West Virginia Oncology Society
211 Marion Square
Fairmont, West Virginia 26554
Phone: 304.368.3575
Fax: 304.367.9470
E-mail: Julie@wvos.info

Pre-Existing Condition Insurance Plan

FOR IMMEDIATE RELEASE-MAY 31, 2011

The U.S. Department of Health and Human Services (HHS) today announced new steps to reduce premiums and make it easier for Americans to enroll in the Pre-Existing Condition Insurance Plan. Premiums for the Federally-administered Pre-Existing Condition Insurance Plan (PCIP) will drop as much as 40 percent in 18 States, and eligibility standards will be eased in 23 States and the District of Columbia to ensure more Americans with pre-existing conditions have access to affordable health insurance. The Pre-Existing Condition Insurance Plan was created under the Affordable Care Act and serves as a bridge to 2014 when insurers will no longer be allowed to deny coverage to people with any pre-existing condition, like cancer, diabetes, and asthma.

READ MORE
Pre-Existing Condition Insurance Plan: West Virginia

PCIP will cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. All covered benefits are available for you, beginning on your coverage effective date, even if it’s to treat a pre-existing condition - there are no waiting periods.

PCIP offers a choice of plan options to fit your needs and provide more affordable premiums. Please note rates have changed in West Virginia as of July 1, 2011. The monthly premiums for your state are:

<table>
<thead>
<tr>
<th>Standard Plan</th>
<th>Extended Plan</th>
<th>HSA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Rate</td>
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<td>$273</td>
<td>45-54</td>
</tr>
<tr>
<td>55+</td>
<td>$380</td>
<td>55+</td>
</tr>
</tbody>
</table>

PCIP applicants who are approved to participate in PCIP can choose from three plan options, with different levels of premiums, calendar year deductibles, prescription deductibles and prescription copays. The HSA Option provides an opportunity to open a Health Savings Account, a tax-exempt account where you can deposit funds for eligible medical expenses. Each of the three PCIP plan options provides preventive care (paid at 100%, with no deductible) when you see an in-network doctor and the doctor indicates preventive diagnosis. Included are annual physicals, flu shots, routine mammograms and cancer screenings. For other care, you will pay a deductible before PCIP pays for your health care and prescriptions. After you pay the deductible, you will pay 20% of medical costs in-network. The maximum you will pay out-of-pocket for covered services in a calendar year is $5,950 in-network/$7,000 out-of-network. There is no lifetime maximum or cap on the amount the plan pays for your care.

If you apply for PCIP coverage, you will be billed for the premium once your application is approved. You will need to send in your payment in order for your coverage to be effective. Please do not send in the premium before you are billed. Note that your premium may increase if you age into a higher rate tier, or if PCIP adjusts its premiums to any changes in the commercial market.
“Lunch and Learn” Series
YOU ASKED – WE LISTENED

WVOS hosted another successful "Lunch and Learn" audio conference on June 7, 2011! This 45 minute seminar was focused on "Implementing Patient Support Programs and Financial Counselors into your Cancer Center Program". The seminar included an overview of the types of programs available, the support of the pharmaceutical industry vs foundations, the ‘best practice’ approach of utilizing a financial counselor and navigating the process of obtaining financial support for cancer patients in West Virginia. The handout is available on the meetings and education page of our website, www.wvos.info. Keep an eye on our newsletter and website for the next "Lunch and Learn" audio conference announcement! If you are interested in sponsoring one of our conferences, please email Michelle Weiss at admin@wvos.info.

Capitol Hill News

March 3, 2011 Representatives Ed Whitfield (R-KY) and Gene Green (D-TX) with 29 co-sponsors (16 Democrat and 13 Republicans) introduced an amendment to the Social Security Act to ensure more appropriate payment for drugs and biologicals by excluding existing prompt pay discounts extended to wholesalers from the manufacturer’s Average Sales Price (ASP), or the “Prompt Pay” Bill (H.R. 905).

H.R. 905-To amend part B of title XVIII of the Social Security Act to exclude customary prompt pay discounts from manufacturers to wholesalers from the average sales price for drugs and biologicals under Medicare.

SECTION 1. EXCLUDING CUSTOMARY PROMPT PAY DISCOUNTS FROM MANUFACTURERS TO WHOLESALERS FROM THE AVERAGE SALES PRICE FOR MEDICARE PAYMENTS FOR DRUGS AND BIOLOGICALS.… READ MORE


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
Ordered/Referred Services: Important Reminders

Know the requirements for ordering and referring services under Medicare Part B. This article includes helpful information regarding these requirements and how to ensure that you meet the requirements. READ MORE

New Customer Service Phone Number: South Carolina and West Virginia

Beginning June 20, 2011, South Carolina and West Virginia providers will have a new contact number to reach customer service representatives (CSRs) at Palmetto GBA. If you have a question that cannot be handled through the Interactive Voice Response (IVR) Unit, please call the CSR-only telephone number at (866) 830-3043. Our provider contact center hours of operation will be 8 a.m. to 4:30 p.m. ET Monday through Friday. The IVR phone number is (888) 414-8592.

Pharmacy Billing for Drugs Provided "Incident To" a Physician Service

This article is based on Change Request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided 'incident to' a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined. READ MORE

Early Payments: South Carolina and West Virginia Part B

To ensure that cash flow is not negatively impacted by the upcoming Jurisdiction 11 (J11) implementation, claims scheduled to be paid to South Carolina and West Virginia Part B on June 21 and 22 will be paid early and will be included in the payments issued on June 20, 2011. Palmetto GBA will not issue payments or remittance advices on June 21 or 22. Normal payment cycles will resume on June 23, 2011.

South Carolina and West Virginia Part B Redetermination Requests: New Address

South Carolina and West Virginia Part B providers should begin submitting all redetermination requests to the new J11 Palmetto GBA redetermination address beginning June 13, 2011. You may complete the J11 Part B Redetermination Form electronically, then print the form, and mail or fax the form along with any supporting documentation.

E-mail/Listserv Registration: South Carolina and West Virginia Part B

Please help us spread the word! Palmetto GBA needs your assistance in getting staff and associates to sign up for free e-mail updates. Be the first to know about implementation issues and Medicare guidelines, we don't want you to miss out on valuable information. Verify that you've selected the correct categories that are important to your business and always include 'General.'

Workshop

Implementation: Webinar Tour Updated
Saturday
June 18th, 2011
7:00 a.m.

DETAILS
J11 South Carolina and West Virginia Part B Welcome Letter and Implementation Guide

Palmetto GBA is pleased to be your contractor for the new J11 A/B MAC. We anticipate a smooth J11 South Carolina and West Virginia Part B implementation, and assure you that we have taken measures that will provide the least disruptive impact to day-to-day operations. Please check out the ‘J11 South Carolina and West Virginia Part B Welcome Letter’ (PDF, 48 KB) and ‘Implementation Guide’ (PDF, 86 KB) for South Carolina and West Virginia Part B providers. This implementation applies to services billed on the CMS-1500 / 837B from South Carolina and West Virginia Part B providers. The effective date for the implementation of the J11 A/B MAC Part B South Carolina and West Virginia workload is June 18, 2011. New Payer Identification numbers will be effective June 18, 2011. The new Payer ID for South Carolina Part B is 11202, and the Payer ID for West Virginia Part B is 11402. You should begin to submit claims using the new Payer IDs on June 18, 2011.

