West Virginia Oncology Society
Annual Spring
CME Membership Meeting
Friday, April 8th, 2011

along with

West Virginia Oncology Society
Statewide Cancer Clinical Trial
Network Dinner
Thursday, April 7th, 2011

BE SURE TO
REGISTER TODAY!!
NEW Monthly "Lunch and Learn" Series
YOU ASKED – WE LISTENED

We understand how difficult it is to stay on top of reimbursement changes in oncology. In support of our WVOS members we will be providing, free of charge, monthly “Lunch and Learn” seminars on different reimbursement topics for both private practice and outpatient hospital.

The next session:

SAVE THE DATE – A CAN’T MISS PROGRAM FOR ALL ONCOLOGY PRACTICES IN WEST VIRGINIA!!!

March 29th, 2011
Private Practice (Part B) J11 Implementation Audio Conference

Palmetto GBA is the contractor for the new J11 A/B MAC. To assure a smooth transition for our membership, WVOS has partnered with Palmetto GBA to bring you an audio conference specific for our members. Share this information with your facility and DO NOT MISS THIS OPPORTUNITY!

Audio Conference Date: Tuesday, March 29, 2011
Time: 12:00 – 12:45 est
Registration: No need to pre-register
Dial-in Number: 1-213-342-3000
Participant Access Code: 4658667

Download your slides or have the slides on your computer screen and dial in for the call a few minutes before noon!

Future Lunch and Learn sessions will be held May 3rd and June 7th.

Participate In E-prescribing Today or Receive Penalty in 2012

You should be e-prescribing TODAY if you want to avoid Medicare penalties in 2012. Remember, the Centers for Medicare & Medicaid Services (CMS) is basing the 2012 penalties (minus 1% of allowed Medicare charges) on e-prescribing behavior in 2011 (specifically, January 1 to June 30, 2011). See ASCO for further details on requirements and what to do to earn the 2011 incentive AND avoid the 2012 penalty.

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

WE NEED YOUR HELP
Please report any Underwater Drug Reimbursement to reimbursement@wvos.info
Ambulatory Pump Drug - DME or Part B

– CMS RESPONDS –

DRUG PUT INTO AN AMBULATORY PUMP WHILE THE PATIENT IS
“Incident To” THE PHYSICIAN CAN BE BILLED TO MEDICARE PART B!!!

Attempting to obtain clarification, WVOS inquired with our local Carrier, Palmetto GBA, our outpatient hospital Fiscal Intermediary, NGS, two DME contractors, the National Supplier Clearinghouse who processes DME applications for the country, ASCO, and CMS National. The answer received varied by the person we spoke with.

Ultimately, it was established that the drug would be considered, “Incident to” per Chapter 15 of the Medicare Benefit Policy Manual, Section 50.3 incident to provisions for drugs since:

- the drug is not usually self-administered
- the drug represents an expense incurred by the physician
- the initiation of the drug was administered by the physician or by auxiliary personnel employed by the physician and under the physician’s supervision

The final decision was made by the “Incident To” expert, Cheryl Gilbreath, PharmD, MBA, R.Ph., Health Insurance Specialist, Division of Ambulatory Services, Hospital and Ambulatory Policy Group. Center for Medicare Management, Centers for Medicare & Medicaid Services. Ms Gilbreath stated, “The short answer is if the physician incurs the cost for furnishing the drug to the beneficiary, then the physician – not the pharmacy - must bill the Part B Carrier for the drug under the “incident to” benefit. Otherwise, if the pharmacy furnishes the drug directly to the beneficiary, then the pharmacy would bill the DME MAC (or the Carrier if for implantable DME) for the drug under the DME benefit.”

This is great news for our membership and all oncology offices throughout the country since many do not have a DME license and are currently not able to bill the DME. The extensive DME application process and billing separately for this drug would be a significant burden to our practices.

WVOS would like to thank Phyllis Avery, Avery Law Offices, PLLC for her assistance in resolving this issue.

(1)
Faslodex and 5FU Medically Unlikely Edit Revisions

The Medically Unlikely Edit (MUE) for HCPCS code J9395 - Fulvestrant, 25 mg and J9190 – Fluorouracil, 500 mg will be increased and is scheduled for April 1, 2011.

**HCPCS code J9395** - Fulvestrant will be increased to reflect the September 9, 2010, FDA approved dose of 500 mg. During the interim period, providers may submit two claim lines with units of 10 to report the 500 mg dose. To receive reimbursement for a denied claim, you may select one of the following options:

- resubmit with 10 units in each line
- add HCPCs modifier 59 to the second line
- submit a redetermination request (first level appeal)
- hold the claim until the April 1, 2011, revision

**HCPCS code J9190** – Fluorouracil is under review for a final MUE value. Providers are asked to hold claims and submit after the April 1, 2011, MUE revisions are complete.

Update to the Healthcare Provider Taxonomy Codes (HPTC) April 1, 2011

CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HPTC) list. Medicare carriers and DME MACs will update their HPTC tables with this new version effective on April 1, 2011.

**DETAILS**

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Want To Enhance Your Medicare Knowledge?

When will a Medicare representative be in your area? Need a Medicare refresher course but can't find the time to leave the office? Check out the Learning & Education page on the Palmetto GBA Web site.

Palmetto GBA offers many programs to meet your needs. Health care providers and their staff members can attend in-person workshops, Web-based seminars (Webinars) or dial into one of our Ask the Contractor Teleconferences (ACTs) for free!

Registration and other important details are available on the Learning & Education page of our Web site. Select 'Learning & Education' on the left side of this Web page.

For your convenience, select the link below to view a calendar of events to give you an at-a-glance preview of what we have to offer. We are looking forward to working with you.

