Mission Statement

To engender and promote improvements in patient care, education, clinical trial accrual and pertinent economic and legislative issues as they affect all elements of oncology in the State of West Virginia.

NEW Monthly "Lunch and Learn" Series

YOU ASKED – WE LISTENED

The next session June 7th:
“Utilizing Patient Assistance and Financial Counselors into Your Cancer Center”

NOTE: Before month end we will be offering an inservice on the Highmark Oncology Management Program/P4 Pathways presented by Highmark. See page 39 for more information!

National Nurses Week is held May 6-12 each year and this year’s theme is “Nurses Trusted to Care”. There is no better time of year to show nurses how much you appreciate their contributions to patients and your institution. All across the United States, registered nurses are being saluted. Make it a point to recognize your indispensable nurses!
West Virginia Oncology Society
Annual Spring Membership Meeting

SUMMARY

This year’s WVOS Annual Spring Meeting was held on April 7 – 8, 2011. Thursday Evening was dedicated to the WVOS Statewide Cancer Clinical Trials Network (CCTN). The evening included an overview of the accomplishments to date and the future growth of the CCTN. (See article below.)

The CME program on Friday was designed to provide training to members to ensure state-of-the-art clinical oncology practice in West Virginia. The program focused on clinical practice, management, and policy advances related to the identification and treatment of cancer.

With nearly 100 attendees, WVOS was pleased to bring together speakers from several key areas to educate our members. Topics included, Practice Changing Developments with updates on Lung Cancer, the 33rd Annual San Antonio Breast Cancer Symposium and the ASCO GU Symposium. A legislative update by ASCO and Medicare wrapped up the morning sessions. The afternoon focused on multiple National Scientific Meeting Updates on 2010 ASCO, Radiation Oncology-ACRO, ASH and much more. The day also included an update by the West Virginia Oncology Nursing Society.

Once again WVOS received an overwhelming positive response from our membership stating this meeting provided them with great information!

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
Front Page News

WVOS Statewide Cancer Clinical Trials Network

On the evening of April 7th Kelley Simpson from the consulting firm Oncology Solutions presented to WVOS members a summary of the surveys and interviews conducted with members over the last several months. Overall goals expressed by those interviewed include:

- To raise the level of cancer care in WV
- To access more metastatic trials and quality pharmaceutical trials
- To provide innovative treatment alternatives locally to WV patients
- To increase enrollment potential and build name recognition
- To minimize outmigration of patients

The group reviewed and commented on the recommendations for the next steps in the development of the West Virginia Cancer Clinical Trials Network. A strong commitment to move forward with network development was expressed by WVOS members. A PowerPoint summary of Oncology Solutions recommendations for the network is posted in the Clinical Trials Section of the WVOS website. A small workgroup was established to work on several next steps. The committee will be chaired by Jame Abraham. Other members are John Azar, Manish Monga, Maria Tirona, and Jim Frame. Jim Keresztury will provide the administrative support for the group. The group’s focus over the next few months will include:

- How will the West Virginia Cancer Clinical Trials Network (CTN) be structured?
- What staffing/staff resources are needed to formalize the organization and ensure operational effectiveness?
- What is our goal for the mix of cooperative group versus pharma/industry studies within 2-3 years? 5 years?
- How will the network coordinate Institutional Review Board usage?

The workgroup will provide WVOS members with regular updates regarding the progress of the network. If members would like additional information please contact Jim Keresztury at keresztury@hsc.wvu.edu or 304-293-0481.

NLM Director's Comments Transcript
Clinical Trial Transparency & Challenges: 04/25/2011

Listen to the NLM Director's Comments on "Clinical Trial Transparency & Challenges". The transcript is also available.

Two recently published studies suggest author conflicts of interest are not frequently revealed in comprehensive analyses of clinical trials and note some of the challenges to provide a public resource of clinical trial findings...[LISTEN HERE](1)
THE INFORMATION PROVIDED BELOW AND ON THE NEXT FEW PAGES WAS EXTRACTED DIRECTLY FROM PALMETTO GBA

2011 PQRS and eRx Incentive Program
National Provider Call: May 17

The Centers for Medicare & Medicaid Services’ (CMS) Provider Communications Group will host a national provider conference call on the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. This toll-free call will take place from 1:30 p.m. to 3 p.m. ET on May 17, 2011. You must register in advance to attend this call. DETAILS

Medicare Part B Update

The Medicare Part B Update handout is now available. It includes a summary of new Medicare initiatives, updates on existing Medicare programs and resources for troubleshooting the most common problems. DETAILS

CMS Proposes to Expand Access to Seasonal Influenza Immunization

The Centers for Medicare & Medicaid Services (CMS) proposed new requirements for Medicare-certified providers that are designed to expand access to seasonal influenza vaccination. The notice of proposed rulemaking would update the conditions of participation and conditions for coverage for a number of provider types, in an effort to increase access to the vaccine, increase the number of patients receiving annual vaccination against seasonal influenza, and to decrease flu-linked morbidity and mortality. READ MORE

Implementation: Webinar Tour for West Virginia Part B

Please join us for a Webinar Tour to learn valuable information about the West Virginia Part B implementation that will be helpful to you in the MAC world. DETAILS

Reporting of Recoupment for Overpayment on the Remittance Advice (RA)

This article was revised on April 25, 2011, to correct a statement on Page 2 that stated the RAC must report a recoupment in two steps. Actually, it is the remittance advice that reports the recoupment in two steps and the article has been corrected accordingly. All other information is the same. DETAILS

Screening for the Human Immunodeficiency Virus (HIV) Infection

This article is based on Change Request 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries. DETAILS

Drugs & Biologicals: Maximum Allowed Units (MAUs) Updated 4/25/11

DETAILS
### Local Coverage Determination Updates
(No new updates in May)

<table>
<thead>
<tr>
<th>LCD</th>
<th>Change</th>
<th>Effective Date</th>
</tr>
</thead>
</table>

---

### April 2011 MAU Update

Effective 04/01/2011 the MAU table has been revised to reflect the following changes:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>MAU</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2275</td>
<td>Injection, morphine sulfate (preservative-free sterile solution), per 10 mg</td>
<td>40</td>
<td>Increase</td>
</tr>
<tr>
<td>J9100</td>
<td>Cytarabine, 100 mg</td>
<td>72</td>
<td>Increase</td>
</tr>
<tr>
<td>Q2040</td>
<td>Injection, Incobotulinumtoxin A, 1 Unit</td>
<td>120</td>
<td>New</td>
</tr>
</tbody>
</table>

The May 2011 “Medicare Advisory” for Ohio and West Virginia is now available. This issue is packed full of useful information for submitting Medicare Part B claims. Be sure to share the updates with the appropriate staff.

*This is a MUST READ for every practice.*

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

**QUESTION:** Can you charge patients/payers differently?

**ANSWER:** This question represents a common misconception. The only requirement for a fee schedule and subsequent collections is that you do not charge more to a Medicare patient than you would to another patient in your office. Obvious exceptions to this rule are write-offs for patients who have financial hardships.

In fact, if you have a contract with a payer, you have most likely already determined that you will accept payments at levels different from your Medicare reimbursements; in effect, you are establishing a fee schedule that is different from Medicare. Thus, if it were illegal to charge patients with different payers differently, then all contracts would be illegal. At this point, they are not.

This brings up another issue that many practices have begun to implement in response to the increasing number of patients who have lost their insurance coverage during the recession: cash discounts or decreased fees for self-pay patients. These discounts are a sound strategy for most offices, as they can be offered prior to service provision and will increase the likelihood of payment and decrease the number of write-offs. As the amount of work and cost of collection at the time of or prior to a service is decreased, it makes sense to offer patients a significant incentive to pay for the services they will be provided.

Discounts are a great incentive. Make certain all non-financial hardship discounts, be they published or pre-set, stay above Medicare rates. You are asking the legal implications of charging different fees depending on the payer. This isn’t a question we receive often because so much of our reimbursement is set by the payer themselves. Hope this helps!

**QUESTION:** Has anyone started using Provenge? I’m somewhat aware of how this vaccination is used, but can anyone tell me what all is involved in using this drug? Does the lab bill the drug or the office etc......Just not sure how an office prepares for this?

**ANSWER:** We are in the process of getting ready to use this. Your best bet is to contact your area drug rep as your office needs to have an inservice and there is a financial agreement to be signed before they will certify you to provide. This also must be done before you can register the patient in their support program. Once the training is complete, the patient goes to an apheresis center for collection. That center ships the cells to the manufacturer who then ships to you. It seems to be a very organized process with drug company involvement from the first.

**QUESTION:** We do clinical trials in our office and I am trying to find some information from Medicare about billing for clinical trials, can you help?