Anticoagulation Services: Guidelines

CPT code 99211 represents the lowest level office visit and may be reported ‘incident to’ for a patient encounter with the physician’s licensed auxiliary personnel. To report CPT code 99211 in addition to a venipuncture for drug treatment monitoring, such as anticoagulation therapy or for a maintenance injection service, the licensed personnel must perform a face-to-face service and document at least one of the following reasonable and necessary criteria…READ MORE

Affordable Care Act Gives Providers New Options to Better Coordinate Health Care

On May 17, the Centers for Medicare & Medicaid Services (CMS) announced three Affordable Care Act initiatives designed to help put doctors, hospitals and other health care providers on the path to becoming Accountable Care Organizations (ACOs) and improve health care for Americans with Medicare. READ MORE

No Date Set for Expanded Ordering/Referring Provider Claim Edits

The Centers for Medicare & Medicaid Services (CMS) has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims. These edits are applicable to ordering/referring providers that do not have a record in the Provider Enrollment, Chain and Ownership System (PECOS). READ MORE

The June 2011 “Medicare Advisory” for J11 MAC Part B is now available HERE

- Be sure to review the LCD guide beginning on page 7
- Be sure to share these updates with the appropriate staff

This is a MUST READ for every practice.
**WVOS Private Practice Reimbursement Q & A’s**

**QUESTION:** I am looking for some good information on Health Care Reform. Can you point me in the right direction?

**ANSWER:** There is SO much information out there on Health Care Reform! Below you will find a couple of websites I found useful. Additionally I have attached the legislation.


Also some newer updates:

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**QUESTION:** We have hired a financial counselor. Can you tell me where I can find a summary of the various foundations we can contact for assistance for our patients?

**ANSWER:** One of my favorite resources is found on the [www.cancercare.org](http://www.cancercare.org) website. While Cancer Care has their own Foundation (which is wonderful), their website is VERY patient friendly and when you look under the “get help” tab on the top, then click on financial help, then “Tips for finding assistance”, you will find at the bottom the PDF titled, “Financial Help for People with Cancer”. Beginning on page 3 you will not only find a great listing of the various organizations, you will also find information on how to reach them and, what diagnosis’ the can assist with. Here is the direct link: [http://www.cancercare.org/pdf/fact_sheets/fs_financial_en.pdf](http://www.cancercare.org/pdf/fact_sheets/fs_financial_en.pdf)

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**QUESTION:** I looked under the RAC website “issues” section I could not find anything that pertained to us (i.e., oncology). If you have any information we would appreciate it.

**ANSWER:** Regarding the RAC - visit [http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx](http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx) and click on the issues link. You cannot search by “oncology” and there are many issues listed in alphabetical order. You will need to scroll through the issues and be sure to look closely at the following: Add -On Codes, Bevacizumab, Blood Transfusions, Bone Marrow Transplant, Carboplatin, Cetuximab, Chemo with Acute Leukemia, Chemotherapy Administration Codes, Clinical Social Worker Services, Darbepoetin alfa, Docetaxel, Dolasetron, Filgrastim, Fulvestrant, Infliximab, Irinotecan, IV-Hydration Therapy, J2505 Neulasta, Leuprolide, Paclitaxel, Palonosetron, Pamidronate, Rituximab, Zoledronic acid, Filgrastim. Hope this helps.

*Continued on next page...*
QUESTION: I've been approached by a company who gets the drugs from Canada. They say it is ok if we buy drugs from them and use them for our patients. The drugs are much cheaper and we would like to do this but, it doesn't feel right. Can you provide any information on this subject?

ANSWER: According to the FDA, you cannot import, re-import or resell ANY drugs from Canada in the United States. Some say that obtaining Canadian drugs for your own personal use is ok; however, the FDA states that this is also illegal;

"Under the Federal Food, Drug, and Cosmetic Act (FD&C Act), the interstate shipment of any prescription drug that lacks required FDA approval is illegal. Interstate shipment includes importation--bringing drugs from a foreign country into the United States.

Drugs sold in the United States also must have proper labeling that conforms with the FDA's requirements, and must be made in accordance with good manufacturing practices."

"The FD&C Act also states that prescription drugs made in the United States and exported to a foreign country can only be re-imported by the drug's original manufacturer. Even when original manufacturers re-import drugs, the drugs must be real, properly handled, and relabeled for sale in the United States if necessary."

"Virtually all prescription drugs imported for personal use into the United States from Canada violate the Act because they are unapproved new drugs (21 U.S.C. § 355), labeled incorrectly (21 U.S.C. §§ 352, 353)), or dispensed without a valid prescription (21 U.S.C. § 353(b)(1)). Importing a drug into the United States that is unapproved and/or does not comply with the labeling requirements and dispensing requirements in the Act is a prohibited act under 21 U.S.C. §§ 331(a), and/or (d) may be enjoined or prosecuted. See also 21 U.S.C. §332(a), 333(a)."

Here is a link to an article to the Minnesota Mayor regarding the FDA overview of imported drugs and specifically, CanadaRx: http://www.fda.gov/Drugs/DrugSafety/ucm179322.htm. Within the article they clearly state that importation is illegal.

Also, below is another article I think will help to clarify:

ARTICLE: Every few months a flurry of faxes and flyers are sent to oncology offices across the country with announcements of huge savings on oncology drugs from Canadian pharmacies. And with each new advertising campaign questions arise as to the legitimacy of the pharmacy, the transaction and the almost irresistible pricing.

First, the FDA has clearly stated that virtually all drugs imported to the United States from Canada and any other foreign country would violate U.S. law.

Second, as described in the press release below, billing Medicare for drugs imported from a foreign company has been determined to be a violation of the Federal False Claims Act.

In a press release dated April 24, 2008 the United States Attorney's Office Eastern District of New York announced that a NY oncologist and his wife agreed to
settle civil fraud allegations involving importation of oncology drugs from Canada.

The oncologist and his wife agreed to pay $275,000 in damages to the United States to resolve allegations that they violated the federal False Claims Act in connection with claims they submitted to the Medicare program for oncology drugs that were imported from Canada. They also agreed to enter into an integrity agreement with the Department of Health and Human Services.

The settlement was announced by Benton J. Campbell, United States Attorney for the Eastern District of New York, Gary Heuer, Special Agent in Charge, Department of Health and Human Services, Office of Inspector General, New York Regional Office, and Mark J. Mershon, Assistant Director-in-Charge, Federal Bureau of Investigation, New York Field Division.

The government alleged that for a one year period between October 2004 and October 2005 the defendants purchased oncology drugs that were imported from Canada and then billed and were reimbursed by the Medicare program despite knowing that the drugs were not subject to reimbursement. In settling the case, the defendants have not admitted to engaging in the conduct at issue.

The government began its investigation after another physician filed a "qui tam" (whistleblower) lawsuit in the Eastern District of New York on behalf of the United States. In the lawsuit the physician alleged that doctors throughout the United States were importing oncology drugs from Canada because they could be purchased at a lower price than domestic oncology drugs. He further alleged that patients were generally not informed that they were being administered an imported drug.