**CALENDAR OF EVENTS**
Smoking and Tobacco-Use Cessation Counseling

Medicare Part B covers two levels of counseling, intermediate and intensive, for smoking and tobacco-use cessation. This article includes information about these covered benefits and was revised on February 24, 2011, to add a reference in the Additional Information section. [DETAILS](1)

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CMS Staff to Conduct Follow-up Calls for CERT Program

The Centers for Medicare & Medicaid Services (CMS) will be conducting follow-up calls to providers related to the Comprehensive Error Rate Testing (CERT) program. CMS staff may contact you to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although you may have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation may change your claim’s status from ‘improper payment’ to ‘proper payment.’ This will allow us to calculate a more accurate Medicare fee-for-service (FFS) error rate and reduce the amount of improper payments. [1]

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Palmetto Contacts and Resources

The Contacts and Resources ebook is now available. It includes: a list of resources to assist your Medicare patients, helpful Web sites to bookmark, information on submitting appeals and correcting claims, and a list of key, recent changes to Local Coverage Determinations. [READ MORE](2)

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West Virginia Part B Carrier Written Transcript and Audio Recording for the 'Preparing for ICD-10 Implementation in 2011' January 12 Teleconference

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider teleconference on 'Preparing for ICD-10 Implementation in 2011' on January 12, 2011. The written transcript and audio recording are now available on the [CMS Web site](2) (refer to the downloads section and select the appropriate file).

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Medical Review Findings: Teleconference Handout Materials

Within this document you will find specifics on:

- Treatment plan with objective measures, and/or
- Time spent for time-based therapy CPT codes
- E/M Specific Concerns
  - Use of “noncontributory”
  - Documenting “labs reviewed” without further information
  - Ancillary staff or scribe documentation requirements were not met
  - Billing provider referred to another provider’s documentation
- When billing CPT code 36415 (venipuncture), the documentation must support this service was rendered
- Split/Shared Services - physician must have a face-to-face with the same patient

[1] [2]
Local Coverage Determination Updates
(No new updates in March)

<table>
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<tr>
<th>LCD</th>
<th>Change</th>
<th>Effective Date</th>
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Claims Submission: Implantable Tissue Markers (HCPCS Code A4648)

When submitting claims to Palmetto GBA for HCPCS code A4648-tissue markers, an invoice is required with each claim. Failure to include the invoice with your claim will result in rejection of your service. [READ MORE](#)

Changes to the Time Limits for Filing Medicare Fee-For-Service Claims …Pg 4

- Ask-the-Contractor Teleconferences and Webinars …Pg 22

- Modifications to the Implementation of the Paperwork (PWK) Segment for X12N Version 5010 …Pg 23

- Clinical Laboratory Fee Schedule: Medicare Travel Allowance Fees for Collection of Specimens …Pg 33

This issue of the Palmetto GBA "Medicare Advisory" contains the information listed and much more.

This is a MUST READ for every practice.

Download the March edition of the Medicare Advisory in PDF format [HERE](#)
**WVOS Private Practice Reimbursement Q & A’s**

**QUESTION:** I am looking for information on the FDA Medication Guides that we are supposed to give to a patient. Can you tell me where I would find something like that?

**ANSWER:** FDA requires that Medication Guides be issued with certain prescribed drugs and biological products when the Agency determines that:
- certain information is necessary to prevent serious adverse effects
- patient decision-making should be informed by information about a known serious side effect with a product, or
- patient adherence to directions for the use of a product are essential to its effectiveness.

There are currently 279 drugs on the list. To review the list and access the medication guides, visit: [http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm](http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm). You will also find information about Risk Evaluation and Mitigation Strategies (REMS) programs, drug shortages, and much more on this site.

**QUESTION:** I need your help. I've been given the task by our billing manager to figure out the reimbursement for two new drugs we are using: Jevtana and Xgeva. To figure that out I need to know what the Medicare allowable is. Where can I find this information for new drugs?

**ANSWER:** The Jevanta (Cabazitaxel) is listed on the CMS ASP NOC file:  Cabazitaxel - 1MG - $141.33. The Xgeva – (denosomab) is also on the list:  Denosumab- 1 MG - $14.54

You can download the ASP NOC file at: [www.cms.gov](http://www.cms.gov). Click on Medicare, then look on the right side for Medicare Fee for Service Part B Drugs and click on Medicare Average Sales Price. Once there chose the file with NOC (not otherwise classified).

**QUESTION:** I know Palmetto has a place on their website we can post questions but they have up to 45 days to answer and usually we get answers that are vague or not even relevant to the question we asked. Is there any other way to get a question answered by Palmetto?

**ANSWER:** One excellent way is to participate in the “Ask the Contractor” session. Under the Medicare Modernization Act, Medicare contractors are required to hold these sessions to give providers a opportunity to be informed about the Medicare and Medicare contractors rules and “bill

*Continued on next page...*
correctly”. During these calls Palmetto is required to attempt to answer the questions and provide follow up if necessary. They like when questions are submitted in advance of the conference. These may be sent via fax to (614) 473-6812 addressed to ‘Ask the Contractor Teleconference.’ The next ATC meeting is May 2 at 2:00 p.m. EST. No registration required. Call in number is 877-789-3907 and participant code 13795607.

**QUESTION:** We have a protocol where we give the patient the drug and then they stay in the chair, hooked up to saline for 1 hour in case they have a reaction. Can we bill hydration during this time?

**ANSWER:** Only if the hydration that the patient receives in “medically necessary”. If the patient is just hooked up to the line so the nurses can react quickly, then answer is no. If the patient receives the drug and NEEDS the saline (hydration) then it would be appropriate to bill for the hydration, CPT 96361.

**QUESTION:** Has anyone used the long term Emend, J1453 (150mg) that covers for 5 days? We would like to use this but are concerned about all of the pre-auths and reimbursement problems on newer drugs?

**ANSWER:** Here is a response received from one of our WVOS members;

We have switched all of our 115 mg to 150 mg and get paid without a problem, plus you don't need the bi-pack anymore so no additional pre-auth for that.

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**REIMBURSEMENT QUESTIONS?**
reimbursement@wvos.info
Latest Production Alerts

**Hepatitis Vaccines Not Reimbursing on Type of Bill 131 | 03/01/2011**
Hepatitis vaccines 90740, 90743, 90744, 90746, and 90747 are not reimbursing on type of bill (TOB) 131.

**Coinsurance and Deductible Incorrectly Applying to Certain Claims | 03/01/2011**
Due to a problem with the January 2011 release, coinsurance and deductible are being incorrectly applied to some preventative care healthcare common procedure coding system (HCPCS) codes. Some of these claims are suspending with a reason code 39930.

**Multiple Procedure Payment Reduction Being Incorrectly Applied | 02/08/2011**
The multiple procedure payment reduction (MPPR) is being incorrectly applied to therapy claims with dates of service on or after 01/01/2011 and for some therapy HCPCS codes regardless of dates of service.