*Continued on next page...*
**ANSWER:** The discharge I would begin at the CMS website. Medicare has an entire section on Medical Clinical Trial Policies. Here is a link to the site: [http://www.cms.gov/ClinicalTrialPolicies/](http://www.cms.gov/ClinicalTrialPolicies/). Additionally here is a link to the National Coverage Decision; [https://www.cms.gov/ClinicalTrialPolicies/Downloads/finalnationalcoverage.pdf](https://www.cms.gov/ClinicalTrialPolicies/Downloads/finalnationalcoverage.pdf).

**QUESTION:** Can you clarify whether we will be able to receive our E-prescribing incentive payment in 2011 if we also enroll in the EHR Medicare incentive before fall of this year? I've read articles that say we will still get it and other articles that say we will not! Help!

**ANSWER:** No, it is Since E-prescribing is a component of ‘meaningful use’ EMR they will not pay an incentive for both. “Medicare EPs may not earn incentives under the eRx and Electronic Health Records incentive programs at the same time.” You can receive incentives for both EMR and PQRS. Here is a link to a CMS EHR, PQRS and ePrescribing comparison; [https://www.cms.gov/MLNProducts/downloads/EHRIIncentivePayments-ICN903691.pdf](https://www.cms.gov/MLNProducts/downloads/EHRIIncentivePayments-ICN903691.pdf).

**QUESTION:** The oncologist ordered a 90-minute chemotherapy infusion service, but the infusion lasted a few minutes longer than that. Is it OK to report the entire infusion time?

**ANSWER:** You may report the codes for the entire infusion time, but be sure the medical record is documented with a medically necessary reason why the infusion took longer. You want to be able to prove medical necessity to an auditor because it is not appropriate to extend an infusion time just to increase reimbursement.

For example: If the patient has a chemotherapy infusion for one hour and 33 minutes, you would report 96413 *(Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug)* for the first hour and +96415 *(… each additional hour [List separately in addition to code for primary procedure]*) for the additional 33 minutes beyond the first hour. As your question suggests, if the patient receives a 90-minute infusion, you would report only an initial hour code (96413). A parenthetical note following +96415 indicates it is “for infusion intervals of greater than 30 minutes beyond 1-hour increments.” 90 minutes is only 30 minutes beyond one hour. It is not “greater than 30 minutes” beyond the hour.

**Bottom line:** While some infusions will last longer than the prescribed 90 minutes, slowing the infusion rate to ensure billing for an additional code would not be appropriate.
UPDATE: Hepatitis B Claims Not Reimbursing | Since the implementation of the April system release, claims for Hepatitis B HCPCS codes are not reimbursing. **READ MORE**

### Latest Production Alerts

**Proper Coding When Both a Primary and Secondary Diagnosis are Required to Demonstrate Medical Necessity**

There are a number of instances when it is necessary to provide both a primary and secondary diagnosis to establish medical necessity of a service or procedure. For example, when referencing Local Coverage Determination (LCD) L25233, Computed Tomographic (CT) Colonography; for the purposes of that LCD, ICD-9-CM code V64.3 indicates that the instrument colonoscopy has been attempted and was incomplete or when a board certified or board eligible gastroenterologist, a surgeon trained in endoscopy, or a physician with equivalent endoscopic training determined from an evaluation of the patient that optical colonoscopy cannot be safely attempted.

**V64.3 - PROCEDURE NOT CARRIED OUT FOR OTHER REASONS**

In addition to reporting ICD-9-CM code V64.3, one (or more) of the ICD-9-CM codes below must be reported in order to support medical necessity.

- 004.9 SHIGELLOSIS UNSPECIFIED
- 006.1 CHRONIC INTESTINAL AMEBIASIS WITHOUT ABSCESS
- 006.2 AMEBIC NONDYSENTERIC COLITIS

The three sample codes above are at the beginning of the listing of codes indicated in the LCD which are required to accompany code V64.3 to determine medical necessity.

Listed below are the top five current procedural terminology (CPT) codes that are denied and appealed due to the primary and secondary diagnosis LCD requirements.

1. 91110 – LCD for Endoscopy by Capsule (L25468)
2. J1740 – Article for Ibandomate Sodium (e.g., Boniva) – related to LCD L25820 (A46087)
3. J3487 – Article for Zoledronic Acid (e.g., Zometa, Reclast) – Related to LCD L25820 (A46096)
4. J0881 – LCD for Erythropoiesis Stimulating Agents (ESA) L25211

It is recommended that provider representatives refer to the LCD and/or the supplemental instructional article (SIA) corresponding to a particular service or procedure in order to avoid claim denials, and appeal of those claims. LCDs are also an excellent source for documentation guidelines.
Do Not Cancel Claims in Medicare Secondary Payer Situations

Contrary to the Centers for Medicare & Medicaid Services (CMS) guidelines, providers are canceling (bill type XX8) Medicare primary or conditional claims in situations in which these providers have later been paid by a primary payer. The canceling of claims in this type of situation is not appropriate and should not be done.

If a provider, that has already been paid by Medicare for a claim, later receives payment for the same claim from a primary payer (no-fault, medical-payment, personal injury protection, workers compensation, Government research grant, Black Lung Program, Veteran’s Affairs, or an Employer Group Health Plan) it should adjust (not cancel) the claim to change it to a Medicare Secondary Payer (MSP) claim. Note: When such a payment is later received from a Liability Insurance/Liability Insurance settlement, the provider should follow the guidelines in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), Publication 100-05, Medicare Secondary Payer Manual, Chapter 2, Section 40.2, “Billing in MSP Liability Insurance Situations” under letter “E”.

Preparing the MSP Adjustment Claim

Before preparing the MSP adjustment claim, the provider will want to validate whether or not the other payer is, in fact, primary to Medicare based on the applicable MSP Provision conditions/criteria. The MSP adjustment claim, referencing the original claim’s document control number (DCN), is prepared as follows:

- Bill type: XX7
- Condition code (also known as claim change reason code): D7
- The appropriate MSP claim coding as described in our article “Preparing MSP Claims” which can be found on our Web site, www.NGSMedicare.com under Claims > Medicare Secondary Payer > Preparing Medicare Secondary Payer Claims. This article also provides a link to our Medicare Secondary Payer and Conditional Claims Billing Code Reference chart.

Submitting the MSP Adjustment Claim

Before submitting the MSP adjustment claim, the provider will want to make sure that there is a matching MSP file present in the Common Working File (CWF). If there is not, then please contact the Coordination of Benefits Contractor (COBC) at 800-999-1118 so that one can be established.

The MSP adjustment claim may be submitted electronically via the 837I claim (preferred method) or in hard copy claim format (UB-04/CMS-1450 claim form) but may not be submitted in the Fiscal Intermediary Shared System Direct Data Entry (FISS DDE). For our Claim Department’s mailing address, refer to our Web site, www.NGSMedicare.com under Resources > Contact Us > P.O. Box Mailing Addresses > Claims (look for your state since there are some differences in the addresses).

Again, it is very important that providers follow these instructions and do not cancel claims in the situation described above. Make sure all of your internal processes are updated accordingly and that staff who handle Medicare claims are informed of this instruction.
Helpful Tips When Requesting Claims Appeals

In an effort to facilitate the appeals process, the National Government Services Appeals Department recommends that providers consider the following tips when requesting an appeal of a claim:

- Identify the specific service(s) being appealed. Claims may contain many lines, only some of which are being addressed for consideration of appeal. To avoid possible delays for clarification, please be sure to specify line items appealed.
- Appeal requests must be complete. To avoid a dismissal for an incomplete request, the name and signature of the person filing the request is required.
- Appeal requests must be legible. Both the request and any additional documentation provided must be legible in order to allow the reviewer to make an appropriate decision. Do not mark portions of the medical record with a highlighter, because this alters the record. The imaged record appears blacked out with a marker rather than a highlighter.
- If a Clerical Error Reopening (CER) is requested, identify the correction made to the claim. If adding an omitted diagnosis, include the ICD-9 code(s). It is extremely important to include the diagnosis code itself, and not just the definition of the code(s).

NGS May Medicare Monthly Review

**Articles of Note:**

- Documentation Submission Responsibilities in a Review Situation (pg 3)
- Affordable Care Act – Section 3113 – Laboratory Demonstration for Certain Complex Diagnostic Tests (pg 10)
- Medicare Electronic Health Record Incentive Payment Process (pg 24)
- Payment for Implantable Tissue Markers and Implantable Radiation Dosimeters (pg 27)
- Specialty Code for Advanced Diagnostic Imaging Services (pg 28)
- Advanced Diagnostic Imaging Accreditation Enrollment Procedures (pg 29)

*Read this and much more... HERE*

April Interactive Voice Response System Enhancements

The following enhancements were made to the National Government Services Interactive Voice Response (IVR) system during the month of April:

- The eligibility option has been modified to allow callers to change the date of service without having to re-enter the patient Medicare information.