In announcing the settlement United States Attorney Campbell stated, “Health care providers who violate the law will be held accountable. We are committed to vigorously investigating and prosecuting fraud on the Medicare program.”

And HHS OIG Special Agent-in-Charge Heuer said, “Fighting the misrepresentation of pharmaceuticals and services provided by physicians is a priority of this office. This investigation is a further example of our commitment to root out schemes generating inflated profits at the expense of the taxpayers and vulnerable recipients.”

* Here is the link to a letter from the FDA regarding importing Canadian drugs: http://www.oplinc.com/Uploaded-Files/FDA%20LETTER%20CANADIAN%20DRUGS.pdf

REIMBURSEMENT QUESTIONS?
reimbursement@wvos.info
THE INFORMATION PROVIDED BELOW AND ON THE NEXT FEW PAGES WAS EXTRACTED DIRECTLY FROM Palmetto GBA J11 MAC Part A

It’s the beginning of a new era as we move away National Government Services and onward to the NEW Jurisdiction 11 Part A Medicare Administrative Contractor
PALMETTO GBA

J11 Part A Comprehensive Error Rate Testing (CERT) Webinar Handout

The J11 Part A CERT Webinar Handout is now available. Select the PDF file below to download, view or print this document.

05242011_J11A_CERT_Webinar_Handout.pdf (PDF, 142 KB)

July 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected
This article is for providers submitting claims to Medicare Contractors (Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed
This article is based on Change Request (CR) 7443 which describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). Be sure your billing staffs are aware of these changes.

Please Use Correct Address to Send Overpayments and Other Related Information

This article affects Jurisdiction 11 (J11) Virginia and West Virginia Part A providers only.

Palmetto GBA reminds J11 Virginia and West Virginia Part A providers to use the following address for sending extended repayment plan (ERP) requests and checks submitted to repay cost report overpayments:

Palmetto GBA
Medicare Part A Overpayments
Mail Code: AG-340
P.O. Box 100109
Columbia, SC 29202-3109

Providers can submit ERP requests and requests for overpayment immediate offsets via fax to (803) 419-3275.

If you have any questions regarding overpayments, please call the J11 Part A Provider Contact Center at (866) 830-3455.
Virginia and West Virginia Providers

Effective with the Virginia and West Virginia Part A implementation, providers will begin billing claims to Palmetto GBA and receiving claim edits (reason codes) in Direct Data Entry (DDE). The majority of Medicare claims will process similarly to the way they were processed under National Government Services (NGS). However, as with any large scale migration, providers will notice some changes. In an effort to ensure a smooth transition from NGS to Palmetto GBA claims processing, Palmetto GBA has compiled a reference tool to assist providers in identifying these differences. The tool lists (by reason code) the status/location NGS used and the new status/location Palmetto GBA will use. The listing is sorted and grouped by the NGS status/location. Providers will note that there are instances where NGS rejected the claim (R status) or Returned To Provider (T status) where Palmetto GBA suspends the claim for processing and vice versa. Full narrative descriptions for each reason code can be found in DDE.

Additionally, the following reason codes are commonly used by Palmetto GBA. Further explanation regarding these codes can be found in the Centers for Medicare & Medicaid Services’ (CMS’) Internet-Only Manuals (IOMs) at www.cms.gov or in the reason code narrative found in the DDE system.

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Reason Code Narrative</th>
<th>Explanations and Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>70224</td>
<td>Please review the remarks on Page 4 of the claim. Please resubmit with requested information. If you are unable to review the remarks, please call the provider contact center at (866) 830-3455.</td>
<td>This is a skilled nursing facility (SNF) edit for denial of payment for new admissions (DPNA) when a facility is not in substantial compliance with requirements of participation. Claims will be held in a suspended location and will require manual review by Palmetto GBA. For additional information, please read more...</td>
</tr>
<tr>
<td>70223</td>
<td>Provider out of compliance. Deny new admissions. <strong>Note:</strong> If billing for readmission during a sanction period, occurrence span code 80 must be present.</td>
<td>(1)</td>
</tr>
</tbody>
</table>

May 12, 2011 J11 Ask the Contractor Questions and Answers

**Question**
The provider has billed services for a beneficiary who had come through the emergency room with admitting, primary and secondary diagnoses, and none of which were related to ESRD yet services were rejected by Medicare as ESRD related. How does the provider determine if claim charges are related to ESRD or not?

**Question**
In follow-up to the ESRD-related question, if we have a patient that comes in because of a clotted shunt and in order to find out that the shunt is functioning we provide outpatient dialysis to this patient, would we file under outpatient dialysis using the 'G' code or do we in turn bill the ESRD facility for those treatments?

Answers and additional questions can be found [HERE](#).
The June 2011 “Medicare Advisor” for J11 MAC Part A is now available HERE

This is a MUST READ for every practice.

Quick Tips for Navigating the New J11 MAC Website

- Monthly newsletter “Medical Advisory” CLICK HERE
- Latest News “What’s New” CLICK HERE
- Active LCD’s CLICK HERE
- FAQ’s CLICK HERE
- Sign up for “Email Updates” CLICK HERE

New Workload Numbers for West Virginia Part A

PART A - West Virginia
MAC Number – 11401
Effective Date – May 16, 2011

Important Jurisdiction 11 Information for Virginia and West Virginia Part A Providers

Palmetto GBA recently posted important information for Virginia and West Virginia Part A providers on their Web site, including the

‘J11 Virginia and West Virginia Part A Welcome Letter’
and
‘Implementation Guide’.

A new Payer Identification number (11003) is effective May 16, 2011. You should begin to submit claims using the new Payer ID on May 11, 2011, at 5:00 p.m.

Visit the Palmetto GBA J11 Part A Web site for additional information.

J11 MAC CONTACT INFORMATION

Telephone
(866) 830-3455
Contact a specific Palmetto GBA department

Address
Palmetto GBA
J11 Part A PCC
Mail Code: AG-620
P.O. Box 100238
Columbia, SC 29202-3238
WVOS Oncology Outpatient Hospital Reimbursement Q & A’s

**QUESTION:** I am confused about the e-prescribing penalty everyone is talking about. My doctors have told me that they will make the 25 this year (even though they have started out really slow) and I shouldn’t be concerned. Are they right? Also, we also have radiation oncologists, are they exempt?

**ANSWER:** No and possibly no. Medical Oncology; if they do not e-prescribe at least 10 times, claims based, by June 30th, they will receive a penalty in 2012. Here is a great article you may want to show them; [http://www.ama-assn.org/resources/doc/hit/faq-cms-incentive-program.pdf](http://www.ama-assn.org/resources/doc/hit/faq-cms-incentive-program.pdf)

Physicians who are eligible but choose not to participate in the 2012 or 2013 Medicare ePrescribing incentive program and do not qualify for a significant hardship exemption would be subject to a 1% Medicare payment reduction based on their Medicare Part B allowed charges (1.5% in 2013). CMS is basing the 2012 penalty on e-prescribing activity that occurs during Jan. 1, 2011 through June 30, 2011. Penalties for 2013 are based on e-prescribing activity for the entire 2011 calendar year. Please note that the 10 electronic prescriptions requirement to avoid the 2012 eRx Payment Adjustment must be completed using claims-based reporting.