**RESOLVED: Over- and Underpayments as a Result of Incorrect Units Issue | 02/08/2011**
Providers may be seeing underpayments and/or overpayments as a result of the release issue that caused claims to be processed with incorrect units.

**Claims Returning to Provider with Reason Code 711M2 | 02/01/2011**
Reason code 711M2 is being used for claims that were returned to the provider (RTP) due to the units of service issue. 711M2: “Claims processed with incorrect units due to a system issue. No action required by the provider. Please do not return this claim in RTP status as this could cause the claim to process incorrectly.”

**IMPORTANT UPDATE**

J11 Part A Medicare Administrative Contractor (A/B MAC) New Workload Numbers for West Virginia Part A

PART A - West Virginia

MAC Number - 11401

Effective Date – May 16, 2011

Current Contractor Number - 00453

For more information visit the J11 Website: www.palmettogba.com/J11A

If you missed our recent lunch and learn that was held on March 1st, the handouts from Palmetto are still available on the WVOS website...CLICK HERE
A New Feature Has Been Added to the EDI Section of the NGSMedicare.com Web site!

The EDI section of the NGSMedicare.com Web site now offers a Post Call Survey page to allow all trading partners the opportunity to rate the customer service experience they have had with our EDI Help Desk. Please take a moment to give us your opinion on our EDI Help Desk Technicians. The feedback given allows EDI to continuously improve ourselves and serve you better in the future. The survey is available on our Web site at www.NGSMedicare.com. Select "Electronic Submissions (EDI)" under the "Claims" section; look for the EDI Help Desk Post Call Survey Link. If you have any questions, please contact the EDI Help Desk at 877-273-4334 or via e-mail at http://apps.ngsmedicare.com/applications/carrierinquiry_enrol.aspx?CatID=2.

March 2011 LCD/Article Revisions

Article for Doxorubicin, Liposomal (Doxil) – Related to LCD L25820 (A47585)

Article published March 2011: The following language, primary or metastatic, has been added to the indication for breast carcinoma. Hodgkin lymphoma, Non-Hodgkin lymphoma (NHL) – AIDS related B-cell lymphoma, diffuse large B-cell lymphoma, mycosis fungoides, sezyary syndrome, primary cutaneous B-cell lymphoma and uterine neoplasms – endometrial carcinoma have been added to the “Indications” section of the article. The following paragraph has been added to the “Coding Guidelines” section of the article:

- Doxorubicin is approved for the treatment of metastatic malignancy. Correct coding requires the use of the secondary cancer code (196, 197, 198 and 199 series of ICD-9-CM codes) as the primary diagnosis and the original cancer site (V10 series of ICD-9-CM codes) as the secondary diagnosis. The secondary cancer sites will not be listed in the drug article, only the appropriate “History of,” V10-codes are listed.

The following ICD-9-CM codes 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8 and 188.9 have been added to the article effective for dates of service on or after 07/18/2008. Based upon compendia review, the following ICD-9-CM codes; 182.0, 200.70-200.78, 200.80-200.88, 202.80-202.88, 203.12, 203.82 and V10.3, have been added effective for dates of service on or after 03/01/2011. In the paragraph section for “ICD-9 Codes that are Covered,” the following note has been added: Note: ICD-9-CM codes:188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8 and 188.9 should be used when reporting sarcomas of the urinary bladder.042 and 200.70-200.78 and 202.80-202.88 should be used to report AIDS related B-cell lymphoma. In the “Sources of Information” section, the formatting of the Web sites for Clinical Pharmacology, National Comprehensive Cancer Network and Micromedex DrugDex® has been revised.

LCD for Erythropoiesis Stimulating Agents (ESA) L25211 R14 (Correction published 03/01/2011): Due to a typographical error, ICD-9-CM codes 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82 and 205.90 were inadvertently omitted from the “ICD-9-CM Codes that DO NOT Support Medical Necessity” section. Minor changes made to reflect current template language. No comment or notice periods required and none given.
Contacting National Government Services

Did you know that there are several ways to contact National Government Services, depending on the type of question/issue you need us to address?

The Centers for Medicare & Medicaid Services (CMS) requires National Government Services to maintain a Provider Customer Service Program (PCSP)* to help providers and suppliers understand and comply with Medicare’s operational processes, policies, and billing procedures.

The PCSP strengthens and enhances Medicare’s provider education efforts by delivering accurate and consistent information in a courteous and professional manner. These practices enable providers and suppliers to understand, manage, and bill the Medicare program correctly, and to reduce their Medicare paid claims error rate and improper payments.

Per our PCSP, one way we ensure the most accurate, reliable, and timely customer service is by providing several telephone, e-mail, and Web site contact options to the provider and supplier communities. The Contact Us index on our Web site includes all of the contact options that we offer providers and suppliers.

You can access the Contact Us subnavigation under the Resources section located in the site’s top navigation.

If you are not sure who to contact with your specific question, please call the Provider Contact Center for your business type and state/jurisdiction. Our representatives will ensure that your call is properly routed if they are not able to help you on the spot.


2011 Electronic Prescribing (eRx) Incentive Program Reminder-Avoiding the Adjustment

In November, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between January 1, 2011 – June 30, 2011, may be subject to a payment adjustment on their Medicare Part B Physician Fee Schedule (PFS) covered professional services. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99 percent of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5 percent of their Medicare Part B PFS covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2 percent, resulting in an eligible professional or group practice receiving 98 percent of their Medicare Part B PFS covered professional services.