The patient status option has been modified to allow callers to request “next day” after receiving patient status information. This feature will quickly search patient status for the next sequential date of service without requiring the patient information to be reentered.
Electronic Data Interchange Help Desk
Interactive Voice Response System Changes effective Monday, May 16, 2011

To better serve our National Government Services electronic data interchange (EDI) customers, effective Monday, May 16, 2011, the EDI Help Desk menu options on our interactive voice response (IVR) system will be changed to reflect all providers served by National Government Services EDI Services.

Please remember that the IVR also houses a feature allowing providers to check status of submitted EDI Enrollment forms. The IVR feature will be available to our customers 24 hours a day, and status for your online form submission will be available after 24 hours from the time the form was submitted.

Detailed information can be found at the NGS website under News Articles dated 4/14/2011.

Understanding Eligibility Screen Webinar

Attention All Medicare Part A Providers
This session will provide a live system demonstration showing providers how to verify a beneficiary’s Medicare eligibility using Health Insurance Query Medicare Part A (HIQA)/Common Working File (CWF).

Date: Thursday, May 26, 2011       Time: 10:00 a.m.-12:00 p.m. ET

Registration for this session is now open. Visit our Web site for details at www.NGSMedicare.com. Select the ‘Go to Home Page’ link for your business type and location. Select the Training Events Calendar option under the Education and Training category (on the left hand side). Your registration is complete only when you receive a confirmation at your e-mail address immediately after submitting your registration.

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
New Workload Numbers for West Virginia Part A

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

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

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
Improving Inpatient-Outpatient Transitions: What Can Be Done?

by Steve Frandzel

Many hospitals and oncology group practices are failing to effectively manage cancer patient’s transition from inpatient hospital care to the outpatient setting, according to a new report by the Association of Community Cancer Centers (ACCC). Practices are falling short in their efforts to adequately coordinate medical services, maintain complete medical records and obtain essential case information during the complex process.

READ MORE

Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009

WVOS Oncology Outpatient Hospital Reimbursement Q & A’s

**QUESTION:** We are having a problem with taxotere. We used diagnosis 198.89 as primary, v10.02 as secondary. We received a rejection on the v code. We found out there was a revision on the LCD and it states we can no longer use diag v10.02. What diagnosis are you using to replace v10.02z, if the original site is oropharynx? Any help would be appreciated.

**ANSWER:** You will want to review the NGS LCD which is located on their website. You can go to Medical Policy section and just put in the J-code under the search (J9170). For Taxotere you will find that the secondary V-code must be one of the following:

- V10.00   Personal History Of Malignant Neoplasm Of Unspecified Site In Gastrointestinal Tract
- V10.03   Personal History Of Malignant Neoplasm Of Esophagus
- V10.04   Personal History Of Malignant Neoplasm Of Stomach
- V10.11   Personal History Of Malignant Neoplasm Of Bronchus And Lung
- V10.3    Personal History Of Malignant Neoplasm Of Breast
- V10.46   Personal History Of Malignant Neoplasm Of Prostate
- V42.82   Peripheral Stem Cells Replaced By Transplant

The LCD has VERY specific criteria, especially related to first line vs second line therapy and should be reviewed by your physician to determine the appropriate coding.

The LCD also states and shows up in red to alert you; Docetaxel 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.

Continued on next page...
Reviewing the LCD you should also check to be sure that your primary diagnosis code falls within the approved DX. The LCD shows all ICD-9 Codes that are covered.

QUESTION: How do I obtain my NPI information if my claims are rejecting?

ANSWER: CMS has contracted with Fox Systems, Inc. to serve as the NPI Enumerator. The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in NPPES. Go to the National Plan and Provider Enumeration System (NPPES) website for further information. You will need to have your login ID available to log in to the site to verify your NPI information. Visit the Fox Systems Web site for contact information.

QUESTION: Where can I find information on UB-04 billing?

ANSWER: The guidelines can be found on the CMS Web site CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 25.

QUESTION: The 2011 Current Procedural Terminology (CPT) update added three procedure codes for subsequent observation care: 99224, 99225, and 99226. I did not admit the patient to observation care. Should I use these procedure codes when the admitting physician asks me to see the patient in observation care?

ANSWER: No, only the physician admitting the patient to observation care status (or a member of the same group with the same specialty) may bill the observation procedure codes. This includes the admission (99218 - 99220), subsequent observation (99224 - 99226), and discharge from observation (99217) procedure codes. Anyone else seeing the patient while in observation care would bill using an office or other outpatient procedure code 99201 - 99215 as appropriate. The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.8 discusses observation care. It does not mention the new subsequent observation care codes. It does state, "All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient services must bill the appropriate outpatient service codes."

REIMBURSEMENT QUESTIONS?
reimbursement@wvos.info
CMS Fact Sheet - Comprehensive Error Rate Testing (CERT) Signature Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements and provides information on the documentation needed to support a claim submitted to Medicare for medical services. READ MORE (1)

Revised April 2011 ASP Files Available

The Centers for Medicare & Medicaid Services (CMS) has posted revised average sales price (ASP) files for April 2011 and restated files for prior quarters. All are available HERE. (1)

Accountable Care Organizations (ACOs)

Learn about ACOs:

From ASCO HERE  From ASH HERE  From CMS HERE

Physician Quality Reporting System & Electronic Prescribing Incentive Program Announcement

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2009 Physician Quality Reporting System & Electronic Prescribing Incentive (eRx) Programs Reporting Experience Report is now available.

The 2009 experience report summarizes the experience of eligible professionals in the 2009 Physician Quality Reporting System and eRx Incentive Programs, as well as trends in the program over time, including early results from 2010.

The 2009 experience report is available in the "Downloads" section of the “Overview” page on the Physician Quality Reporting System web page, located at http://www.cms.gov/PQRS/ on the CMS website. It is also posted as a download on the “Overview” page under “Related Links Inside CMS” on the eRx web page, located at http://www.cms.gov/ERxIncentive/ on the CMS website. (1)
Oncology Community Concerned about CMS ACO Proposal

By Lola Butcher

After reading the federal government’s proposed rules for accountable care organizations, the oncology community has arrived at a quick consensus of how to proceed.

Step 1: Try to get the Centers for Medicare & Medicaid Services to make significant changes in the final rule that will be published later this year.

Step 2: Make an end-run around CMS’s proposal to prove that other delivery and payment reform ideas will work better for oncologists.

“Frankly, if you look at the rule itself, you wonder how oncology fits in,” said Ted Okon, Executive Director of the Community Oncology Alliance. “That reinforces something that I think we all know, which is that the government really doesn’t know what to do with cancer care.”

Why the ACO Rule Matters to Oncologists

The government does, however, know what it wants to do with primary care. The proposed ACO rule is written with primary care physicians in mind, giving them more responsibility for coordinating high-quality, low-cost care and the opportunity to make more money for doing so.

That is why Cary Presant, MD, a hematologist/oncologist at Wilshire Oncology Medical Group in Los Angeles, sees oncologists so eager to learn about the ACO movement.

“Assuming that the ACOs do, in fact, come to fruition, it is very likely that within every community, there will be one, two, or three ACOs that are dominant. And if oncologists wish to continue to treat the Medicare patients who belong to the participating primary care physicians, then they will have to be participating with an ACO,” he said.

More than 350 oncology professionals dialed in to an April conference call about ACOs sponsored by the Association of Community Cancer Centers.

READ MORE (1)

The Centers for Medicare and Medicaid Services (CMS) Launches a Dedicated Web Page for the Medicare Shared Savings

On March 31, 2011, The Centers for Medicare and Medicaid Services (CMS), published in the Federal Register, proposed rule CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations that implements the Medicare Shared Savings Program and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated web page for Medicare fee-for-service (FFS) providers and other providers of services and suppliers. Bookmark the web page and check back often, as CMS continues to add information on the program.

READ MORE (1)
CMS Data Show Gains in Key Quality Indicators through Physician Quality Reporting System and ePrescribing Incentive Program

2009 data show increases in how many eligible professionals successfully participate as well as how many instances professionals report delivering evidence-based care that can lead to better patient outcomes.