You can also visit the CMS website for information; [http://www.cms.gov/ERxIncentive/](http://www.cms.gov/ERxIncentive/)

This area of their site is confusing but you will find the current info at the very bottom link: All eRx FAQs. I hope this is helpful.

Continued on next page...
**QUESTION:** We were under the impression that we could bill NGS for smoking cessation counseling but we are receiving denials. We are using the patient's cancer diagnosis, is this wrong?

**ANSWER:** According to the CMS site and the NGS site, smoking cessation counseling services are payable in the outpatient setting. There are new codes as of January 1, 2011 and specific diagnosis codes you need to report:

- ICD-9 code 305.1 (nondependent tobacco use disorder), or ICD-9 code V15.82 (history of tobacco use).

The CMS has created two new G codes for billing for tobacco cessation counseling services to prevent tobacco use for dates of service on or after January 1, 2011. These are in addition to the two CPT codes 99406 and 99407 that currently are used for tobacco cessation counseling for symptomatic individuals. Medicare will waive the deductible and coinsurance/copayment for counseling and billing with these two new G codes on or after January 1, 2011. The new G codes for use on claims with dates of service on or after January 1, 2011 are:

- G0436: **Long Descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes, **Short Descriptor:** Tobacco-use counsel 3-10 min;
- G0437: **Long Descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes, **Short Descriptor:** Tobacco-use counsel >10 min.

Medicare will pay claims not paid under the Outpatient Prospective Payment System (OPPS) with dates of service on or after August 25, 2010, through December 31, 2010, but received prior to January 1, 2011, when billed with diagnosis code 305.1 (non-dependent tobacco-use disorder) or V15.82 (history of tobacco use) and unlisted HCPCS code 99199 for Counseling to Prevent Tobacco Use Services. Code 99199 is Medicare contractor-priced.

However, two new, temporary C codes have been created for facilities paid under the OPPS when billing for Counseling to Prevent Tobacco Use and Tobacco-Related Disease services during the interim period of August 25, 2010, through December 31, 2010. (Facilities paid under the OPPS may not bill the unlisted 99199 code.) The two new C codes are:

- C9801: **Long Descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes, **Short descriptor:** Tobacco-use counsel 3-10 min;
- C9802: **Long Descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes, **Short descriptor:** Tobacco-use counsel >10 min.

CMS will allow two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to 8 sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than 3 minutes up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt. Please review the MedLearn Matters Document: [MM7133](#) for more information.

**REIMBURSEMENT QUESTIONS?**

[reimbursement@wvos.info](mailto:reimbursement@wvos.info)
CMS Provides First Medicare Electronic Health Record (EHR) Incentive Payments Totaling $75 Million; Providers Offered Flexibility in Adopting E-Prescribing

CMS announced last Thursday that the first payments of the Medicare EHR Incentive Program were distributed on May 19. As part of the American Recovery and Reinvestment Act, the Medicare EHR Incentive Program provides payments to eligible professionals (EPs) and hospitals that demonstrate meaningful use of certified EHR technology.

CMS Administrator Donald Berwick, MD, explained in a statement that the payments are a crucial part of the nation's future, "We can bring America's health care system into the 21st century by adopting electronic health records and using electronic prescribing systems. Today's announcements are steps on the right path - toward the health IT system America needs, which will save lives, save money."

CMS noted that in addition to the $75 million given to providers participating in the Medicare program, fifteen states have initiated their Medicaid EHR Incentive Programs since January 2011, and, to date, over $83 million in incentive payments has been made to qualified Medicaid providers.

The National Coordinator for Health Information Technology, Farzad Mostashari, MD, ScM, said in a statement, "Through the EHR Incentive Programs, we are helping eligible providers invest in their technology infrastructure. But this isn't just about technology. The goal is better and safer health care, and that means it's about patients - about their health care and protection of their information."

Last Thursday, CMS also announced proposals for new flexibilities to help providers phase in the use of electronic prescribing. This program provides financial incentives, including payment adjustments beginning January 1, 2012, for EPs to encourage electronic prescribing (eRx).

The full press release can be found on the CMS website. Detailed fact sheets on both the e-prescribing proposed rule and the EHR incentive payments can be found in the fact sheet section of the CMS website.

Want more information about the EHR Incentive Programs?
Make sure to visit the CMS EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

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CMS Set to Release Medicare Data to Rank Docs

June 7, 2011
WASHINGTON -- Medicare claims data would be used to compare physician performance under new rules proposed by the Centers for Medicare and Medicaid Services (CMS)... READ MORE
Transcript for the Medicare Shared Savings Program Proposed Rule Overview

The Transcript for the Medicare Shared Savings Program Proposed Rule Overview National Provider Teleconference is Now Available on the CMS Website

On May 24, 2011, the Centers for Medicare & Medicaid Services (CMS) held a national provider teleconference on the Medicare Shared Savings Program proposed rule CM-1345-P, that implements the Shared Savings Program and establishes the requirements for Accountable Care Organizations (also referred to as an ACO), as established under section 3022 of the Affordable Care Act. This teleconference was one in a variety of teleconferences and listening sessions held by CMS during the proposed rule 60 day comment period. CMS Subject matter experts gave an overview of the proposed rule to help the public understand how CMS is proposing to administer the program and to ensure that the public understands how to participate in the formal comment process. A question and answer session followed the presentation. The written transcript is now available at http://www.cms.gov/sharesavingsprogram/40_Events.asp (external link) on the CMS website. Once on the webpage, select the teleconference title to access the full transcript.

The public comment period on this proposed rule will end on Monday, June 6. Please visit the Shared Savings Program website at http://www.cms.gov/sharesavingsprogram (external link) for more details.

NOTICE - Medicare Reprocessing of Claims

Over the next several weeks, CMS will begin reprocessing claims affected by provisions in the Affordable Care Act (ACA) and corrections to the 2010 Medicare Physician Fee Schedule (MPFS). ACA was signed into law on March 23, 2010. Various provisions in ACA were implemented some time after their effective date. Corrections to the 2010 MFPS were implemented concurrently with ACA and had an effective date retroactive to Jan. 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-schedule claims will be reprocessed. In a post to the agency's Physicians Listserve, CMS states:

We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule)
cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, we believe that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (http://www.cms.gov/manuals/downloads/clm104c34.pdf). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contractors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a $25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than $10, your contractor will not request repayment until the total amount owed accrues to at least $10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (www.cms.gov/manuals/downloads/fin106c04.pdf) for more information.

CMS reminds physicians, practitioners, suppliers, and other providers affected by the retroactive increases in payment rates for claims affected by ACA and the 2010 MPFS changes of the OIG’s policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. Available at: oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf. Contact your Medicare claims administration contractor with any questions.

More information:
Claims Reprocessing: Questions & Answers for Providers
Affordable Care Act Provisions Requiring Reprocessing of Medicare Fee-For-Service Claims
http://wpsmedicare.com/j5macparta/departments/claims/aca-provisions.shtml
Claims Reprocessing: Questions & Answers for Providers
https://www.highmarkmedicareservices.com/claims/aca-table-ga.html

Accountable Care Organizations (ACOs)

Learn about ACOs:

(1)
Reminder: No Date Set for Expanded Ordering/Referring Provider Claim Edits

The Centers for Medicare & Medicaid Services (CMS) has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims. These edits are applicable to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied.