Continued on next page...
The payment adjustment does not apply if <10% of an eligible professional’s (or group practice’s) allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

Please note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment

- **Eligible professionals**—An eligible professional can avoid the 2012 eRx Payment if (s)he:
  - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Jun 30, 2011 based on primary taxonomy code in NPPES;
  - Does not have prescribing privileges. **Note:** (S)he must report (G8644) at least one time on an eligible claim prior to June 30, 2011;
  - Does not have at least 100 cases containing an encounter code in the measure denominator;
  - Becomes a successful e-prescriber; and
  - Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

- **Group Practices**—For group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice **MUST** become a successful e-prescriber.
  - Depending on the group’s size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the “Getting Started” Web page at [http://www.cms.gov/erxincentive](http://www.cms.gov/erxincentive) on the CMS Web site for more information; or download the Medicare’s Practical Guide to the Electronic Prescribing (eRx) Incentive Program under Educational Resources.
WVOS Oncology Outpatient Hospital Reimbursement Q & A’s

**QUESTION:** How do APCs work?

**ANSWER:** Each APC is composed of services which are similar in clinical intensity, resource utilization and cost. All services (identified by submission of CPT codes on the hospital’s UB 04 claim form) which are grouped under a specific APC result in an annually updated Medicare “prospective payment” for that particular APC. Since this payment is a prospective and “fixed” payment to the hospital, the hospital is at risk for potential “profit or loss” with each APC payment it receives. The payments are calculated by multiplying the APCs relative weight by the OPPS conversion factor and then there is a minor adjustment for geographic location. The payment is divided into Medicare’s portion and a patient co-pay. Co-pays vary between 20 and 40% of the APC payment rate. Eventually this percent will be capped at 20% of the payment rate.

**QUESTION:** Where can I find the payment rate and APC for the infusion codes?

**ANSWER:** These can be found on the CMS website within the Addendum B Update; https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage

**QUESTION:** Can you tell me the difference between a pass-through drug and a non-pass through drug? Where can I find information on the CMS site?

**ANSWER:** Pass-Through Drugs-Section 1833(t)(6) of the Social Security Act provides for temporary additional or “pass-through” payments for certain drugs, devices, and biological agents that meet identified criteria. Under the statue, transitional pass through payments can be made for at least two years, but no more than three years.

Non Pass-Through Drugs-Drugs, biologicals (including blood and blood products), and radiopharmaceuticals that do not have pass-through status are either packaged into existing Ambulatory Payment Classification (APC) payments for service or receive separate APC payment. To find a listing of HCPCS codes used to bill for drugs and biologicals, reference Addendum B of the OPPS Final Rule (updated annually) or the CMS Web Site: http://www.cms.hhs.gov/

**QUESTION:** If the reason code indicates that the service may be reprocessed with an appropriate modifier, where can I obtain the modifier?

**ANSWER:** Refer to the CMS Publication 100-04, Claims Processing Manual, Chapter 4, Section 20.6

Continued on next page…
**QUESTION:** What is a PTAN?

**ANSWER:** A PTAN is the provider transaction access number, which is also known as the six-digit provider number, OSCAR number or legacy number. Providers will be asked for their PTAN when calling the Provider Contact Center (PCC).

**QUESTION:** Does the MUE Problem for Faslodex I am reading about apply to our outpatient hospital billing as well?

**ANSWER:** Yes, the MUE will affect all claims billed for that drug regardless of location of service reported.

**QUESTION:** I recently started receiving edits for medical necessity on my clinical trial claims. I am using the V707 diagnosis code. Was there a recent change to this diagnosis code for medical necessity?

**ANSWER:** You must ensure, based on the year of your claim, that the appropriate modifiers are present on the claim so that it may process correctly. For outpatient clinical trial claims:

1. **All services on the claim are related to the trial** - Institutional providers billing clinical trial claims that contain only clinical trial line item services do not have to report the routine HCPCS modifiers QV or Q1. The presence of condition code 30 along with the absence of the QV or Q1 HCPCS modifier is the provider’s attestation that all line item services on the claim are routine clinical trial services with the exception of any investigational item on the claim that would be identified with a Q0 HCPCS modifier on or after January 1, 2008, or a QA modifier before January 1, 2008.

2. **Claim contains both services related and unrelated to the trial** - Institutional providers billing clinical trial claims that contain both clinical trial line item services and non-clinical trial line item services, must bill the following elements:
   - **Claims with dates of service on or after January 1, 2008:**
     - HCPCS modifier Q1 only on line items related to the clinical trial and diagnosis code V70.7 (examination of participant in clinical trial) reported as the secondary diagnosis and condition code 30.

Reference:
- CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 32, Section 69 (PDF, 1 MB)
EHR Incentive Program & New Update on Health Information Technology

New Update on Health Information Technology: ONC Explains How 2011 Marks Age of Meaningful Use

The latest public letter from Dr David Blumenthal, National Coordinator for Health Information Technology, marks 2011 as the year when medical care entered a new era - the age of meaningful use of health information. The letter highlights the programs ONC has implemented in order to build an infrastructure to support meaningful use, and also examines the role of meaningful use as a vision of how information can be used in innovative ways to revolutionize the work of health professionals and healthcare institutions. READ MORE

Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers

This brochure provides an overview of the five levels of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. READ MORE

New Listserv for the Medicare and Medicaid Electronic Health Record Incentive

The Centers for Medicare & Medicaid Services (CMS) has a new listserv about the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The listserv will provide timely, authoritative information about the programs, including registration and attestation updates, and details about the payment process. Visit the CMS website to join the listserv and learn more. READ MORE

Medicare Proposes New Rules for Notifying Beneficiaries of Their Right to Lodge Quality of Care Complaints

Providers Would Have to Give All Beneficiaries Written Notice of Their Rights

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule today that would require most Medicare-participating providers and suppliers to give Medicare beneficiaries written notice about their right to contact a Medicare Quality Improvement Organization (QIO) with concerns about the quality of care they receive under the Medicare program. READ MORE
New Information from CMS’ Medicare Learning Network

CMS’ Medicare Learning Network publishes educational pieces for providers and other healthcare professionals. Below are some recent publications and information released. Orders can be placed on the MLN Product Ordering Page.

- **EHR-Related Fact Sheets Now Available in Print** - [CLICK HERE](#)
- **"Publications for Your Medicare Beneficiaries"** Fact sheet - [CLICK HERE](#)
- **"Guidelines for Teaching Physicians, Interns, and Residents"** Fact sheet – [CLICK HERE](#)
- **"HIPAA EDI Standards"** Web-Based Training Revised - To take this training, visit the MLN product page and click on "Web-Based Training Modules" under "Related Links Inside CMS."
- **"Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers"** Publication Revised - [CLICK HERE](#)
- **"Evaluation and Management Services Guide"** Publication Revised - [CLICK HERE](#)
- **"CMS Email Subscription Service"** Publication - Available on the MLN Product Ordering Page.

