



Oncology Review

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WVOS Fall Membership Meeting/Dinner Program
Euro-Suites Morgantown, WV
Thursday, October 8, 2009

AND

WVU Fall Cancer Conference
in cooperation with WVOS
Erickson Alumni Center
Morgantown, WV
Friday, October 9, 2009

Visit wvos.info for details!

Governor Joe Manchin on WVOS

Straight from The Governor's Desk: A weekly column



Whether it is a loved one or a friend who has been diagnosed, all West Virginians have been affected by cancer, which according to the National Center for Health Statistics causes nearly 23 percent of all deaths. However, in our state we are fortunate to have a dedicated medical community and teaching hospitals that have joined together to bring the most advanced cancer treatments to every part of the state.

The West Virginia Oncology Society was organized in 2008 and recently accepted as a full member by the American Society of Clinical Oncology. The group has already attracted more than 85 percent of the state's cancer specialists. They elected Dr. John Azar of Fairmont as their first president and Dr. James Frame (CAMC) as vice president. Their goals include advocacy for cancer care, patient and professional education, and increased access to cancer clinical trials.

Cancer specialists say clinical trials are the gold standard treatment

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What You Need to Know About the ARRA on Oncology and EHR Use

With the signing of the American Recovery and Reinvestment Act (ARRA), allocating approximately \$19 billion towards Electronic Health Record (EHR) adoption, physicians who demonstrate meaningful use of certified EHRs could be eligible for up to \$44,000 in incentives over five years beginning in 2011. Defining the standards for qualified EHRs, as well as the "meaningful use" requirements for physicians using qualified EHRs, will be key to the way these incentives are earned. To qualify, as a "meaningful EHR user" physicians will need to:

- Use a certified EHR product that complies with federal standards for interoperability, or sharing data between electronic systems;
- Use e-prescribing software;
- Use a certified EHR to exchange health information to improve the coordination and quality of care;

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WVOS

Mission Statement

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

Use of the GA and GY Modifier with an ABN



The new Advance Beneficiary Notice of Non-coverage (ABN) replaces the former Advance Beneficiary Notice (ABN-G and ABN-L) and may also be used for voluntary notifications in place of the Notice of Exclusion from Medicare Benefits (NEMB) form. The revised ABN can fulfill both the mandatory and voluntary notice function.

Mandatory Function: Providers should consider providing an ABN to their patients whenever they believe Medicare will deny the service based on medical necessity. Providers use the GA modifier to indicate they expect Medicare will deny a service as not reasonable and necessary and they provided the patient with an ABN. Appending the GA modifier to the procedure code establishes the beneficiary's financial liability should

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options for most primary cancers. Unfortunately, only about 3 percent of adult cancer patients across the country enroll in clinical trials. West Virginia has a low rate of participation in these trials. Hopefully, through this network, community oncologists in the state will be able to match cancer patients with the most promising new treatments.

WVU's Mary Babb Randolph Cancer Center, Marshall's Joan C. Edwards Comprehensive Cancer Center, United Hospital Center in Clarksburg, CAMC's David Lee Cancer Center, WVU Hospitals-East in Martinsburg, and Wheeling Hospital's Schiffler Cancer Center all offer clinical trials. The network's goal is to allow oncologists everywhere in the state to form partnerships with the cancer researchers and if needed to partner with larger institutions and bring advanced clinical trials to their communities.

The effort benefits patients, doctors and the research community. Patients get earlier access to new cancer drugs and other treatments in their home communities. Doctors are better informed on the latest developments in cancer care and better able to offer their patients the most advanced treatments. Researchers can draw more patients into their cancer studies, making it more likely that West Virginia's research efforts will continue to grow.

We've all lost friends, family members and co-workers to cancer, and that is why this is so important. This effort truly defines what a partnership means and how successful something can be when we come together. I thank those who work on a daily basis to bring vital medical treatment to those who need it the most.

Coordinating such a massive statewide effort isn't easy. Dr. Jame Abraham, chief of hematology and oncology at WVU, got the ball rolling and encouraged his fellow cancer doctors to organize themselves. The Benedum Foundation and Susan G. Komen for the Cure provided funding to the network to support clinical trial nurses at several facilities across the state. The American Cancer Society is helping match patients with promising clinical trials. And the oncologists, hospitals, community clinics and other health care organizations around the state that have joined this effort have invested hundreds of hours of time and work.

We all will benefit from their dedication.