For information on the requirements for billing for ordering/referred services, review the Medicare Learning Network's "Medicare Enrollment Guidelines for Ordering/Referring Providers" fact sheet at:

Recent LearnResource & MedLearn Matters Articles

- 2011 Physician Quality Reporting System & Electronic Prescribing Incentive Program National Provider Call
  http://www.cms.gov/PQRS/04_CMSSponsoredCalls.asp
- HIPAA 5010 & D.0 Implementation Calendar and Important Reminders for June 2011
  http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf
- Quarterly Healthcare Common Procedure Coding System Drug/Biological Code Changes - July 2011 Update
- New Frequently-Asked-Questions Available about HIPAA Version 5010 Implementation
  http://questions.cms.hhs.gov/app/answers/detail/a_id/10647/kw/5010
- July Update to the CY 2011 Medicare Physician Fee Schedule Database (MPFSDB)
- Pharmacy Billing for Drugs Provided "Incident To" a Physician Service
ATTENTION ALL WEST VIRGINIA WVOS MEMBERS!

There has been a recent increase in RAC audit activity by Connolly within the State of West Virginia over the past few weeks. Member private practice offices have reported receiving RAC audits related to:

- Hospital AND practice billing for bone marrow biopsy
- Oxaliplatin
- Timed infusion codes

The number of charts requested has been very limited. Make sure you and your staff are watching carefully for Connolly RAC audit requests! Make sure you are prepared to respond timely, the deadlines are tight!

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

Developing Story: Part D RAC Program to Start Third Quarter

In anticipation of rolling out its Part D RAC program, The Centers for Medicare & Medicaid Services announced it has contracted with ACLR Strategic Business Solutions to perform Part D recovery auditing. READ MORE

Modifier 59: The Devil is in the Details

EDITOR'S NOTE: A recent Webinar conducted by eduTrax®’s Paula Digby generated a considerable number of questions. So we asked Ms. Digby to write this three-part article because there’s so much to cover when reporting Modifier 59.

PART I PART II PART III

(1)
The Division of Drug Information (DDI) is CDER's focal point for public inquiries. We serve the public by providing information on human drug products and drug product regulation by FDA.

FDA recognizes the significant public health consequences that can result from drug shortages and takes tremendous efforts within its legal authority to address and prevent drug shortages. These shortages occur for many reasons, including manufacturing and quality problems, delays, and discontinuations. FDA is aware that in 2010 there was a record number of shortages and in 2011 FDA has continued to see an increasing number of shortages, especially those involving older sterile injectable drugs.

When quality/manufacturing issues are discovered by the company or the public and reported to FDA or are found by FDA upon inspection, the FDA works closely with the firm to address risks involved to prevent harm to patients. FDA also considers the impact a shortage would have on patient care and access and works with the firm to restore supplies while also ensuring safety for patients. FDA works with other firms who manufacture the drug, asking them to ramp up production, if possible, in order to prevent or mitigate a shortage.

FDA works to communicate information about shortages based on information provided by the manufacturers. Companies voluntarily provide the shortage information posted on the FDA website. Manufacturers are not required to report information about shortages to FDA, and are not required to report the reasons for shortages or the expected duration of shortages on the FDA website. FDA encourages and appreciates all reporting of shortages by manufacturers.

Shortage notifications and updates may be reported to FDA at drugshortages@fda.hhs.gov.

For more information, please visit: Drug Shortages

For another good resource with detailed information about the various drug shortages please CLICK HERE.

Critical Drug Shortages Leave Doctors Scrambling

INDIANAPOLIS — Indiana hospitals are being forced to delay some treatments and find alternate medications because of a growing shortage of drugs that medical professionals say is the worst in a decade.

The number of drugs in short supply has risen from 70 in 2006 to 211 last year, and this year isn't looking any better, according to the University of Utah's Drug Information service, which has tracked drug shortages for the past 10 years. In the first quarter of this year 89 drugs were in short supply, the service said.
FDA Approves Incivek for Hepatitis C

The U.S. Food and Drug Administration today approved Incivek (telaprevir) to treat certain adults with chronic hepatitis C infection. Incivek is used for patients who have either not received interferon-based drug therapy for their infection or who have not responded adequately to prior therapies. Incivek is approved for use with interferon therapy made up of peginterferon alfa and ribavirin. READ MORE

FDA Approves Sylatron

FDA Approves Merck's SYLATRON™ (peginterferon alfa-2b) for Injection, a New Adjuvant Treatment for Melanoma with Microscopic or Gross Nodal Involvement. READ MORE

Guidance on Purchasing Drugs in Short Supply

If your practice is experiencing a shortage of a particular therapy, the American Society of Health-System Pharmacists (ASHP) has prepared a document offering guidance on purchasing drugs in short supply. The document contains excerpts from ASHP’s Guidelines on Managing Drug Shortages. READ MORE

FDA Approves Sutent for Rare Type of Pancreatic Cancer

The U.S. Food and Drug Administration today approved Sutent (sunitinib) to treat patients with progressive neuroendocrine cancerous tumors located in the pancreas that cannot be removed by surgery or that have spread to other parts of the body (metastatic). READ MORE

Three Senators Seek GAO Study of Drug Shortages, Potential Solutions

Three Senate Democrats have asked the Government Accountability Office to conduct a study of drug shortages in the United States, citing reports of frequent shortages of lifesaving pharmaceuticals at hospitals across the country.

In a May 4 letter, Sens. Bob Casey (D-Pa.), Tom Harkin (D-Iowa), and Richard Blumenthal (D-Conn.) asked GAO Comptroller General Gene L. Dodaro to examine how the Food and Drug Administration identifies and responds to drug shortages and to identify what steps FDA could take under its current authority to better identify and resolve drug shortages. Harkin is chairman of the Senate Health, Education, Labor, and Pensions Committee.

ACCC supports efforts to pass the “Preserving Access to Life-Saving Medications Act,” S. 296 introduced by Senator Amy Klobuchar (D-MN) and Robert Casey (D-PA). This bill shifts shortage reporting responsibility from providers to manufacturers; requires all manufacturers to report upcoming drug shortages to the FDA; increases manufacturer accountability by requiring them to anticipate and notify of future manufacturing stoppages, but does not impose fines or other sanctions for reporting; and allows providers to better anticipate impending shortages so both providers and patients can prepare for alterations in treatment regimens.

Read more on ACCCBuzz about the drug shortage issue and ACCC’s advocacy efforts to address the issue.
HHS Announces Proposed Changes to HIPAA Privacy Rule

A Notice of Proposed Rulemaking concerning the accounting of disclosures requirement under the Health Insurance Portability and Accountability (HIPAA) Act Privacy Rule, is available for public comment. The proposed rule would give people the right to get a report on who has electronically accessed their protected health information. READ MORE

Oncologists Hold Key to Curbing Cancer Costs

VCU Massey Cancer Center researchers propose evidence-based changes in oncologists' practice to cut cancer costs, ensure quality care for all and save money for future medical advances

Richmond, Va. (May 25, 2011) – The cost of cancer care is threatening to bankrupt our healthcare system. New drugs are prolonging life, but at staggering costs. This coupled with aging baby boomers and an increasing population mean the U.S. will spend $173 billion annually on cancer care by the year 2020. This trend is not sustainable; however, there are evidence-based ways to maintain or improve the quality of care while saving money for the new therapies being discovered every day.