Recent LearnResource & MedLearn Matters Articles

- CMS Staff to Conduct Follow-up Calls for CERT Program [http://www.palmettogba.com/palmetto/providers.nsf/ls/OWV~8EBMXL7277?opendocument](http://www.palmettogba.com/palmetto/providers.nsf/ls/OWV~8EBMXL7277?opendocument)
Connolly Healthcare has posted new CMS “Approved Issues” on their website. See details below.

For a complete listing of “Approved Issues” please use this link: http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

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**Issue Name**: Duplicate Claims – Outpatient
**Description**: Providers should not bill duplicate claims. Therefore, an issue may exist when duplicate services are billed and reimbursed under Medicare.
**Provider Type Affected**: Outpatient Hospital
**Date of Service**: 10/01/2007 – Open

***************

**Issue Name**: Lymphoma and Nonacute Leukemia without CC/MCC: MS-DRG 84
**Description**: DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record. Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG 842.
**Provider Type Affected**: Inpatient Hospital
**Date of Service**: 10/01/2007 – Open
FDA New and Generic Drug Approvals - February 10, 2011

- Gemzar (gemcitabine hydrochloride) Injection, Eli Lily and Co., Labeling Revision
- Temodar (temozolomide) I.V. Powder, Schering Corp., Labeling Revision
- Xeloda (capecitabine) Tablets, Hoffmann-La Roche, Inc., Efficacy Supplement with Clinical Data to Support
- Zometa (zoledronic acid) I.V. Injection, Novartis Pharmaceuticals, Inc., Labeling Revision

Drug Shortages

- Adriamycin (doxorubicin) lyophilized powder [DETAILS]
- Bleomycin Injection [DETAILS]
- BICNU (carmustine) Injection [DETAILS]
- Cisplatin for Injection [DETAILS]
- Cytoxan Injection [DETAILS] Updated 3/1/2011
- Etoposide Injection [DETAILS]
- Furosemide Injection 10 mg/ml [DETAILS]
- Leucovorin Calcium Lyophilized Powder or Injection [DETAILS]
- LevoLeucovorin 50mg [DETAILS]
- Sodium Chloride [DETAILS]

Another good resource for detailed information about the various drug shortages please visit: [http://www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/DrugShortages.aspx](http://www.ashp.org/Import/PRACTICEANDPOLICY/PracticeResourceCenters/DrugShortages.aspx)

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FDA Grants Hearing on Withdrawal of Bevacizumab Approval

To read article [CLICK HERE](http://www.fda.gov/Drugs/InformationOnDrugs/ucm290487.htm)

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Health Plan Payers Considered Major Part of What Ails the US Health System

Managed care has really become a major part of what ails the healthcare system, according to a healthcare executive who serves with a large government entity.

"The managed care industry is challenged to prove its claims that it is a viable strategy for curtailing healthcare costs when the evidence seems more and more convincing that managed care has merely shifted costs from direct care to administration of the healthcare dollar, ultimately resulting in more limited access to care by those covered," said an executive who participated in the "Managed Care Leadership Survey." [READ MORE](http://www.fda.gov/Drugs/InformationOnDrugs/ucm290487.htm)
Advance Directive Electronic Registry Being Developed in WV New DNR Cards Available

According to the West Virginia Center for End-of-Life Care about half of West Virginians have filled out at least one advance directive that helps ensure they will receive the level and kind of treatment they prefer as they near the end of life.

Advance directive completion in West Virginia is significantly higher than the national average, which ranges from 18 percent to 36 percent, according to a 2008 U.S. Department of Health and Human Services report to Congress. Dr. Alvin Moss, director of the West Virginia Center for End-of-Life Care, said West Virginia's 49 percent figure is the highest among those states reporting such numbers.

In late 2011 an electronic registry will house and make available to treating health care providers West Virginians’ advance directive forms, POST forms and do not resuscitate cards. This is a password-protected – HIPAA compliant registry that will make accurate, relevant information available in a medical crisis, be accessible 24/7 to health care providers through the WV Health Information Network, be accessible for consumers to who want to verify the accuracy of their records, and ensure that patients' wishes will be respected throughout the continuum of health care settings. The completion of advance directives and POST forms is an important survivorship issue for cancer patients and their families.

The West Virginia Center for End-of-Life Care is distributing a revised version of the West Virginia Do Not Resuscitate (DNR) card in anticipation of the "go live" date for the West Virginia e-Directive electronic registry in late 2011. The new DNR cards are now immediately available from the Center by online request at www.wvendoflife.org or by calling 877-209-8086. According to the West Virginia Center for End-of-Life Care all health care providers are strongly encouraged to start using the new DNR cards immediately and to shred unused older versions.

The new DNR cards have more complete demographic information such as the last four digits of the person’s social security number. This will ensure that persons will be accurately identified in the Registry. The Center wants to avoid having a person’s DNR card confused with another's because there was not sufficient information about the person to distinguish from another.

After completion, the TOP portion of the new DNR cards should be mailed to the Center for Health Ethics and Law at the address on the back of the card or FAXed to the e-Directive Registry at 304-293-7442 instead of the Office of Emergency Medical Services as in the past.

WVOS members should contact Jim Keresztury at 304-293-0481 or the West Virginia Center for End-of-Life Care 877-209-8086 for more information.

(1)
More Candor Urged In Care Of Dying Cancer Patients

Patients do not want to hear that they are dying and doctors do not want to tell them. But new guidance for U.S. cancer specialists says they should be upfront and do it far sooner.

The American Society of Clinical Oncology says too often, patients are not told about options like comfort care or even that their chemotherapy has become futile until the bitter end.

To help families broach the topic, too, the group developed an easy-to-read booklet about those choices, from standard care to symptom relief, and advice about what to ask to maximize remaining time.