The Centers for Medicare & Medicaid Services (CMS) today issued a report that highlights significant trends in the growth of two important “pay-for-reporting” programs. The report also articulates key areas in which physician-level quality measures appear to show positive results in quality of care delivered to Medicare beneficiaries. READ MORE

Additional 2009 program results can be found in a CMS Fact Sheet here: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

Summary of Proposed Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary. READ MORE

Healthcare Common Procedure Coding System (HCPCS) Public Meeting Agendas for Drugs, Biologicals and Radiopharmaceuticals

The Centers for Medicare and Medicaid Services (CMS) is pleased to announce the scheduled release of the May 17 & 18, 2011 HCPCS Public Meeting Agendas for Drugs, Biologicals and Radiopharmaceuticals. These documents and the link for the corresponding public meeting registrations are located on the CMS HCPCS website. READ MORE

MLN Matters Information for Healthcare Providers

MLN Matters® has published information on signature requirements and print copies of the E/M guide can be ordered online. These guides are created to provide education to healthcare providers on the proper documentation process for claims to Medicare.

If you have missed any of the MLN Matters® articles notices in the last 24 months you can review the archive available.
Recent LearnResource & MedLearn Matters Articles


- HCPCS Public Meeting Agendas for Drugs, Biologics, and Radiopharmaceuticals [http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp#TopOfPage](http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp#TopOfPage)


- New FAQs on CMS EHR Incentive Programs [https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage](https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage)
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!

CMS Reports $365.8 Million in Improper Payments

The Recovery Audit Contractor (RAC) program has identified $365.8 million in improper payments in the period from October of 2009 through the end of March 2011. From this number, $313.2 million were overpayments and $52.6 million were underpayments that were returned to providers, according to an update on the CMS website under "Recent Updates."

<table>
<thead>
<tr>
<th>Demonstration</th>
<th>National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overpayments Collected</td>
<td>$992.7 M</td>
</tr>
<tr>
<td>Underpayments Returned</td>
<td>$37.8 M</td>
</tr>
<tr>
<td>Total Corrections</td>
<td>$1.03 B</td>
</tr>
</tbody>
</table>

In accordance with Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS conducted a Recovery Audit demonstration from March 2005 to March 2008. The U.S. Congress authorized the nationwide expansion of the Recovery Audit program through the Tax Relief and Health Care Act of 2006. Recovery Auditors are CMS contractors who are tasked with detecting and correcting past improper payments.

READ MORE

(1) 2011 FFS Newsletter
Random Sampling, Extrapolation and Appeals: Core Components of Defending a RAC Audit

In our recent survey of medical practices that have undergone Recovery Audit Contractor (RAC) audits, respondents reported that in more than 50 percent of cases random sampling was claimed to have been used by a RAC auditor.

Normally, there is only one reason to do this: to establish that there is a high and sustained rate of error, which authorizes the auditor to use extrapolation to determine overpayments. Yet only 21 percent of these same respondents indicated that they were aware that extrapolation had taken place. So either there is a communication problem that is occurring during the audit process or there is a great deal of confusion over what constitutes extrapolation.

I have read many RAC audit letters and reports, so I can testify that contractors are not always clear regarding what was done and how. This is a very important component of the audit to understand, because if random sampling drives extrapolation, practices need to have an awareness of which (if either) are being applied to their specific audit.

In the past I have discussed how a practice can perform an initial randomness assessment by comparing the average (or median) paid amount per claim for the sample to the universe. Without getting into the details of how to conduct a statistically significant two-sample test, the purpose is to eye the figures and get help if the variance seems too large.

Lately, however, I have found some situations in which, when comparing these figures, the sample appeared random at first - but when I dug deeper and looked at the distribution of the codes being audited, I discovered a great deal of disparity. READ MORE

How do I get paid for the Electronic Health Record (EHR) Incentive Programs?

Payments for the Medicare and Medicaid EHR Incentive Programs are distributed based on each year of participation, and they follow a specific payment schedule. Located below are payment details on the Medicare and Medicaid EHR Incentive Programs. For an overview, see the Medicare Learning Network (MLN) Matters Special Edition article (SE1111) – Medicare Electronic Health Record (EHR) Incentive Payment Process (PDF, 87 KB).

Medicare EHR Incentive Program

- **Eligible professionals (EPs):** EPs can receive up to $44,000 over five years under the Medicare EHR Incentive Program. There's an additional incentive for EPs who provide services in a Health Professional Shortage Area (HPSA). To get the maximum incentive payment, Medicare EPs must begin participation by 2012.
- **Eligible hospitals and critical access hospitals (CAHs):** Incentive payments to eligible hospitals and CAHs may begin as early as 2011, and they are based on a number of factors, beginning with a $2 million base payment

READ MORE
Senators Casey and Blumenthal Send Letter to FDA Regarding Drug Shortages Workshop

U.S. Senators Robert Casey (D-PA) and Richard Blumenthal (D-CT) have sent a letter to Food and Drug Administration Commissioner (FDA) Margaret Hamburg asking the agency to schedule a planned workshop on drug shortages earlier than its planned date of September 26, 2011. Senators Casey and Blumenthal are both cosponsors of the Preserving Access to Life-Saving Medications Act, legislation that includes recommendations from the November 5 Drug Shortages Summit, which was co-convened by ASCO.

Drug Shortages

- Adriamycin (doxorubicin) DETAILS
- Bleomycin Injection DETAILS
- Cisplatin for Injection DETAILS
- Cytarabine Injection DETAILS Updated 4/18/2011
- Daunorubicin DETAILS New 4/26/2011
- Dexamethasone Injection DETAILS
- Etoposide Injection DETAILS
- Furosemide Injection 10 mg/ml DETAILS
- Leucovorin Calcium Lyophilized Powder DETAILS
- Levoleucovorin 50mg DETAILS
- Lorazepam Injection DETAILS Updated 5/9/2011
- Sodium Chloride DETAILS
- Thiotepa for Injection DETAILS Updated 4/15/2011
- Xeloda 500 Tablets DETAILS

Drug Shortages Update: Manufacturer Releases Small Amounts of Cytarabine; Thiotepa Supplies Imported from Overseas

The United States is currently experiencing drug shortages, particularly for generic drugs. Shortages of drugs used to treat patients with hematologic malignancies, including leukemia and lymphoma, have become critical and life-threatening. An increasing number of physicians have been forced to take their patients off therapies mid-treatment, delay treatment, choose alternative therapies that are less effective, and ration their remaining supplies of these therapies.

FDA Needs Teeth to Avert Drug Shortages

The number of medications in short supply has been rising, including some needed daily in hospitals, and regulators lack the tools to address the problem. One Senate bill in the works could help. In 2004, the authoritative drug information service of the University of Utah recorded critical shortages for 58 drugs. Last year the number of new shortages reached 211, and this year reports of new shortages are arriving at a pace of more than one a day.

For another good resource with detailed information about the various drug shortages please CLICK HERE.
FDA Approves New Treatment for Rare Form of Thyroid Cancer

(Vandetanib is first drug approved for medullary thyroid cancer)

The U.S. Food and Drug Administration today approved vandetanib to treat adult patients with late-stage (metastatic) medullary thyroid cancer who are ineligible for surgery and who have disease that is growing or causing symptoms.

Thyroid cancer is a cancerous growth of the thyroid gland, which is located in the neck. Medullary thyroid cancer involves specific types of cells that are found in the thyroid gland and can occur spontaneously, or be part of a genetic syndrome.

About 44,600 new thyroid cancer cases were diagnosed in the United States during 2010, and about 1,690 people died from the disease, according to the National Cancer Institute. Medullary thyroid cancer is estimated to represent 3 to 5 percent of all thyroid cancer; its estimated incidence in the United States for 2010 is about 1,300 to 2,200 patients, making it one of the rarer forms of thyroid cancer.

READ MORE

FDA Approves Fusilev® for Use in Patients with Colorectal Cancer

Spectrum Pharmaceuticals (NasdaqGS: SPPI), a biotechnology company with fully integrated commercial and drug development operations with a primary focus in oncology, received approval from the U.S. Food and Drug Administration (FDA) on April 29, 2011, for the use of Fusilev® (levoleucovorin) in combination with 5-fluorouracil in the palliative treatment of patients with advanced metastatic colorectal cancer.

READ MORE

Resistance to FDA on Avastin Limits

By ALICIA MUNDY

WASHINGTON-Genentech Corp. has a team of Washington lawyers, lobbyists and a national public-relations giant on its side in the company's aggressive campaign to protect its blockbuster drug Avastin from efforts by federal regulators to end the drug's approval for treating breast cancer.

Genentech also has in its corner people like Terry Kalley, who has taken a leave from the small Michigan automotive-tools company he founded to fight the Food and Drug Administration's bid to limit approved uses of Avastin, which he says saved his wife Arlene's life.

READ MORE

ODAC Approves Everolimus for Treatment of Pancreatic Neuroendocrine Tumors

The FDA's Oncologic Drugs Advisory Committee voted unanimously today to approve a supplemental new drug application from Novartis to use everolimus for the treatment of pancreatic neuroendocrine tumors. The vote was 10-0.