READ MORE

May 18 ICD-10 National Provider Teleconference is now Available

The slide presentation for the May 18, 2011 ICD-10 national provider teleconference is now available on the CMS website. Please visit http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998 and scroll down the page to the “Downloads” section for the presentation. The topics covered were ICD-10 overview Lab, NCDs conversion process from ICD-9-CM to 1CD-10-CM, Home health conversion, OASIS and procedure code reporting, Update on claims spanning the implementation date, and National ICD-10 implementation issues.

READ MORE
Executive Summary
Our audit found that 1,619 of the 1,913 selected line items for which Noridian Administrative Services, LLC (Noridian), made Medicare payments to providers for outpatient services for the period January 1, 2006, through June 30, 2009, were incorrect. The line items included overpayments totaling approximately $5.8 million, which the providers had not refunded by the beginning of our audit. Providers refunded overpayments on 108 line items totaling approximately $2.2 million before our fieldwork. The remaining 186 line items were correct........ READ MORE!

Excerpt from the actual report: Another provider billed for 17 line items with an HCPCS code for a cancer treatment drug rather than using the correct HCPCS code involving the administration of a cancer treatment drug, the procedure actually performed. As a result of these errors, Noridian paid the provider $55,861 when it should have paid $149, an overpayment of $55,712.

Inspector General: Audits, Legal Actions May Net Up to $3.4 Billion

The Office of Inspector General (OIG), Department of Health & Human Services (HHS), today announced $3.4 billion in new expected recoveries (in accounting terms "receivables") related to its investigations, audits, and other reviews, mainly of Medicare and Medicaid. These expected recoveries are largely made up of restitutions, fines, penalties, other assessments, and settlements. This announcement was made in connection with presenting OIG’s Semiannual Report to Congress for October 2010 through March 2011. READ MORE

OIG Advisory Opinion 11-05

Concerning a tax-exempt charitable organization's: (1) proposal to provide financial assistance with cost-sharing obligations for certain genetic tests to financially needy individuals, including but not limited to Medicare and Medicaid beneficiaries, and (2) current practice of providing vouchers for free genetic tests to individuals who are uninsured or whose insurance does not cover genetic tests. READ MORE
Affordable Care Act Helps Fight Unreasonable Health Insurance Premium Increases

Today, The Department of Health and Human Services (HHS) issued a final regulation to ensure that large health insurance premium increases will be thoroughly reviewed, and consumers will have access to clear information about those increases. Combined with other important protections from the Affordable Care Act, these new rules will help lower insurance costs by moderating premium hikes and provide consumers with greater value for their premium dollar. [READ MORE](1)

Changes in Oncology Practice Could Save Billions

June 1, 2011 — If the cost of cancer care continues to rise at its current rate, it will eventually bankrupt the American healthcare system.

Cancer spending is slated to grow from $104 billion in 2006 to more than $173 billion in 2020, and this trend is just not sustainable, argue Thomas Smith, MD, and Bruce E. Hillner, MD, in the May 26 issue of the *New England Journal of Medicine*. Annual costs are projected to keep rising, and are primarily driven by the dramatic rise in the cost of therapy. [READ MORE](1)
Shaping Future Physician Payment Systems

The Affordable Care Act (ACA) calls for pilot-testing new physician payment and care delivery models. Following ACA enactment, key questions for many physicians centered on the changes that may be required of their practices and the future of Medicare and other payment systems.

With respect to Medicare, the current sustainable growth rate (SGR) formula has produced recurring threats of steep cuts in Medicare payments, to which Congress has responded with stop-gap measures 12 times over the past decade. As a result, physician practices have been coping with continuous fiscal uncertainty while Medicare payments have lagged far behind the rate of growth in the cost of providing health care services. READ MORE

CMS Proposes Exemptions to Medicare ePrescribing Penalty Policy

The Centers for Medicare & Medicaid Services (CMS) announced last week that it would modify the penalty policy for the Medicare ePrescribing Incentive Program, a move that drew applause from the AMA. According to a proposed rule from CMS ... READ MORE

AMA's Comments on ACO Regulation to Call for Interim Final Rule

The AMA will call for the Centers for Medicare & Medicaid Services to issue its upcoming regulation on accountable care organizations (ACO) as an interim final rule, not a final one, when it submits comments regarding the proposed rule in ... READ MORE


The rejection of a valid CPT® code is a violation of the Health Insurance Portability and Accountability Act. Included within the Healthcare ... READ MORE
SGR Repeal Just One Step to Improving ACA

Dr. Wilson writes about AMA efforts to improve the Affordable Care Act (ACA), starting with Medicare physician payment reform.  READ MORE

Get Guidance on Negotiating a Hospital Contract

AMA physician members thinking of making a career move to becoming a hospital employee can look to the AMA for help in navigating employment agreements. READ MORE

NIH Study Addresses Concerns About High Folate Levels

Increased folic acid from supplements, fortified foods not likely to affect B12 deficiency

Taking folic acid supplements or eating fortified grain products is unlikely to worsen problems related to low levels of vitamin B12, according to researchers at the National Institutes of Health and five other institutions in the United States, Ireland and Norway. READ MORE

Experts Develop Guidelines for Treating Anemia in Multiple Myeloma Patients (IMW 2011)

A group of leading myeloma specialists, known as the International Myeloma Working Group, recently collaborated to develop guidelines for the proper management of anemia with erythropoietin therapy in multiple myeloma patients. The group advised erythropoietin therapy for anemic myeloma patients receiving chemotherapy in order to improve quality of life and to reduce the need for red blood cell transfusions. They further recommended the addition of iron to improve the efficiency of erythropoietin therapy. READ MORE

Thwarting Leukemia Drug Resistance

Researchers identify a pathway that allows leukemia to evade a common cancer treatment -- and develop a way to block it

Tyrosine kinase inhibitors (TKIs) quell unregulated cell growth and are commonly used to treat cancer, but many tumors develop resistance to the therapy. New research published today in Nature identifies a pathway that keeps the cancer cells alive long enough to evolve such resistance, and shows that inhibiting this pathway in mice with acute lymphoblastic leukemia (ALL) can prevent treatment evasion and cancer reemergence. READ MORE
UPDATE 1 - Cancer Costs Put Treatments Out Of Reach for Many

(Reuters) - The skyrocketing cost of new cancer treatments is putting advances in fighting the deadly disease out of reach for a growing number of Americans.

Cancer patients are abandoning medical care because the costs are simply too high and medical bills -- even among the insured -- are unmanageable and put patients at a greater risk of bankruptcy, studies show.

READ MORE

Studies Find New Drugs Boost Skin Cancer Survival

Two novel drugs produced unprecedented gains in survival in separate studies of people with melanoma, the deadliest form of skin cancer, doctors reported Sunday.

In one study, an experimental drug showed so much benefit so quickly in people with advanced disease that those getting a comparison drug were allowed to switch after just a few months.