NCCN Compendia Listings Do Not Guarantee Medicare Payment on the Initial Claim

“The indication is listed in NCCN Compendium, why are we getting rejected by Medicare?” A question frequently asked. While CMS acknowledges the NCCN Drugs & Biologics Compendium™ as a mandated reference for the establishment of coverage policy and coverage decisions regarding “medically-accepted indications” related to the use of drugs and biologics in cancer care, they do not *automatically* add these off label uses to their existing policies. This means that providers will most likely have to status an initial claim and provide supportive information to the payer.

Medicare Carriers and MAC’s are not *required* to purchase any of the approved Compendia and instead rely on physicians to submit supportive information including a Compendia listing when requesting reimbursement for an off-label drug.

- *“The contractor may maintain its own subscriptions to the listed compendia or peer-reviewed publications to determine the medically accepted indication of drugs or biologics used off-label in an anti-cancer chemotherapeutic regimen. Compendia documentation or peer-reviewed literature supporting off-label use by the treating physician may also be requested of the physician by the contractor.”*
 - *Excerpt from Medicare Benefit Policy Manual, Chapter 15, pg 61, Section 50.4.5 - Off-Label Use of Drugs and Biologics in an Anti-Cancer Chemotherapeutic Regimen*

While you may receive a denial on your initial claim, providing Compendia documentation which meets Medicare’s criteria will ultimately get your claim approved.

Medicare will reimburse for medically accepted indications of Food and Drug Administration-(FDA) approved drugs and biologics used in an anti-

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- Use a certified EHR to electronically report on the quality of care.

The Department of Health and Human Services is required to adopt, through the regulatory rule-making process, an initial set of standards, implementation specifications, and certification criteria by December 31, 2009.

ASCO has provided [comment](#) on the initial definition of “meaningful use” to highlight the needs of oncology. ASCO is also hosting its 2nd **EHR Symposium: Harnessing the EHR, From Incentives to Sustainability, October 6-7 in San Francisco**, to prepare oncologists for these changes in health care, specifically how ARRA and the final “meaningful use” criteria will affect their health care IT plans in the community-based oncology practice.

Register now at www.asco.org/ehrsymposium for this important event.

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“ASCO has provided comment on the initial definition of “meaningful use” to highlight the needs of oncology.”

Corporate Sponsor of the Month

The Board of Directors, Officers, and Physicians of the West Virginia Oncology Society (WVOS) would like to **thank** ABRAXIS Oncology for its interest and support of our association.

Abraxis Oncology supports WVOS at the highest possible level with their **PLATINUM** membership. With this support, physician members, their staff and ultimately their patients will receive substantial benefits in the areas of advocacy, clinical and professional education, information dissemination and quality care.

*Thank you for all you do
and your continued
support!*



Who are they. “Abraxis Oncology is the proprietary pharmaceuticals division of Abraxis BioScience, LLC, an integrated global biopharmaceutical company. Abraxis Oncology is dedicated to the discovery and development of novel cancer therapies that target tumor biological pathways. Our focus is to challenge current standards and develop next-generation therapies that revolutionize the treatment of cancer. Through innovative science and creative thinking, Abraxis Oncology is redefining cancer therapy as we know it. It is our hope that the discovery of new technologies and new compounds will improve survival, as well as tolerability, across a range of tumor types.”

Corporate Memberships in WVOS are available in three levels, with increasing rights and benefits at each level. For more information please visit the [WVOS Website](#).

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cancer chemotherapeutic regimen when supported in either one or more of the compendia or in peer-reviewed medical literature. As mandated in the Medicare Provider Manual, Medicare Carriers and MAC’s should not deny coverage based solely on the absence of FDA-approved labeling for the use, if the use is supported by any of the following compendia and the use is not listed as unsupported, not indicated, not recommended, or equivalent terms, in any of the following compendia:

- Existing - American Hospital Formulary Service-Drug Information (AHFS-DI)
- Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Effective June 10, 2008 - Thomson Micromedex DrugDex
- Effective July 2, 2008 - Clinical Pharmacology

The listed compendium employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium.

In general, a use **is** identified by a compendium as medically accepted if the:

- indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use **is not** medically accepted by a compendium if the:

- indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

If you do not have access to any of the above referenced Compendia, you may consider contacting the manufacturer of the product. Through their Medical Information Services Departments, many are allowed to provide you with that information.

For more information on Medicare Off-Label Use of Drugs, visit the Medicare Benefit Policy Manual at:

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Chapter 15 - Covered Medical and Other Health Services, beginning on page 61,

50.4.5 - Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (Rev. 96, Issued: 10-24-08, Effective: 06-05-08 NCCN/06-10-08 Thomson Micromedex/07-02-08 Clinical Pharmacology, implementation: 11-25-08)

Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2010

“Once again, physicians are facing a significant reduction in Medicare payment. . . ”

While Members of the House and Senate continue to wrangle over the specifics of proposed health-care reform legislation, it is anyone’s guess what Medicare reimbursement will be in 2010 however, annually at this time of the year The Centers for Medicare & Medicaid Services (CMS) releases the proposed changes to the physician fee schedule. This information lays the groundwork to what could happen to our reimbursement the following year.