Source: CNBC

FDA Grants Priority Review For Romidepsin For Peripheral T-Cell Lymphoma

The FDA has granted priority review to the supplemental New Drug Application for romidepsin injection for patients with peripheral T-cell lymphoma who have received at least one therapy. READ MORE

Trastuzumab Showed Clinical Benefit In HER-2–Positive Breast Cancer

Patients with HER-2–positive breast cancer who crossed over from observation to trastuzumab experienced fewer DFS events than patients who remained on observation, according to study results. READ MORE

PSA Velocity May Not Contribute To Prostate Cancer Screening Process

Inclusion of PSA velocity did not significantly improve the predictive accuracy of prostate cancer screening, according to study results. READ MORE

Clinician Involvement In Cancer Clinical Trials May Be Insufficient

One-third of clinicians affiliated with a Community Clinical Oncology Program or a National Cancer Institute-designated center did not report enrolling patients in clinical trials in a recent 12-month period, according to study results. READ MORE

Everolimus May Be Viable Option For Advanced Pancreatic Neuroendocrine Tumors

Everolimus was linked to PFS more than twice as long as placebo in a cohort of patients with pancreatic neuroendocrine tumors, according to study results. READ MORE

Evolving Insight Into Personalized Therapy Requires Changes In Health Care Delivery, Reimbursement

The possibility that a therapeutic such as iniparib will benefit only a small absolute number of patients (ie, BRCA-positive) raises an important issue: Currently, widely employed breast cancer treatment strategies and clinical research have largely been based upon identifying and capitalizing upon the often small relative benefits a therapeutic may provide when applied across a general population of thousands or even tens of thousands of patients. READ MORE

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(1)
Comparison of Second-Quarter 2010 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2010

Summary
We identified a total of 25 Healthcare Common Procedure Coding System (HCPCS) codes with average sales prices (ASP) that exceeded average manufacturer prices (AMP) by at least 5 percent in the second quarter of 2010. Of these 25 HCPCS codes, 10 had complete AMP data (i.e., AMP data for every drug product that CMS used to establish reimbursement amounts). If reimbursement amounts for all 10 codes with complete AMP data had been based on 103 percent of the AMPs during the fourth quarter of 2010, we estimate that Medicare expenditures would have been reduced by $713,000 in that quarter alone. READ MORE (1)

States Can Apply for Nearly $200 Million to Help Fight Health Premium Increases

Wed, 23 Feb 2011 23:01:00 -0600

Today, the U.S. Department of Health and Human Services (HHS) announced that nearly $200 million in new grant funds are now available to help States develop programs that will make health insurance premiums more transparent. The new funds would also give States the power to stop unreasonable premium increases from taking effect. READ MORE (1)

OIG Offers Free Provider Compliance Training – Request Enrollment Now

Today, the U.S. Department of Health and Human Services (HHS) announced that nearly $200 million in new grant funds are now available to help States develop programs that will make health insurance premiums more transparent. The new funds would also give States the power to stop unreasonable premium increases from taking effect. READ MORE (1)
Senate Rejects Health Reform Repeal Proposal; Republican Efforts Shift to Eliminating Funding for Implementation and Repealing Individual Provisions of Law

The U.S. Senate has rejected an amendment offered by Senate Minority Leader Mitch McConnell (R-KY) that would have repealed the entire reform law enacted last year. READ MORE

Important Information Regarding Alkeran® (Melphalan Hydrochloride) Injection, and Alkeran® (Melphalan Hydrochloride) Tablets

ASH has heard from a number of concerned members who have experienced a difficulty in obtaining Alkeran for their patients. ASH has been able to obtain the following clarifying information from ApoPharma (the company that recently acquired the drug from Glaxo Smith Kline at the end of October). READ MORE
2 Years Later – The Impact of the Recovery Act

The below funding level for Improving and Preserving Health Care, Health IT, and Children and Community Services are actuarial estimates as of January 2011. Amounts reflect extension of the enhanced FMAP provision at a phased down-rate through June 30, 2011. The Education, Jobs, and Medicaid Assistance Act (P.L. 111-226) provides an estimated $13.6 billion in additional assistance for Medicaid and Foster Care, Adoption Assistance and Guardianship.

Where Your Money Is Going

- Improving & Preserving Health Care: $100.3 B
- Health IT: $22.6 B
- Children & Community Services: $13.5 B
- Scientific Research & Facilities: $10.0 B
- Community Health: $2.8 B
- Comparative Effectiveness Research: $1.1 B
- Prevention & Wellness: $1.0 B
- Accountability and IT Security: $0.1 B

HHS Recovery Act Obligations by State (Through January 1, 2011)

Most Recovery Act funding is going to States, Territories, and Tribes, who in turn distribute funds through grants, contracts, and other programs.

For West Virginia Specific Information

CLICK HERE
MLN Matters Special Edition Article on e-Prescribing Available

MLN Matters® Special Edition Article #SE1107 - titled "2011 Electronic Prescribing (eRx) Incentive Program Update: Future Payment Adjustments" - reminds eligible professionals who are not successful electronic prescribers that they may be subject to a payment adjustment and is now available. This article is based on recent updates to the Electronic Prescribing Incentive Program.

(1)

ASCO Issues Updated Guideline on the Role of Bone-Modifying Agents in the Prevention and Treatment of Bone Metastases in Patients with Metastatic Breast Cancer

READ COMPLETE ARTICLE

(1)

Medicare Compliance Newsletter

Read the Medicare Quarterly Provider Compliance Newsletter to review preventable coding errors. The February 2011 edition explains how to use codes correctly to avoid RAC audits. Make sure you are up-to-date on what constitutes a new patient code and initial chemotherapy injections and infusions.

(1)
Rotational IMRT Techniques Compared To Fixed Gantry IMRT and Tomotherapy: Multi-Institutional Planning Study for Head-And-Neck Cases

Recent developments enable to deliver rotational IMRT with standard C-arm gantry based linear accelerators. This upcoming treatment technique was benchmarked in a multi-center treatment planning study against static gantry IMRT and rotational IMRT based on a ring gantry for a complex parotid gland sparing head-and-neck technique.

Successful Radiation Treatment of Anaplastic Thyroid Carcinoma Metastatic to the Right Cardiac Atrium and Ventricle in a Pacemaker-Dependent Patient

Anaplastic thyroid carcinoma (ATC) is a rare, aggressive malignancy, which is known to metastasize to the heart. We report a case of a patient with ATC with metastatic involvement of the pacemaker leads within the right atrium and right ventricle. The patient survived external beam radiation treatment to his heart, with a radiographic response to treatment. Cardiac metastases are usually reported on autopsy; to our knowledge, this is the first report of the successful treatment of cardiac metastases encasing the leads of a pacemaker, and of cardiac metastases from ATCs, with a review of the pertinent literature.