READ MORE
FDA Approves Zytiga for Late-Stage Prostate Cancer

The U.S. Food and Drug Administration today approved Zytiga (abiraterone acetate) in combination with prednisone (a steroid) to treat patients with late-stage (metastatic) castration-resistant prostate cancer who have received prior docetaxel (chemotherapy). READ MORE

Mylan Launches Breast Cancer Drug

Pittsburgh Business Times - by Kris B. Mamula
Date: Monday, April 25, 2011

Canonsburg-based generic drug maker Mylan Inc. on Monday announced the launch of a drug used to treat breast cancer under a previously announced settlement and license agreement with New York City-based Novartis Corp.

Mylan subsidiary Mylan Pharmaceuticals Inc. will have a period of marketing exclusivity because it was the first to file a substantially complete abbreviated new drug application for the product. Letrozole tablets are the generic version of Novartis' Femara, a supplemental treatment for postmenopausal women who have undergone surgery for hormone receptor-positive, early-stage breast cancer. The product had U.S. sales of about $682 million for the year ending Dec. 31, according to Norwalk, Conn.-based IMS Health Inc.

Mylan has 165 drug applications pending Food and Drug Administration approval, representing $98.5 billion in annual sales, according to IMS Health. Of these applications, 46 are potential first-to-file opportunities, representing $25.9 billion in brand sales for the year ending June 30, 2010.

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.
To read more about this bill CLICK HERE

Bristol-Myers Squibb Initiates a Nationwide Voluntary Recall of Coumadin (Warfarin Sodium) Crystalline 5 mg Tablets, Lot Number 9H49374A

FDA Press Release Mon, 02 May 2011 16:51:00 -0500
Bristol-Myers Squibb initiated a voluntary recall of one lot of 1,000-count bottles of Coumadin® (warfarin sodium) Crystalline 5 mg tablets. Bottles of 1,000 tablets are distributed to pharmacies for further dispensing to patients in prescription quantities. READ MORE
Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2009

04/22/2011 – Summary - In 2009, average sales prices (ASP) for 34 Healthcare Common Procedure Coding System (HCPCS) codes with complete average manufacturer price (AMP) data exceeded AMPs by at least 5 percent in one or more quarters. If reimbursement amounts for these 34 codes had been lowered to 103 percent of the AMPs during the applicable quarter(s), Medicare expenditures would have been reduced by an estimated $4.4 million from the third quarter of 2009 through the second quarter of 2010. READ MORE

---

Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC

Our review found that of the 1,340 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, 359 were correct. Providers refunded overpayments on 51 line items totaling $478,000 before our fieldwork. The 930 remaining line items were incorrect and included overpayments totaling $6.2 million, which the providers had not refunded by the beginning of our audit. READ MORE

---

Comparison of Third-Quarter 2010 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2011

We identified 24 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 third quarter of 2010. Of these 24 HCPCS codes, 14 had complete AMP data (i.e., AMP data for every drug product that CMS used to establish reimbursement amounts). If reimbursement amounts for all 14 codes with complete AMP data had been based on 103 percent of the AMPs during the first quarter of 2011, we estimate that Medicare expenditures would have been reduced by $10.3 million in that quarter alone. READ MORE

---

Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia

West Virginia's Department of Health and Human Resources' Bureau for Medical Services (the State agency) did not fully comply with the approved State plan. As a result, the State agency overpaid $22.8 million. The State agency included costs in the calculation of its rates for school-based services that were not included in the reimbursement methodology described in the approved State plan. READ MORE

---

Electronic Newsletter
May 2011
Volume 3 Issue 5
Page 24
CVS Pharmacy Inc. Agrees to Pay $17.5 Million to Resolve False Prescription Billing Case

WASHINGTON – CVS Pharmacy Inc., the retail pharmacy division of CVS Caremark Corporation that operates more than 7,000 retail pharmacies in 41 states and the District of Columbia, has agreed to pay the United States and 10 states $17.5 million to resolve False Claims Act allegations, the Justice Department announced today.

The settlement resolves allegations that CVS submitted inflated prescription claims to the government by billing the Medicaid programs in Alabama, California, Florida, Indiana, Massachusetts, Michigan, Minnesota, New Hampshire, Nevada and Rhode Island for more than what CVS was owed for prescription drugs dispensed to Medicaid beneficiaries who were also eligible for benefits under a primary third party insurance plan (excluding Medicare as the primary payer). READ MORE

Appealing Denied Claims Seems To Work, GAO Report Says

The government is looking for a way to track and report denial rates to consumers as part of health insurance exchanges.

A government review of the rates at which insurers decline to write policies and reject claims for payment found that when physicians and patients appealed denied claims, those appeals were "frequently" successful, with 39% to 59% resulting in a reversal.

The Government Accountability Office report, released March 16, also found that many health insurance claims denials stem from miscodings, incomplete information or other paperwork errors, pointing to the need for further automation of claims processing. READ MORE

Three Glimpses of Integration

1) Two physician practices reconcile different business offices after a merger…READ MORE

2) Common operational and leadership challenges to avoid…READ MORE

3) One clinic's decision to sell to a hospital…READ MORE

Less Than 60 Days Left To Avoid E-Prescribing Penalties

Earning the e-prescribing incentive for 2011 will not necessarily exempt an eligible professional (EP) or group practice from the one percent penalty starting on Jan. 1, 2012. An EP must successfully e-prescribe for Medicare patients 10 times before June 30, 2011 using claims-based reporting to avoid the payment adjustment in 2012. For 2013, the 1.5 percent penalty is based on whether the EP successfully e-prescribes for 25 Medicare patients during 2011 using claims-based, registry, or EHR reporting methods. Even if the EP attests to being a meaningful user of their EHR in 2011 (a program that includes an e-prescribing requirement), they must still separately submit a minimum of 10 e-prescriptions on claims by the end of June.

Continued on next page…
Organizations participating in the Group Practice Reporting Option (GPRO) for the e-prescribing incentive program must submit their required number of e-prescriptions by the end of June to avoid the 2012 penalties.

EPs can avoid the 2012 e-prescribing penalty if they:
- Are not physicians (MDs, DOs, or podiatrists), nurse practitioners, or physician assistants as of June 30, 2011 based on their primary taxonomy code in the National Plan and Provider Enumeration System
- Do not have prescribing privileges. Note: they must report (G8644) at least one time on an eligible claim prior to June 30, 2011
- Do not have at least 100 Medicare cases containing an encounter code in the measure denominator.

MGMA has strongly urged CMS to revise its policy on these e-prescribing penalties. MGMA’s E-prescribing Resource Center has additional information on the e-prescribing penalties.

---

New Practice Management System Vendor Directory Now Available To Members

MGMA and the American Medical Association (AMA) have released a directory to assist physician practices choose the best practice management system software. The two organizations sought to make the software selection process easier by developing an online directory of software vendors that helps physicians determine whether the vendors’ practice management systems comply with the new HIPAA 5010 transaction standard and what administrative features and functions vendors offer. Practices must comply with this updated, government standard for electronic transactions by Jan. 1, 2012, making the appropriate software selection for a medical practice critical.

The directory, which is free for members, is a companion to the recently released Selecting a Practice Management System toolkit, assisting practices identify the software that best fits the needs of their organization.

MGMA encourages all practice management system software vendors interested in being listed in the directory to fill out the MGMA questionnaire.

---

The latest issue of Medical Economics is available for online reading. CLICK HERE
More Medicare Medically Unlikely Edit Updates

On Tuesday, April 26, ASCO reported that Correct Coding Solutions, the CMS contractor that oversees the Medically Unlikely Edits (MUE) and the National Correct Coding Initiative (NCCI) Edits would be increasing the MUE values for the drugs Mesna, (J9209) and ifosfamide (J9208).

The MUE values for both drugs will be updated as of July 1, 2011 and will be retroactive to January 1, 2011. According to ASCO, providers who have received line denials on Mesna or ifosfamide can request a re-opening of a claim or appeal the claim before the July 1 update. Providers can also wait until after July 1 when the updates occur to re-open or appeal the previously denied items.

For more information on the CMS NCCI and MUE program go to: www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

House Energy and Commerce Committee Has Hearing to Address the Sustainable Growth Rate

In its first of a series of hearings to address the Sustainable Growth Rate (SGR), the House Energy & Commerce Committee held a hearing May 5, entitled "The Need to Move Beyond the SGR." Information regarding the Hearing, including the list of witnesses who testified and their corresponding testimony, can be accessed on the Committee’s Web site.

