease expires on October 31, 2010. The physician advises the hospital that she will retire at the end of the year, and she wants to remain in her suite until the end of the year.

*Can she remain in her suite on hold-over status for two months? Also, should a written lease amendment be signed?* ANSWER

**LEASE SCENARIO 3**

A physician leases 10,000 square feet of space from a hospital for a 10-year term. The leased space contains $230,000 of tenant improvements (we’ll assume that the lease is fully signed and complies with Stark Law).

In addition to the 10,000 square feet of leased space, the physician also uses an additional 100 square feet of storage space in the medical office building’s basement. Six months into the term of the physician’s lease, both the hospital and the physician realize that the parties never signed a lease for the additional storage space. The hospital typically signs leases with their physician-tenants for these storage spaces.

*Does the parties’ failure to sign a lease for the storage space constitute a violation of Stark Law?* ANSWER

**LEASE SCENARIO 4**

A hospital and a physician sign a five-year lease on June 1, 2007 for 3,243 rentable square feet of space. The hospital re-measures the medical office building and the leased space on June 1, 2010 and discovers that the lease space was incorrectly measured at lease signing. The leased space actually contains 3,522 rentable square feet of space according to BOMA (Building Owners and Managers Association International) standards.

*Should the hospital charge the physician for this “extra” leased space? And, if the hospital charges the physician for this “extra” leased space, should the hospital charge the physician for this leased space as of June 1, 2007 or as of June 1, 2010?* ANSWER

**LEASE SCENARIO 5**

A physician and his wife, who serves as his office manager, have been tenants in a medical office building for 10 years. They have been a great tenant and have never given the hospital who owns the property any problems. Unfortunately, he has a heart attack and is unable to practice for four months. The wife, who is the office manager, approaches the hospital-landlord and asks if the rent for the four months be waived since her husband was unable to practice and the office was closed during that time period.

*Can the hospital waive the rent that is due for those four months?* ANSWER

**LEASE SCENARIO 6**

A physician and a hospital sign a new five-year lease on July 1, 2008, for medical office space located in Miami. The hospital is also located in Miami. On September 1, 2008, a hurricane hits Miami and destroys the medical office building. The hospital receives significant damage, but is able to operate, but the physician has to relocate to a smaller space in the same building.

*Can the hospital lease space to the physician at a reduced rate until the medical office building is rebuilt?* ANSWER
Heparin Sodium (B. Braun): Recall - Trace Contaminant
[Posted 10/29/2010]

DETAILS

Methotrexate Injection, 50mg/2mL and 250mg/10mL Vials: Recall - Presence of Glass Particulates
[Posted 10/29/2010]

DETAILS

[Posted 10/15/2010]

DETAILS

Excelsior Medical 5 ml Fill in 6 cc Prefilled Saline Flush Syringes: Recall - Potential Loss of Sterility
[Posted 10/15/2010]

DETAILS

CareFusion Corporation Alaris PC Units (Model 8015): Recall - Potential for Delay or Interruption of Therapy
[Posted 10/15/2010]

DETAILS

West Virginia Patient Navigation Network
2nd Annual Meeting

Date: November 16, 2010
Time: 9:00am-4:00pm
Location: Days Hotel, Flatwoods, WV

Happy Thanksgiving
WVOS is keeping an eye on the West Virginia RAC Contractor - Connolly Healthcare

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

- Darbepoetin 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
- Darbepoetin alfa (non-ESRD) - Dose vs. Units Billed


Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted

To read the complete article see link below:

Electronic Health Record Incentive Program

The Medicare and Medicaid EHR incentive programs provide incentive payments for the meaningful use of qualified, certified EHRs to achieve health and efficiency goals. The EHR incentive program final rule was published on July 28, 2010 and can be accessed on the CMS Medicare and Medicaid EHR Incentive Programs Web Site

These new programs, which begin in 2011...

Read the complete article [HERE](http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf)
NCCN recently added a listing for Abraxane for Ovarian cancer that meets the Category 2A which meets the criteria for coverage under CMS transmittal 96, Change Request 6191.