Study Affirms Improved Lesion Detection with Time-of-Flight PET Scans

For the first time, quantitative—not qualitative—data analysis has demonstrated that time-of-flight (TOF) positron emission tomography (PET) scans can improve cancer detection. Research published in the March issue of *The Journal of Nuclear Medicine* shows that oncologic TOF fluorodeoxyglucose (FDG) PET scans yielded significant improvements in lesion detection of lung and liver cancers over all contrasts and body mass indexes.

GE Healthcare Optima MR430s 1.5T Specialty Scanner Receives FDA Clearance

GE Healthcare announced FDA clearance of the Optima™ MR430s, a new specialty scanner that "delivers the comfort patients appreciate and the 1.5T image quality radiologists require," the company stated. The Optima MR430s is a musculoskeletal magnetic resonance system that delivers precise imaging of the arm, including elbow, wrist and hand, or the leg, including knee, ankle, and foot.

Virtual Colonoscopy Takes Off

The technique, also called computed tomographic colonography, involves taking CT scans of the colon and rectum and creating 3-D images to look for cancer and other abnormalities. Many radiologists believe the scans can increase screenings rates for at-risk patients who might be reluctant to undergo traditional colonoscopies, which require snaking a tube with a camera at the end through the colon.
Radiologists Urged to Focus on Daily Impact of Healthcare Reform

Radiologists facing new provisions under the sweeping healthcare reform law are advised to look at them from the viewpoint of what one team of experts calls the three P’s: payment, practice and patients.

Read Complete Article

Hospitals’ Ties Increasingly Risky for Radiology Groups

It was one of the most enduring partnerships in radiology—for more than 80 years, Radiological Associates of Sacramento (RAS) provided radiology services to Sutter Health, a large network of hospitals and physicians in northern California.

But the partnership ended abruptly on April 1, 2010, when Sutter officials chose to let their contract with RAS expire. Despite a unanimous vote of confidence from the medical staff at Sutter Roseville Medical Center, RAS was replaced by the hospital’s newly formed radiology group along with a teleradiology firm hired to pick up the slack. Read Complete Article

Web Exclusive: Medpac Not Likely To Recommend Closing Self-Referral Loophole, Agrees SGR System Is Broken

On February 23, 2011, The Medicare Payment Advisory Commission (MedPAC) met to consider draft recommendations for changes to the exception in the Stark law that permits physicians to self-refer for certain services, including radiation therapy. As previously reported, MedPAC’s recent discussions on this issue have moved away from ASTRO’s position of limiting self-referral for radiation therapy only to robust multispecialty group practices. Instead, MedPAC’s draft recommendations are: Read Complete Article

Web Exclusive: What’s new with IMRT? The latest in IMRT billing, coding, process of care

Due to IMRT’s unique ability to obtain highly conformal dose distributions, utilization of the technology has increased significantly. According to Medicare claims data from 2003-2009, growth in the use of IMRT has increased by 931 percent for CPT code 77418 (Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session) and 685 percent for CPT code 77301 (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications). Moreover, in 2008 Medicare spent an estimated $1 billion on IMRT, largely for the treatment of prostate cancer (Source: Wall Street Journal, A Device to Kill Cancer Lift Revenue, December 7, 2010). Read Complete Article
Honor a Special Oncology Nurse for CURE's 2011 Extraordinary Healer Award for Oncology Nursing

CURE is giving you a unique opportunity to honor an oncology nurse through the 2011 Extraordinary Healer Award for Oncology Nursing! CURE will accept essay nominations from patients, survivors, caregivers, and peers describing the compassion, expertise, and helpfulness that a special oncology nurse has exhibited.

Three nurse finalists and the individuals who nominated them by essay, plus one guest each, will receive round-trip airfare and two-night accommodations in Boston, where they will be honored at a reception to be held in conjunction with the Oncology Nursing Society’s 36th Annual Congress, on April 28th, 2011. One nurse will be presented with the 2011 Extraordinary Healer Award for Oncology Nursing, and will also receive a special gift in recognition of his or her service to cancer patients and survivors. The deadline is March 21, 2011, so submit yours today! READ MORE

Where to Die: The Impact of Setting on Quality of Life for Patients and Caregivers

As this article was being written, we learned of the death of Elizabeth Edwards on December 7, 2010. She was advised that further treatment to control her cancer would be "unproductive," but she continued with hospice services to control her symptoms. She chose to die at home surrounded by loved ones. In an insightful article, "Dying at home, surrounded by family," CNNhealth.com writer/producer Madison Park wrote… READ MORE

Cancer-Related Fatigue: Elusive Causes Challenge Treatment

Fatigue is a symptom of many diseases, and it is one of the most common complaints of patients with cancer. Due to the magnitude of the cancer diagnosis, however, the symptom is given the unique distinction of cancer-related fatigue (CRF) when it manifests in patients with cancer. READ MORE

National Colorectal Cancer Awareness Month

Colorectal cancer is the third most commonly diagnosed cancer and the third leading cause of cancer death in both men and women in the United States. The National Cancer Institute estimated that 102,900 new cases of colon cancer and 39,670 new cases of rectal cancer were diagnosed, and an estimated 51,370 deaths were attributed to colon and rectal cancers in 2010. READ MORE

Researchers to Study Acupressure for Relieving Fatigue in Breast Cancer Survivors

As thousands of breast cancer survivors battle persistent fatigue, a Michigan State University nursing researcher is studying whether acupressure—a technique where physical pressure is applied to acupuncture points by the hand, elbow, or various ... READ MORE
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
- April 13 & 14, 2011 – 8:00 a.m. to 4:30 p.m.
- 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
- April 26, 2011 – 8:00 a.m. to 12 noon
- 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

Information Related to Risks and Benefits of Powdered Gloves; Request for Comments

FDA established a public docket to receive comments on surgeon’s gloves and patient examination gloves that contain or use donning or dusting powder. The agency is interested in the potential health effects from the use of powder and is seeking comments on the risks and benefits of powdered gloves. READ MORE
Patients with lung cancer, whether they smoke or not, feel stigmatized because their disease is strongly associated with smoking, according to a study released today at the Oncology Nursing Society (ONS) 11th National Conference on Cancer Nursing Research. Oncology nurse researcher Janine K. Cataldo, PhD, RN, from the University of California, San Francisco (UCSF) presented the findings.