The drug, vemurafenib, targets a gene mutation found in about half of all melanomas. The drug is being developed by Genentech, part of Swiss-based Roche, and Plexxikon Inc., part of the Daiichi Sankyo Group of Japan.

READ MORE

Roche's Avastin Shows Ovarian Cancer Benefit

Two major studies of Roche Holding AG's (RHHBY, ROG.VX) Avastin showed that the drug may benefit patients with advanced ovarian cancer, but it remains unclear if the drug actually extends lives in the difficult-to-treat disease.

Avastin, which had $6.8 billion in 2010 sales, is already approved to treat lung, colon, kidney and brain cancers and Roche is hoping that use in ovarian cancer will help sustain its sales growth. It has already filed for approval in Europe and has said it plans to do the same in the U.S. later this year.

READ MORE

Cancer Meeting Emphasizes Cost of Care

This year's meeting of the American Society of Clinical Oncology brought more updates than breakthroughs while it re-emphasized one of the biggest issues facing cancer care: continually rising costs.

The Chicago meeting is the world's largest cancer conference, with about 32,000 people attending this year, according to ASCO. While the focus of a meeting like ASCO's is new drugs and treatments, the amount of dollars needed to acquire them is often close behind.

The cost of cancer care is expected to rise to $173 billion in 2020 from $104 billion in 2006, according to a recent article in the New England Journal of Medicine, with most new drugs priced at $5,000 a month or more.

READ MORE
Curative Treatment of Oesophageal Carcinoma: Current Options and Future Developments

Since the 1980s major advances in surgery, radiotherapy and chemotherapy, have established multimodal approaches as curative treatment options for oesophageal cancer. In addition the introduction of functional imaging modalities such as PET-CT created new opportunities for a more adequate patient selection and therapy response assessment. The majority of oesophageal carcinomas are represented by two histologies: squamous cell carcinoma and adenocarcinoma. In recent years an epidemiological shift towards the latter was observed. From a surgical point of view, adenocarcinomas, which are usually located in the distal third of the oesophagus, may be treated with a transhiatal resection, whereas squamous…

READ MORE

Palliative Radiotherapy in Patients with a Symptomatic Pelvic Mass of Metastatic Colorectal Cancer

RT was an effective palliation method in patients with a symptomatic pelvic mass of metastatic colorectal cancer. For improvement of symptom control rate and duration, a BED [greater than or equal to] 40 Gy10 is recommended when possible. Considering the low morbidity and improved symptom palliation, CCRT might be considered in patients with good performance status. READ MORE

ASCO Annual ’11 Meeting
Something for Everyone: Radiation Oncologists’ Corner

Christopher G. Willett, MD, a specialist in gastrointestinal (GI) cancers, is Chair of the Department of Radiation Oncology at Duke University Medical Center.

An ASCO member for many years, Dr. Willett tries to attend the Annual Meeting every year if possible. For him, a large part of the Annual Meeting is the valuable information he and others bring back to the Radiation Oncology Department. READ MORE

Press Release: IMRT Cuts GI Side Effects from Prostate Cancer in Half vs. 3D-CRT

Fairfax, Va., June 1, 2011 - Intensity modulated radiation therapy, a newer, more precise form of radiation therapy, causes fewer gastrointestinal side effects when combined with hormone therapy than using three-dimensional radiation therapy, according to a study published in the June issue of the International Journal of Radiation Oncology•Biology•Physics, the official scientific journal of the American Society for Radiation Oncology (ASTRO).

READ MORE
Coding the Set Up Simulation Procedure

Due to the change in equipment and technology within recent years, coding of the set up simulation has become an area of common billing and coding errors. Unfortunately, the descriptions for the simple, intermediate, and complex simulation codes have not kept up with updates in technology, resulting in confusion and problems in establishing the appropriate level of complexity. An excerpt from the current Palmetto GBA Local Coverage Determination (LCD) for Radiation Oncology: External Beam /Teletherapy (L28297) is provided below.

77280 Therapeutic radiology simulation-aided field setting; simple
If any or all of the following factors are present, the simulation will remain simple:
- Single treatment volume with either a simple port or parallel opposed ports (2) with simple or no blocking;
- Block verification simulation; and/or
- Subsequent simulations (e.g. orthogonal films) for brachytherapy source verification (radioactive or dummy).

77285 Therapeutic radiology simulation-aided field setting; intermediate
If any of the following factors are present, the simulation will be considered intermediate:
- Simulation of three or more converging ports, or two separate treatment volumes; and/or
- Multiple blocks, if clinically necessary.

77290 Therapeutic radiology simulation-aided field setting: complex
If any or all of the following factors are present, the simulation will be considered complex:
- Three or more treatment volumes;
- Rotation or arc therapy;
- Complex blocking, custom made shielding blocks based on clinical necessity;
- Any use of contrast media (e.g. body cavity, GI tract, or intravascular) to define anatomic structures and treatment volume, or for initial brachytherapy simulation;
- Tangential ports with multiple devices;
- Custom immobilization devices.

With the use of CT based simulation techniques, the simulation procedure is now focused on patient positioning and immobilization devices, rather than the determination of treatment fields, gantry angles and blocking as previously performed in the conventional simulator. Therefore, the determination of the appropriate simulation code is tied to the use of custom immobilization devices, contrast or possibly the simulation of more than one treatment area. Each of these items elevates the level of simulation; however, with the lack of these items the simulation is considered simple (77280).

A common misconception is the idea the set up simulation process is complex based on the fact the patient “will be” 3D or IMRT resulting in custom blocking, multiple ports, tangents, arcs, etc. As this work is provided at a later point in the patient care process and as a part of a different procedure, it cannot be used in support of the set up simulation procedure or level of service from a billing perspective. Another similar error is the coding of a simulation based on the fact CT images were acquired as part of the process. Although the imaging is typically performed at the time of the simulation and allows for more complex dosimetry planning, it is a separate billable service (77014TC) and not a determining factor in the level of complexity of the simulation.

It is recommended to evaluate the current coding practices within your facility to ensure the appropriate rationale is used in determining the appropriate simulation code, and the level of complexity is supported within the set up simulation documentation.
Quitting Tobacco for Newly Diagnosed Cancer Patients

In 2010 Fairmont General Hospital did a Quality Improvement project for patients who are newly diagnosed with cancer and are current tobacco users. Research has shown that there are significant benefits to quitting tobacco at the time of a cancer diagnosis and that it is truly never too late to quit. A poster and booklet was developed based on information from Memorial Sloan Kettering that provides facts on the improvement which cancer patients can see in their health and treatment course by eliminating tobacco. Booklets are available and can be shared with any facility or physician’s office that is interested.

The poster may be printed for distribution or display, CLICK HERE.

Color copies of The poster are available by contacting Tricia Julian, Oncology Education Coordinator, Fairmont General Hospital, at julpa@fghi.com or 304-367-7247.

Chemotherapy Courses at Fairmont General

Fairmont General Hospital is offering several chemotherapy programs this year and invites any area health care facility or physician’s office nurses to join us. Both classes are through the Oncology Nursing Society.

**ONS Two Day Chemotherapy and Biotherapy Course**
- Course fee is $190.00
- Registration due three weeks prior to start date
  - August 17 & 18, 2011 – 8:00 a.m. to 4:30 p.m.