The details of the Category 2A designation are as follows: Ovarian cancer - epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer; recurrence therapy as a single agent for
* progressive, stable, or persistent disease on primary chemotherapy
* relapse after complete remission following primary chemotherapy
* stage II-IV disease showing partial response to primary treatment

Please visit NCCN Compendium for more information:
http://www.nccn.org/professionals/drug_compendium/content/contents.asp

NCCN has published updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™) for Breast Cancer. These NCCN Guidelines™ are currently available as Version 3.2010.

The NCCN Guidelines Panel for Breast Cancer affirmed its existing recommendation of bevacizumab in combination with paclitaxel as an appropriate therapeutic option for metastatic breast cancer with the evidence designation 2A meaning that it is based on lower level evidence and uniform agreement of the panel as to its appropriateness. COMPLETE ARTICLE

Investing in Community Health Centers

More than $727 million in grants from the Affordable Care Act will upgrade and expand community health centers as well as provide care for an additional 745,000 underserved patients. Secretary Sebelius announced the awards in a press release today. For the State of Michigan they are:

- Monongahela Valley Association of Health Centers – Fairmont - $3,892,450
- Pendleton Community Care – Franklin - $1,278,632
- Preston-Taylor Community Health Centers – Grafton - $1,179,700
- Lincoln County Primary Care Center – Hamlin - $3,478,347
- Valley Health System – Huntington - $8,760,833

Read complete list of awards by state.
The Centers for Medicare & Medicaid Services (CMS) released a new newsletter aimed at helping providers, suppliers and their billing staffs understand and avoid certain billing errors. The newsletter, Medicare Quarterly Provider Compliance Newsletter: Guidance to Address Billing Errors, identifies eight billing errors that affect a variety of provider types. CMS describes each error and its consequences, provides guidance on avoiding them, and makes several additional recommendations. Errors are identified by a number of sources: the Government Accountability Office, the Department of Health and Human Services Office of the Inspector General, the Medicare Recovery Audit Contractors (RACs) and other program contractors.

The current newsletter includes an issue of concern affecting physicians that was identified during the RAC demonstration project: physician pharmaceutical injectables – incorrect procedure codes and/or number of units billed. The other issues affect hospitals (inpatient and outpatient) and skilled nursing facilities. CMS states in its introduction that future editions will focus on the top issues of a particular quarter, which may focus on a single provider type or item/service.

As a result of MGMA advocacy, the Centers for Medicare & Medicaid Services (CMS) has agreed to clarify a major step in the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). On the page titled “Applicant Decision,” the agency changed the description under “group member only” to “the applicant reassigns their benefits to a group practice, clinic or individual.” CMS uploaded the edit was into the system on Oct. 1. It will resolve some of the confusion surrounding PECOS and will increase the number of providers using Internet-based PECOS, allowing applicants to take advantage of the purported quicker enrollment option.

Last week, an official at the Centers for Medicare and Medicaid Services (CMS) reported that the agency identified a significant problem with the Medicare Ordering and Referring File. This file contains the National Provider Identifiers (NPIs) and the legal names of all physicians eligible to order and refer in the Medicare program and who have an enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS). Some 48,774 physicians were incorrectly left off the list, and CMS has indicated it has now added these physicians to the updated list on the CMS Web site. This error may explain any recent inaccuracies with the list, and MGMA encourages you to check the updated Ordering and Referring File to ensure that your physicians are listed. This problem illustrates some of the difficulties practices face when verifying whether physicians are in PECOS and the frustrations they have with the overall Medicare enrollment process. MGMA continues to communicate these member concerns to CMS and to advocate for a more streamlined, user-friendly enrollment process.

Thank you Wheeling for making the 2010 Light the Night Walk such a success!

The 2010 Wheeling Light the Night Walk raised an amazing $57,000 for blood cancer research and local patient aid. DETAILS
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Please feel free to submit articles, announcements, and other information for publication in the WVOS Oncology Review to Michelle Weiss, Editor & Associate Director, at admin@wvos.info

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Please feel free to submit articles, announcements, and other information for publication in the WVOS Oncology Review to Michelle Weiss, Editor & Associate Director, at admin@wvos.info

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