**Good Grief: Nurses Cope With Patient Deaths**

“We feel that when people die, it doesn’t affect our care, which is absolutely ludicrous because we’re human, too,” says Tina Brunelli, RN, CSN, MSN, ANP-C, a nurse practitioner with Novant Health in Kentucky. Brunelli, who has worked in oncology, hospice and critical care, wrote a concept analysis as a graduate student, published in Nursing Forum in 2005, about how nurses cope with patient death.

**APNs Can Improve Cancer Care for Diverse, Underserved Minorities**

A master’s level oncology specialization program prepares nurses with the clinical, cultural sensitivity, and research skills they will need to deal with issues impacting underrepresented minorities.

**Communicating Bad News Requires Deep Empathy**

To help patients cope with terminal illness, healthcare providers must imagine themselves in the place of these patients. Exercises such as this can help healthcare workers when communicating bad news is really difficult.

**Chemo Could Place Older Breast Cancer Survivors at Higher Risk of Falls**

The combined effects of chemotherapy and endocrine therapy could place breast cancer survivors at higher risk of falling and suffering bone fractures, according to a new study.

Researchers from the Oregon Health & Science University Knight Cancer Institute in Portland surveyed postmenopausal breast cancer survivors about whether they had fallen in the past year, then tracked the patients’ falls during a six-month study period.

**Whether They Smoke or Not, Patients Say Lung Cancer Diagnosis Carries a Social Stigma**

Patients with lung cancer, whether they smoke or not, feel stigmatized because their disease is strongly associated with smoking, according to a study released today at the Oncology Nursing Society (ONS) 11th National Conference on Cancer Nursing Research. Oncology nurse researcher Janine K. Cataldo, PhD, RN, from the University of California, San Francisco (UCSF) presented the findings.
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)
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

HEALTH PLAN OF OHIO  
Home  Provider

HUMANA  
Home  Provider

HIGHMARK (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

A Few Articles You Won’t Want To Miss:

✓ We can now receive electronic corrected/voided claims….pg 1
✓ Note these new vaccine administration codes….pg 3
✓ Medicare physician incentive plan requirements….pg 8
✓ Additions to precertification, quantity limits and step-therapy programs….pg 10

AND MUCH MORE…..

Payer Updates

Provider Newsletter for the 1st Quarter 2011  
NOW AVAILABLE

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

- Change in UnitedHealthcare Coordination of Benefits Payment Policy
- Member Appeals and External Review for UnitedHealthcare Commercial Members

And Much More… Latest Issue Available HERE

Place of Service Requirements Based on Highmark WV Medical Policy

Highmark WV and HHIC New Blue Card Features

Highmark WV and HHIC - Assessing ICD-10 Impacts Including Upcoming Code Freeze

Mountain State Blue Cross Blue Shield officially changes name to Highmark Blue Cross Blue Shield West Virginia ("Highmark West Virginia")

February 2011 issue available HERE

Visit the website at: https://www.humana.com/providers

HUMANA
Guidance when you need it most

Humana's YourPractice 1st Quarter Issue Available HERE

Visit the website at: https://www.humana.com/providers

Network Bulletin
An important message to health care professionals and facilities

www.highmarkbcbswv.com

RECENT BULLETINS & NOTICES

Welcome to Highmark Blue Cross Blue Shield West Virginia
Dear State Societies:

I’m delighted to announce the following changes regarding the requirement for KRAS pathology report submission to obtain coverage for Erbitux (cetuximab) and Vectibix (panitumumab):

- UnitedHealthcare is removing the requirement to submit a pathology report. The change is effective February 25, 2011.
- The Oxford Health Plan will eliminate the requirement for a pathology report submission beginning 4/1/2011.
- The River Valley health plans will eliminate the requirement for pathology reports submission beginning 4/1/2011.

Our medical policy hasn’t changed – the use of Erbitux and Vectibix for treatment of individuals with colorectal cancer should be limited to those individuals with the wild type gene. Our recent audit demonstrates that coompliance has been superb and we are committed to removing these quality checks when they are no longer needed.

Other entities
At this time, the process for Erbitux and Vectibix claims for benefits issued or administered by AmeriChoice, Evercare, Neighborhood Health Partnership Inc., Pacificare, and SecureHorizons® have not been changed. Any changes will be announced in future issues of Network Bulletin.

If you have any questions or comments, please contact us at unitedoncology@uhc.com.

Sincerely,
Lee Newcomer, MD
Web Portal Updates:

2011 CPT Code Rejections
If you have received 824 rejections related to the new 2011 codes, the system has now been corrected and you may now resubmit your claims. We apologize for this inconvenience.

WV Molina Medicaid Solutions Now Supports X12 Upload 270 Transactions
Trading Partners who wish to submit eligibility requests (270/X092A1) in X12 format, via the Upload File Exchange option, may do so by completing the X12 270 Batch Upload Election Form located under "Forms" in the navigation pane to the left. Trading Partners must undergo successful testing with the Molina EDI Helpdesk prior to approval for production submissions.

Effective 11/22/10, all eligibility requests (270/X092A1) require NPI logic unless considered "atypical".

Document link provided: Molina 270 X-12 Upload Election Form

BRAND NEW! Molina now offers WV Medicaid Providers Online Training
Molina has implemented a web-based e-learning system referred to as the West Virginia Medicaid Training Center. This training center is available 24 hours a day, 7 days a week to all WV Medicaid Providers. The WV Medicaid Training Center will assist with claims processing information as well as offer various training sessions that can benefit providers participating in the WV Medicaid Program.

Providers will access the Medicaid Training Center through a link after logging into the web portal. The provider will then select the Medicaid Training Center link. Upon arriving at the Training Center page, the user will need to complete self registration with the correct corresponding access code. This code is available after a successful login on the web portal and located directly below the Medicaid Training Center link. The WV Medicaid Training Center Self Registration Information and WV Medicaid Training Center User Guides are located on the left hand side under "Reference" and then "Documents". Web portal user access can be obtained by contacting our EDI Helpdesk at 1-888-483-0793, option 6. The initial course that's posted will be an introduction to WV Medicaid. This will be a good refresher course for any provider and their billing staff, but it will be especially beneficial to providers and their billing staff who are new to Medicaid. We will give a brief overview of the roles between Molina and West Virginia Medicaid, as well as a brief explanation of the billing process.

If you have any questions or problems with your user registration, please contact wvmedicaidtraining@molinahealthcare.com
2011
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