Prior to the start of the series of hearings, ASH submitted comments to the House Energy and Commerce Committee in response to the Committee’s request for proposals to reform the Sustainable Growth Rate (SGR) system. In its comments, ASH expressed its concern that continual threats to reductions to the conversion factor need to be eliminated and recommended that Congress take the following steps: READ MORE
NCCN 4th Annual Asia Scientific Congress Held in Shanghai, China

More than 1,800 Chinese oncology professionals attended the National Comprehensive Cancer Network® 4th Annual Asia Scientific Congress in Shanghai, China, on April 9, 2011, which featured expert faculty from NCCN Member Institutions and thought leaders in cancer care from major Chinese cancer centers. "This Congress represents a paragon for the developing international standards for the treatment of patients with cancer. Expert oncologists from China and NCCN discussed the most important changes in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™) for many tumor types and worked together to optimize the guidelines for the treatment of patients in China," said Dr. Thomas D'Amico, NCCN Board of Directors Chair and Director of Clinical Oncology at the Duke Cancer Institute.

READ MORE

NCCN Hematologic Malignancies Congress Aims to Further Treatment in China

As part of the 4th Annual Asia Scientific Congress held in Shanghai, China, the National Comprehensive Cancer Network® convened the NCCN Hematologic Malignancies Congress on April 10, 2011. The collaborative Congress presented to more than 75 Chinese hematologists and aimed to further the treatment of hematologic malignancies in China.

READ MORE

Molecular Marker Testing: What Information is Important?

Those practicing in oncology recognize the alphabet soup that is part of routine oncology care. Acronyms such as FOLFOX, R-CHOP, ABVD, and AC, which are used to describe various chemotherapy regimens, are routinely part of the oncology jargon. Recently, clinicians have noticed other types of important acronyms appearing in the oncology lexicon: genes or proteins described by the results of molecular marker testing (e.g., BCR-ABL, EGFR, KRAS, etc.). Molecular marker testing is becoming increasingly important in the care for patients with cancer, but it is clear that many challenges exist in this maturing area. Recently, an expert roundtable panel at the NCCN 16th Annual Conference discussed these challenges of molecular tests in oncology. From this conversation, it can be concluded that more information about these tests would be helpful to clinicians and other stakeholders to make appropriate treatment decisions.

READ MORE

NCCN Flash Update: NCCN Guidelines Updated

DETAILS
Medical Societies Want Flexibility on EHR Meaningful Use Rules

Medical societies want you to have more flexibility in meeting the meaningful use requirements of the EHR incentive program.

The American Medical Association, American College of Physicians, American Academy of Family Physicians, American Osteopathic Association and 34 other societies wrote to the Office of the National Coordinator for Health Information Technology in response to a request for comments on the proposed next stage of meaningful use criteria. READ MORE (1)

NCCN: CME/CE Calendar of Events

Are you looking for:

- Live Events
  - NCCN Congress Series: Respiratory Tract Cancers™
  - NCCN 6th Annual Congress: Hematologic Malignancies™
- Live Webinars
  - NCCN Oncology Case Manager Program™ Webinars
  - NCCN 2011 Congress Series: Breast Cancer™ Webinar Series
  - NCCN 2011 Nursing Program Webinars
- Online Activities
  - NCCN Guidelines Update Webinar Series™: Non-Hodgkin's Lymphomas
  - NCCN Oncology Case Management Program™
  - NCCN Library of Case Studies™

Get details on these and more ..... CLICK HERE (1)

Physician Incorrectly Billed Place of Service 90 Times

The Centers for Medicare & Medicaid Services (CMS) released a special-edition MLN Matters article titled "The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents." This article, released by CMS on March 9, 2011, was a follow-up to a July 2010 report from the acting deputy inspector general for audit services to CMS Administrator Don Berwick.

That report detailed the results of a review of place-of-service coding for physician Part B services billed during the 2007 calendar year. The audit covered 484,218 non facility-coded physician E/M services that were matched to hospital outpatient or ASC for the same patient on the same day, being responsible for more than $42 million in charges.

In a review of 100 sample services, physicians incorrectly coded the place of service 90 times. In this small sample, the resulting overpayments amounted to $4,710. Extrapolated to the larger population, the overpayment for "place-of-service" payments was estimated at $13.8 million. The recommendation of the report was to recover the $4,170 identified in the audit immediately and then reopen the unaudited 484,118 non-sampled services to recover the estimated $13.8 million. READ MORE (1)
Blue Cross Blue Shield Settlement to Expire Soon

Time is running out to protect your practice by holding Blue Cross Blue Shield accountable to the terms of its settlement agreement before the agreement expires May 31. View numerous AMA resources that cover the Blue Cross Blue Shield settlement, including an archived webinar that:

- Explains how the settlement agreement helps your practice
- Provides a summary of the key business practices mandated in the settlement
- Outlines the simple steps for filing a free compliance dispute

You also can access an interactive map that lets you determine which Blue Cross Blue Shield plans and subsidiaries in your state have settled.

Because contracts provided by Blue Cross Blue Shield to physicians in its provider network must conform to the settlement agreement, be sure to review your contracts to ensure that you are receiving all the protections the settlement provides.

Bill Would Give Medicare Patients Greater Choice of Physicians

Legislation introduced Tuesday in the U.S. House of Representatives would allow Medicare patients and their physicians to enter into private contracts without penalty to either party.

Introduced by Rep. Tom Price, MD, R-Ga., the Medicare Patient Empowerment Act, H.R. 1700, would enable beneficiaries to use their Medicare benefits to see physicians who do not accept Medicare, as opposed to paying for the entire cost of their care out-of-pocket as required under current law. The bill also would ... READ MORE

How to File Complaints against Unfair Insurers

Filing a complaint against a payer that isn't following fair business practices can be an important step in curbing unfair business practices... READ MORE

A One-Stop Shop For Health IT

Turn to the AMA for everything you need to know about health IT—from webinars on incentive programs to help in selecting and implementing a health IT system. READ MORE
Court Says Physicians Exempt From FTC Red Flags Rule

The DC Circuit Court dismissed the case of American Bar Association v. Federal Trade Commission on the basis that the Clarification Act precludes the FTC from applying its existing "Red Flags Rule" to lawyers (and by implication physicians because the agency used the same rationale to cover doctors under the rule). While it is good news for physicians, the court acknowledged that it is possible the FTC could modify its rule to change the basis for applying the law to lawyers (and doctors).

The AMA also filed suit last year against the FTC, and ASCO along with other medical societies, filed a motion to intervene in the AMA case. However, it is likely that the AMA case will be dismissed based on the rationale in the ABA case, leaving physicians exempt from the burdens of the FTC rule.

The Red Flags Rule requires many businesses and organizations to implement a written Identity Theft Prevention Program designed to detect the warning signs - or "red flags" - of identity theft in their day-to-day operations. According to the FTC, by identifying red flags in advance, businesses will be better equipped to spot suspicious patterns that may arise, and take steps to prevent a red flag from escalating into a costly episode of identity theft.

ASCO Provides Summary of ACO Proposed Rule

ASCO is helping members to understand the much anticipated proposed rule on Accountable Care Organizations (ACOs) with a new summary document. The proposed rule provides initial considerations for implementing this new model for delivering healthcare services as well as reimbursement regulations. According to the rule, an ACO is a network of doctors and hospitals that shares responsibility for providing care to patients. This new model would create cost-savings incentives by offering bonuses when providers deliver high quality care, and issue penalties when quality measures are not met.

Please note that the analysis represents ASCO's initial impressions of the possible impact of the proposed rule; these may change over time and we will keep you informed of any additional analyses. Nothing in the summary document should be construed as representing financial or legal advice. The proposed rules are complex and subject to change at the time of final rule publication.

Legislation Introduced in Senate to Remove Prompt Pay Discounts from the Average Sales Price

On April 5, Senator Pat Roberts (R-KS), along with Senator Debbie Stabenow (D-MI), introduced S. 733, legislation that would ensure more appropriate payments for cancer drugs by excluding prompt pay discounts extended to wholesalers from the manufacturer's average sales price (ASP).

Many practices are struggling because of this unfair calculation, which in many instances reimburses practices for rates that are lower than the purchase price of the drug. Some practices are being forced to send patients to the hospital where the drive and wait time for the patient are often longer. S. 733 would help address this access issue by removing the prompt pay discounts from the ASP, thereby ensuring that physicians are reimbursed adequately for the chemotherapy drugs they buy.