The “Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2010” published in Federal Register on July 13th, (<http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf>) allows a comment period through August 31st and will be finalized mid-November. Once again, physicians are facing a significant reduction in Medicare payment including a proposed -21.5 percent reduction to the conversion factor unless Congress acts. Our national societies including ASCO, ASH and ACCC have published their analysis of the proposed changes:

[ASCO's Initial Analysis of the Proposed 2010 Medicare Physician Fee Schedule](http://www.asco.org/ASCOv2/Department%20Content/Cancer%20Policy%20and%20Clinical%20Affairs/Downloads/ASCO%20Fee%20Schedule%20Summary.pdf)
<http://www.asco.org/ASCOv2/Department%20Content/Cancer%20Policy%20and%20Clinical%20Affairs/Downloads/ASCO%20Fee%20Schedule%20Summary.pdf>

[ASH's Analysis of the Proposed 2010 Medicare Physician Fee Schedule](http://www.hematology.org/News/2009/2870.aspx)
<http://www.hematology.org/News/2009/2870.aspx>

[ACCC's Analysis of the Proposed 2010 Medicare Physician Fee Schedule](http://www.accc-cancer.org/public_policy/pdf/2010_physician_proposedrule.pdf)
http://www.accc-cancer.org/public_policy/pdf/2010_physician_proposedrule.pdf

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Medicare deny the services based on medical necessity guidelines.

Voluntary Function: Noncovered services are those which cannot be paid by Medicare and are statutorily excluded from being a Medicare covered benefit. Providers can bill a beneficiary for noncovered services. In most cases the beneficiary will be liable for the cost of the service. Providers are not required to bill Medicare unless a beneficiary requests a denial from Medicare.

The ABN is not required for services statutorily excluded from coverage under Medicare. However, the ABN can be issued voluntarily, in place of the NEMB form, for services that are noncovered. If the beneficiary requests a denial from Medicare, the provider may bill the services to Medicare using the GY modifier. The GY modifier defines the service as statutorily excluded or as a service that does not meet the definition of any Medicare benefit. The GY modifier must be appended to a procedure code when the provider wants to indicate that the service is statutorily noncovered or is not a Medicare benefit. The GY modifier is the most appropriate modifier in this situation.

Information regarding the use of the ABN is available on the Centers for Medicare & Medicaid Services (CMS) Website at the following addresses:

http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6136.pdf>

WVOS Reimbursement Q & A

Question: In the middle of the chemotherapy treatment, our patient had a reaction. He received 1.5 hours of the 3 hour infusion. We had to stop the treatment for a period of time so the patient could receive a push of Benadryl. Once the patient was ok, we re-started the treatment which continued for another 1.5 hours. Do we bill the chemo treatment as an initial and then sequential infusion?

Signed: Confused in Clarksburg

Answer: Dear Confused,
No. This would be handled the same as you do for hydration before and after a cisplatin treatment, you would combine the infusion times and bill for one infusion. In this case you would bill for a 3 hour infusion, 96413 and 96415 x 2.

Question: We are an infusion center for Tysabri for MS and per the protocol, we are to hold the patient 1 hour after treatment and give them fluids, can we bill for them?

Signed: Perplexed in Parkersburg

Answer: Dear Perplexed,
If the fluids were "medically necessary" and documented as such, then it would be appropriate to bill for the hydration therapy. If you gave fluids

because the patient was there and needed to be observed for the hour, and/or you needed to keep a line open in case they have a reaction, then no, it would not be appropriate to bill for the hydration therapy.

Question:

When we bill for chemotherapy we also bill the saline or D5W using the J-codes (J7050, etc). I recently heard that we cannot do this, is this true? Where do I find this information?

Signed: Wondering in Wheeling

Answer:

Dear Wondering:

This is true according to the AMA CPT guidelines. If you look in your CPT book, in the administration section (page 437), at the bottom of the first paragraph, it states: "The fluid used to administer the drug(s) is considered incidental hydration and is not separately reportable." Therefore, if you are using either type of fluid to mix the drug (ie: 250 cc bag of saline), you cannot separately bill for the bag of fluid.

REIMBURSEMENT QUESTIONS?

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WVOS Newsletter Disclaimer

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

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