**Treatment Basics Chemotherapy Course**
- Course fee is $50.00
- Registration due three weeks prior to start date
  - June 28, 2011 – 4:00 p.m. to 8:00 p.m.
  - August 23, 2011 – 12 noon to 4:00 p.m.

Additional information is available on the WVOS website, CLICK HERE, or you may contact Tricia Julian at 304-367-7247 or julpa@fghi.com

Adding Zoledronic Acid Improves Breast CA Survival

MONDAY, June 6 (HealthDay News) -- Adding zoledronic acid to either anastrozole or tamoxifen improves disease-free survival in women with endocrine-receptor-positive breast cancer who are receiving adjuvant endocrine therapy, according to a study published online June 4 in The Lancet Oncology. READ MORE

Melanoma Vaccine May Enhance Interleukin-2 Efficacy

WEDNESDAY, June 1 (HealthDay News) -- Patients with advanced melanoma who are treated with interleukin-2 and melanoma vaccine may have an improved clinical response and longer survival than those treated with interleukin-2 alone, according to a study published in the June 2 issue of the New England Journal of Medicine. READ MORE
Rehabilitation Services May Not Meet Patients’ Needs

Patients’ perceptions of their survivorship care shows room for improvement

Up to 39% of cancer patients believed they did not receive the physical rehabilitation they needed, and 10% to 24% believed they did not receive other rehabilitation services they required. These are the findings of a group of Danish researchers who used the Oncology Nursing Society definition of “a process by which individuals within their environments are assisted to achieve optimal functioning within limits imposed by cancer,” to survey 2202 cancer patients regarding their perception of the rehabilitation they received. Their findings further revealed that age predicted rehabilitation offers, leading the researchers to conclude that patients’ needs should be assessed and services offered corresponding to those needs identified.

The complete findings are published online in the May 21 edition of Supportive Care in Oncology (http://www.springerlink.com/content/4062l1402291hu43/).

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2011 Relay For Life of Berkeley County, WV
Saturday, June 4, 2011 at Martinsburg High School

RESULTS
Teams 109
Participants 1826
Dollars Raised $277,038.19

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NCCN 2011 Nursing Program Webinar

- Nursing Considerations in the Treatment of Pancreatic Cancer
  Monday, June 13, 2011, 3:00 – 4:00 PM EDT

Safety in Large Doses

Chemotherapy’s many nuances make patient safety a challenge for RNs

In real estate, the saying goes, success relies on location, location, location. But in oncology nursing, the key, when it comes to patient safety, is education, education, education. It’s education in terms of staying on top of an ever-expanding universe of treatments. It’s education that helps oncology nurses master processes that ensure a safe environment for patients. And finally, it’s education of patients themselves.

The complete findings are published online in the May 21 edition of Supportive Care in Oncology.

FDA Discourages Thermography as Primary Screening for Breast Cancer

The U.S. Food and Drug Administration has issued a warning for women not to substitute breast thermography for mammography when screening for breast cancer.

Unlike mammography, in which an X-ray of the breast is taken, thermography produces an infrared image that shows the patterns of heat and blood flow on or near the surface of the body. According to the FDA, some healthcare providers have claimed…
West Virginia Oncology Nursing Society Chapters

West Virginia Chapters Include....

North Central West Virginia ONS Chapter:
http://ncwv.vc.ons.org
Announcements
Click here to subscribe to the Chapter Announcements.

Subscribe to Calendar Events
Click here to receive calendar events.

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

Cancer Nursing
(www.nursingcenter.com)
The Journal of Hospice and Palliative Nursing (journals.lww.com/jhpn/pages/default.aspx)
Oncology Nursing Forum (www.ons.org/Publications/ONF)
ONS News (www.ons.org/Newsroom)
Seminars in Oncology Nursing (www.harcourthealth.com)
Clinical Journal of Oncology Nursing (www.ons.org/Publications/CJON)
Journal of Pediatric Oncology Nursing (www.harcourthealth.com)
Oncology Nursing News (www.oncologynursingnews.com)
ONS Online (www.ons.org)
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

CHC WEST VIRGINIA
Home Provider

CIGNA
Home Provider

THE HEALTH PLAN
Home Provider

HUMANA
Home Provider

HIGHMARK WEST VIRGINIA BLUE CROSS BLUE SHIELD
Home Provider

OPTIMUM CHOICE
Home Provider

PALMETTO GBA
Home Provider

UMWA HEALTH & RETIREMENT
Home Provider

UNITED HEALTHCARE
Home Provider

A Few Articles You Won’t Want To Miss:

- Clinical payment, coding and policy changes…pg 2
- Electronic precertification – let us do the work for you..pg 4
- Federal employees have tobacco cessation benefits…pg 6
- Education on Genetics…pg 7
- Ensure accurate billing for medically covered drugs…pg 8

AND MUCH MORE…..

Articles of Interest:

- Beginning January 1, 2011 JCodes and Immunizations
- Services Requiring Preauthorization 2011
  - Clinical Trials
  - CT Scans
  - Genetic Testing and Genetic Counseling
  - Hospital Observation Stays
  - Injectable and Self-Administered Injectable Drugs, if covered under Medical and Surgical Benefits instead of Prescription Drug Benefits
  - Inpatient Admission Stays: includes Acute, Skilled Nursing Facility Care and Inpatient Hospice

And much much more!!
Payer Updates

Articles of Interest

✓ Smoking Cessation Benefit for Federal Government Employees
✓ KRAS Pathology Submission Requirement Change Related to Erbitux and Vectibix
✓ Drugs & Biologicals
✓ Medical Policy Updates

And Much More… May 2011 Bi-Monthly Issue Available HERE

Highmark West Virginia Launching Oncology Management Program

Summer 2011 Highmark West Virginia is planning on launching their Oncology Management Program with a two-tiered reimbursement structure. P4 Pathways has been selected to be the vendor supporting some of the aspects of the program. Currently Highmark West Virginia is targeting West Virginia community practices and is putting together a steering committee. The official launch date is still July 1st however, as of the first week in June, Highmark West Virginia had not chosen the steering committee and implied that the date may be pushed back. WVOS has asked for an audio conference or webinar for our members to make sure everyone understands the program and has an opportunity to have all of their questions answered prior to making their participation decision. WVOS will be announcing the date of this meeting very soon!
ePrescribing

An ePrescribing tool, **WVeScript**, is now available to all enrolled WV Medicaid prescribers at no charge and can be used to transmit prescriptions for patients with any insurance carrier. WVeScript is located within the BMS MediWeb Portal and can be accessed with a UserID, password, and Pin. For more information about WVeScript, please call the Help Desk at (304) 558-7309 or email DHHRMedicaideScript@wv.gov.

The Point of Sale claims processing system for WV Medicaid is enabled to fully support electronic prescribing and can return information for all electronic queries including eligibility, pharmacy history, and formulary.

More information about electronic prescribing and Health Information Technology can be found at www.WVeScript.com. The [WVeScript Online Learning Center](#) provides two courses about Health Information Technology and videos of the ePrescribing process. To find out more about the BMS MediWeb Portal or to access an enrollment application, please click [Here](#).

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