There will need to be significant support to move this bill forward, so send a message today to your Senators and ask them to cosponsor S. 733. Be sure to personalize the message to include details of how this issue is directly impacting your practice. The House version of the bill (H.R. 905) was introduced in March, so if you haven't already, please take a minute to send a message, using ASCO's ACT Network, to your Representative as well.
The Alkylphospholipid, Perifosine, Radiosensitizes Prostate Cancer Cells both In Vitro and In Vivo

Perifosine is a membrane-targeted alkylphospholipid developed to inhibit the PI3K/Akt pathway and has been suggested as a favorable candidate for combined use with radiotherapy. In this study, we investigated the effect of the combined treatment of perifosine and radiation (CTPR) on prostate cancer cells in vitro and on prostate cancer xenografts in vivo. Methods: Human prostate cancer cell line, CWR22RV1, was treated with perifosine, radiation, or CTPR. Clonogenic survival assays, sulforhodamine B cytotoxicity assays and cell density assays were used to assess the effectiveness of each therapy in vitro. Measurements of apoptosis, cell cycle analysis by flow cytometry and Western blots were used to evaluate mechanisms of action in vitro. Tumor growth delay assays were used to evaluate radiation induced tumor responses in vivo.

READ MORE (1)

Society of Nuclear Medicine Advocates Visit Capitol Hill

On May 2, 30 Society of Nuclear Medicine (SNM) members visited Capitol Hill to meet with congressional offices on a variety of issues facing the nuclear medicine and molecular imaging community. Forty-eight meetings were held with staff members from key congressional committees and from the local districts of the SNM members.

"Going to Capitol Hill has a profound impact on how members of Congress view the issues," said Robert Atcher, MBA, PhD, chair of SNM's Commission on Government Affairs. "According to the Congressional Management Foundation, a visit from a local constituent has a 99 percent rating for ability to influence a member of Congress who has not already arrived at a firm decision on an issue. That's what we hoped to accomplish in our visits to the Hill this week." READ MORE (1)

First FDA-approved Mobile Radiology App Poised for Daily Use

The clearance process took more than two years, but the first U.S. Food and Drug Administration (FDA)-approved mobile diagnostic radiology application for the iPhone®/iPad® could quickly become part of the daily work routine for radiologists in remote locations.

"I see these devices being a mainstay for radiologists on call away from a clinical workstation," said Keith Dreyer, D.O., Ph.D., vice-chair of radiology for informatics at Massachusetts General Hospital (MGH) and an associate professor of radiology at Harvard Medical School in Boston. "The devices may currently be too limited in functionality and screen size to provide adequate throughput for a heavy case load, but for answering an immediate question, they will be quite adequate for many examination types." READ MORE (1)

Use of Advanced Radiation Influenced by Medicare Reimbursement

From 2001 to 2005, billing for intensity-modulated radiation therapy for breast cancer treatment increased 10-fold, according to an article published in the Journal of the National Cancer Institute. The cost of radiation therapy increased sharply during the study period. READ MORE (1)
Compliance with Medicare Rules, Regulations Necessary for Physicians

In the wake of health care reform and the government implementing initiatives to tackle improper payments, Medicare reimbursement is under increased scrutiny. This focus on fraud and abuse has heightened the pressure on physicians to ensure the accuracy of their claims. READ MORE

ASTRO Publishes Evidence-Based Guideline for Thoracic Radiotherapy

The American Society for Radiation Oncology (ASTRO) has developed a guideline for the use of external beam radiation therapy, endobronchial brachytherapy and concurrent chemotherapy to palliate thoracic symptoms caused by advanced lung cancer. READ MORE

New Coding Tips Available Online

A new feature is now available on the ASTRO website that highlights coding tips. The first coding tip discusses CPT code 57156 (Insertion of vaginal radiation afterloading apparatus for clinical brachytherapy) and can be viewed on the Coding FAQs and Tips page. Updated coding FAQs are also available on this page.

Humana Corrects Claim Code Edit for IGRT Reimbursement

Humana will no longer implement a claim code edit bundling the professional component for image guided radiation therapy (IGRT) with radiation treatment delivery or brachytherapy. The claim code edit was scheduled to take effect April 10, 2011. Humana has corrected the claim edit in its system so these procedures may continue to be billed and reimbursed separately. Please visit ASTRO's Medicare and Private Insurer page for further details.

Transitioning From Carrots to Sticks and What This Means for the Practicing Radiation Oncologist

Since mid-2007, Medicare has been operating a voluntary quality reporting program, the Physician Quality Reporting System (PQRS), formerly known as the Physician Quality Reporting Initiative (PQRI). Through this program, the Centers for Medicare and Medicaid Services (CMS) provides an incentive payment to eligible professionals who satisfactorily report data on quality measures. 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
- 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

A Urine Test Can Identify Risk for Cancer of the Stomach

Certain proteins excreted in the urine can indicate the presence of gastric cancer, scientists from the University of Georgia (UGA) have learned. READ MORE

Autoimmune Vitiligo May Help Fight Melanoma

Inducing vitiligo in persons with melanoma might enhance the natural immune response of these patients, according to data yielded by a recent study.

In the immunotherapy approach to cancer treatment, T cells attack tumors after recognizing antigens generated by the tumor cells. But noncancerous cells may produce molecules that are identical to those antigens, causing T cells to stage an unwanted autoimmune attack against the normal cells. READ MORE
Treating Breakthrough Cancer Pain Requires Recognition, Matching Drug to Goal

Effective management of breakthrough cancer pain requires optimizing background therapy for chronic pain and accurately assessing the type of breakthrough pain, said presenters at the 45th American Society of Health-System Pharmacists Midyear Clinical Meeting & Exposition. [READ MORE](1)

Passive Safety Device Features 10 Times More Effective in Preventing Needlesticks

This article discusses a study where evidence is presented that passive SEDs that require no input from the user are more effective than active SEDs for NSI prevention. The authors note that further studies are needed to determine whether their higher cost may be offset by savings related to fewer NSIs and to a reduced need for user training. [READ MORE](1)

NCCN 2011 Nursing Program Webinars

- **Improving Survivorship Care for Patients with Cancer**
  Monday, May 23, 2011, 2:00 – 3:00 PM EDT

- **Recognition and Treatment of Depression in Patients with Cancer**
  Wednesday, May 25, 2011, 3:00 – 4:00 PM EDT

- **Updates in the Management of Venous Thromboembolism**
  Friday, May 27, 2011, 2:30 – 3:30 PM EDT

- **Management of Cardiac Complications from Cancer Therapy**
  Friday, June 3, 2011, 3:00 – 4:00 PM EDT

- **A Multidisciplinary Approach to Prostate Cancer**
  Tuesday, June 7, 2011, 12:00 – 1:00 PM EDT

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

[READ MORE](1)

RN Recognition Has Lasting Results

In a profession where nurses focus on patients, it’s important for employers and outside organizations to turn that attention toward the nurses, as well. Through recognition programs, hospitals boost nurses’ self-esteem and practice confidence while also improving workplace morale for their colleagues. [COMPLETE ARTICLE](1)

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

[DETAILS](1)
West Virginia Oncology Nursing Society Chapters

**West Virginia Chapters Include…**

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

Subscribe to Calendar Events
Click [here](http://ncwv.vc.ons.org) 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](mailto:MeekerK@somc.org) if you are interested in becoming a member or know someone who might like more information about membership.

Visit [ORC Chapter](http://ohioriver.vc.ons.org) website for archived newsletters, minutes and photos of the 2009 Regional Cancer Nursing Symposium.

---

**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

THE HEALTH PLAN
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…..

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!!
**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*

---

**Oncology Management Program Coming in Summer 2011**

This summer, Highmark West Virginia will launch an Oncology Management Program. Our program will promote the establishment of evidence-based medical oncology drug treatment protocols. The protocols will be guided by network oncologists in collaboration with Highmark West Virginia. Read entire Highmark announcement [HERE](#)

---

**Humana's YourPractice 2nd Quarter Issue Available HERE**

Visit the website at: [https://www.humana.com/providers](https://www.humana.com/providers)
E-Prescribing

An e-Prescribing 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 DHHRMedicaidScript@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 e-Prescribing process. To find out more about the BMS MediWeb Portal or to access an enrollment application, please click Here.

Cigna Provider Newsletter

The March 2011 issue of Cigna’s bi-monthly NetworkNews is available HERE.
FRONT PAGE
June 7th - WVOS Lunch & Learn Series Announcement
Page 1
West Virginia Oncology Society Annual Spring Membership Meeting SUMMARY
Participate in eRx Today or Receive a Penalty in 2012
WVOS Underwater Drug Reimbursement Initiative
Page 2
WVOS Statewide Cancer Clinical Trials Network
Outpatient Hospital Only HCPCS C-Code Unique To Halaven®
NLM Director’s Comments Transcript Clinical Trial Transparency & Challenges: 04/25/2011
Page 3

PALMETTO & PRIVATE PRACTICE
2011 PQRS and eRx Incentive Program National Provider Call: May 17
Medicare Part B Update
CMS Proposes to Expand Access to Seasonal Influenza Immunization
Implementation: Webinar Tour for West Virginia Part B
Reporting of Recoupment for Overpayment on the Remittance Advice (RA)
Screening for the Human Immunodeficiency Virus (HIV) Infection
Drugs & Biologicals: Maximum Allowed Units (MAUs) Updated 4/25/11
Page 4
Local Coverage Determinations: Find Them Quickly
April 2011 MAU Update
Palmetto Medicare Advisory – May 2011
Page 5
WVOS Private Practice Reimbursement Q & A’s
Page 6

NGS & OUTPATIENT HOSPITAL
Latest Production Alerts
Proper Coding When Both a Primary and Secondary Diagnosis are Required to
Demonstrate Medical Necessity
Page 8
Do Not Cancel Claims in Medicare Secondary Payer Situations
Page 9
Helpful Tips When Requesting Claims Appeals
NGS May Medicare Monthly Review
April Interactive Voice Response System Enhancements
Page 10
NGS Self Service Center
Electronic Data Interchange Help Desk Interactive Voice Response System

Changes effective Monday, May 16, 2011
Understanding Eligibility Screen Webinar
New J11 Part A MAC
Page 11
New Workload Numbers for West Virginia Part A
Quick Tips for Navigating the New J11 MAC Website
Important Jurisdiction 11 Information for Virginia and West Virginia Part A Providers
J11 MAC CONTACT INFORMATION
Page 12
Improving Inpatient-Outpatient Transitions: What Can Be Done?
Review of Medicare Payments Exceeding Charges
NGS Self Service Center
WVOS Oncology Outpatient Hospital Reimbursement Q & A’s
Page 13

NATIONAL MEDICARE
CMS Fact Sheet - CERT Signature Requirements
Revised April 2011 ASP Files Available
Accountable Care Organizations (ACOs)
National Government Services News
PQRS & e-Prescribing Incentive Program Announcement
Page 15
Oncology Community Concerned about CMS ACO Proposal
The Centers for Medicare and Medicaid Services (CMS) Launches a Dedicated
Web Page for the Medicare Shared Savings
Page 16
CMS Data Show Gains in Key Quality Indicators through Physician Quality
Reporting System and ePrescribing Incentive Program
Summary of Proposed Rule Provisions for Accountable Care Organizations
under the Medicare Shared Savings Program
Healthcare Common Procedure Coding System (HCPCS) Public Meeting
Agendas for Drugs, Biologicals and Radiopharmaceuticals
MLN Matters Information for Healthcare Providers
Page 17
Recent LearnResource & MedLearn Matters Articles
Page 18
RAC ATTACK-ATTENTION ALL WEST VIRGINIA WVOS MEMBERS!
RACs Identify $162 Million in Overpayments in Q2 FY 2011 Alone; $77 per Month
for Every Hospital Bed in the U.S.
CMS Reports $365.8 Million in Improper Payments
Page 19
Random Sampling, Extrapolation and Appeals: Core Components of Defending a RAC Audit
How do I get paid for the Electronic Health Record (EHR) Incentive Programs?
Page 20
MEDICAL ONCOLOGY
Senators Casey and Blumenthal Send Letter to FDA Regarding Drug Shortages Workshop
Drug Shortages
ACCC-Drug Shortages Shocker
Drug Shortages Update: Manufacturer Releases Small Amounts of Cytarabine; Thiopeta Supplies Imported from Overseas
FDA Needs Teeth to Avert Drug Shortages
Page 21
FDA Approves New Treatment for Rare Form of Thyroid Cancer
Resistance to FDA on Avastin Limits
FDA Approves Fusilev® for Use in Patients with Colorectal Cancer
ODAC Approves Everolimus for Treatment of Pancreatic Neuroendocrine Tumors
Page 22
FDA Approves Zytiga for Late-Stage Prostate Cancer
Capitol Hill News
Mylan Launches Breast Cancer Drug
Bristol-Myers Squibb Initiates a Nationwide Voluntary Recall of Coumadin (Warfarin Sodium) Crystalline 5 mg Tablets, Lot Number 9H49374A
Page 23
Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia
OIG-Comparison of Third-Quarter 2010 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for 1st Qtr 2011
OIG-Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC
OIG-Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2009
Page 24
CVS Pharmacy Inc. Agrees to Pay $17.5 Million to Resolve False Prescription Billing Case
Appealing Denied Claims Seems To Work, GAO Report Says
MGMA-Three Glimpses of Integration
MGMA-Less Than 60 Days Left To Avoid E-Prescribing Penalties
Page 25
MGMA-New Practice Management System Vendor Directory Now Available To Members
Medical Economics Issue
Page 26
The Hematologist May-June Issue
More Medicare Medically Unlikely Edit Updates
ASH-House Energy and Commerce Committee Has Hearing to Address the SGR
Page 27
NCCN 4th Annual Asia Scientific Congress Held in Shanghai, China
NCCN Hematologic Malignancies Congress Aims to Further Treatment in China
NCCN-Molecular Marker Testing: What Information is Important?
NCCN Flash Update: NCCN Guidelines Updated
Page 28
Medical Societies Want Flexibility on EHR Meaningful Use Rules
NCCN Oncology Case Management Program™
NCCN: CME/CE Calendar of Events
Physician Incorrectly Billed Place of Service 90 Times
Page 29
AMA-Blue Cross Blue Shield Settlement to Expire Soon
AMA-Bill Would Give Medicare Patients Greater Choice of Physicians
AMA-How to File Complaints against Unfair Insurers
AMA-A One-Stop Shop For Health IT
Page 30
ASCO-Court Says Physicians Exempt From FTC Red Flags Rule
ASCO Provides
Summary of ACO Proposed Rule
ASCO-Legislation Introduced in Senate to Remove Prompt Pay Discounts from the Average Sales Price
Page 31
RADIATION ONCOLOGY
The Alkylphospholipid, Perifosine, Radiosensitizes Prostate Cancer Cells both In Vitro and In Vivo
Society of Nuclear Medicine Advocates Visit Capitol Hill
First FDA-approved Mobile Radiology App Poised for Daily Use
Use of Advanced Radiation Influenced by Medicare Reimbursement
Page 32
2011

West Virginia Oncology Society
Board Officers and Directors

President:
James Frame, M.D., F.A.C.P.

Vice President:
Arvind Shah, M.D.

Treasurer:
Carl Larson, M.D.

Secretary:
Mike Craig, M.D.

Past President:
John J. Azar, M.D., F.A.C.P.

Members at Large:
Jame Abraham, M.D., F.A.C.P.
Gerrit A. Kimmey, M.D.
Sushil K. Mehrotra, M.D.
Jon David Pollock, M.D., PhD
Magesh Sundaram, M.D.
Maria Tria Tirona, M.D., F.A.C.P.

Executive Director
Julie Shroyer

Associate Executive Director
Michelle Weiss

Assistant Director
Bob Burkley

ASCO-Compliance with Medicare Rules, Regulations Necessary for Physicians
ASTRO Publishes Evidence-Based Guideline for Thoracic Radiotherapy
ASCO-New Coding Tips Available Online
ASCO-Humana Corrects Claim Code Edit for IGRT Reimbursement
ASCO-Transiting From Carrots to Sticks and What This Means for the Practicing Radiation Oncologist

ONCOLOGY NURSING
Quitting Tobacco for Newly Diagnosed Cancer Patients
Chemotherapy Courses at Fairmont General
A Urine Test Can Identify Risk for Cancer of the Stomach
Autoimmune Vitiligo May Help Fight Melanoma

Treating Breakthrough Cancer Pain Requires Recognition, Matching Drug to Goal
Passive Safety Device Features 10 Times More Effective in Preventing Needlesticks
2011 Relay For Life of Berkeley County, WV June 4
NCCN 2011 Nursing Program Webinars
RN Recognition Has Lasting Results

West Virginia Oncology Nursing Society Chapters

PAYER UPDATES
Aetna OfficeLink Updates – March Issue

Coventry Provider Newsletter – 1st Quarter
Page 37
UnitedHealthCare Network Bulletin - NEW
Humana’s YourPractice 2nd Qtr Issue - NEW
Highmark BCBS – Oncology Management Program
Coming in Summer 2011
Highmark BCBS Provider News – April 2011
Page 38
West Virginia Medicaid – ePrescribing
Cigna Provider Newsletter
The Health Plan Provider Newsletter - NEW
West Virginia Medicaid - Provider Workshop Invitation
Page 39

WVOS Newsletter Disclaimer
This newsletter is intended for informational purposes only. WVOS makes no warranties or representations, express or implied, as to the accuracy or completeness, timeliness or usefulness of any opinions, advice, services or other information contained or referenced in this newsletter. Information is provided for reference only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions. CPT codes are owned and trademarked by the American Medical Association. All Rights Reserved.