

January 2010

A PUBLICATION OF THE WASHINGTON STATE MEDICAL ONCOLOGY SOCIETY

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**President's Update**

*Change, It Is A Comin'*

I am writing this letter from seat 7D on Alaska flight 3, returning from an ASCO Clinical Practice Committee (CPC) Meeting. I am actually rewriting my president's message, you can see the first one somewhere else in this newsletter.



*Jeffery Ward, MD*

I must admit that I have stolen this title, not once but twice. Once from Bob Dylan and once from Michael Neuss, ASCO's CPC chair. However, the sentiments that follow are mine alone. I have served on the CPC for 15 months now. From day one I have voiced an observation that MMA was not just something we have had to adjust for, but that it is fundamentally changing the oncology landscape in Washington State.

My reward for this observation is the opportunity to chair an ASCO education session on the implications of the financial challenges facing oncology under MMA and continuing healthcare reform. In particular I have been tasked to speak to the exodus we are seeing in Washington State oncologists from freestanding to hospital based cancer centers. Some of you have heard from me as I seek to better understand its underpinnings. Soon, all of you will receive a request to participate in a short computerized survey addressing this as well.

So I am taking this opportunity to unabashedly encourage your participation and your attendance. But actually that wasn't the impetus for rewriting this message. There was an explicit theme at ASCO headquarters this week, not something that is always evident at CPC meetings. That theme is change.

Oncology, and healthcare in general, is consolidating. The reasons are myriad. They include politics, mirrored consolidation in the insurance industry, workforce issues, generational attitude shifts, gender differences, economies of scale, and a quest for security and stability. In Massachusetts the State Attorney General has prohibited Harvard's Physician Group from acquiring more practices. Something to do with having the Blues over the barrel I understand. In California, once robust, solo practices and small groups are closing their doors. It is postulated by those following current trends in bellwether states, like those and ours, that groups smaller than 15 physicians will not survive the changes that will eventually come from healthcare reform.

If the number of new, or nearly new acronyms I heard this weekend is an indication, the change will be immense. There is VPB (value based

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Corporate Members

WSMOS is appreciative of the following Corporate Members for their continued support of our society and our mission to provide advocacy for cancer patients and to promote standards of excellence for high-quality cancer care:

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**Corporate Membership**

WSMOS now offers Corporate Membership opportunities for those industry professionals working in the field of oncology. With the support of our corporate sponsors, WSMOS will continue to be the leading professional organization for oncologists in the state of Washington and a resource for the oncology community through professional education, and information dissemination.

A Corporate Membership application and information is available on the WSMOS website at [www.WSMOS.org](http://www.WSMOS.org) on the Membership page, or for more information contact Liz at: 360.258.0443

purchasing), CER (comparative effectiveness research, ACO (Accountable Care Organizations), PAF (patient assistance foundation), MBS (market based solutions), IMAB (independent medicare advisory board, kind of like a MedPAC on steroids), FOB (follow on biologic), HIT (health information technology), AHRQ (Agency for Healthcare Research and Quality), and my favorite, MSE (medical subject expert, you know like ASCO, ASH, and ACCC)

But I am not rewriting this in order to write a depressing message. I think I did that the first time. I was energized the last two days. Oncology will never be what it was 10 years ago. If those were the golden years, they are gone. But where there is change there is opportunity. We can resist change or we can accept it. If resistance is our path, it will happen to us. If we accept it, we can shape it. Just as one example, if you are one of our state's practices joining a hospital based system, they need you. Not just your oncologic expertise, but also your business expertise. With rare exceptions, your understanding of what it takes to efficiently run outpatient cancer care will not be in the tool kit of the hospital administrator used to running hospital inpatient departments.

The future is one in which oncology will exist in either independent cancer centers comprised of radiologists, pathologists, and radiation, gynecologic, neurologic, and urologic (did I miss anybody?) partnering with medical oncologists in market share dominant and regionalized business savvy mega-groups, or large vertically oriented regional multi-hospital healthcare providers with the vision to build with physicians. Anything less will fail. If the historical lay of the land and recent events in our state are any indication, we are well on our way to the latter model.

Finally, if we listen to a younger generation of doctors, one that will be more than 50% female and values security, lifestyle, healthcare quality more than entrepreneurship and salary, and independence, we can help shape healthcare in a way that will serve us when we are the patients. But first we must hark back to the beginnings of our generation and remember back to when we were young, change was a comin' and we were excited about it. Then we need to embrace it.

**Jeffery Ward MD**  
President, WSMOS

*Register Now!*

**WSMOS Spring Membership Meeting & Cocktail Networking Reception**

*March 12, 2010*

Meeting 8:00 AM – 4:00 PM

Reception 4:00PM-6:00PM

**Diamond Member Awards**

*See pages  
8 and 9.*

Cedarbrook Conference Center & Lodge  
18525 36<sup>th</sup> Avenue South  
SeaTac, WA 98188

WSMOS is dedicated to providing outstanding educational programs for our members and our Spring Membership Meeting is no exception. Nationally recognized experts will provide answers to some of today's most critical and pressing business issues in oncology. Sessions will include a national update on the health of oncology, understanding and preparing for Medicare's Recovery Audit Contractors (RACs), physician documentation of E/M services, the business model of hospital based cancer centers including case-studies of physician-hospital affiliations and financial counselors in the oncology clinic.

**Questions? -Please contact Liz Cleland  
at 360-258-0443 or via [email](mailto:liz@wsmos.org).**

## ASCO State Affiliate Grants

*Jonathan C. Britell, M.D.*

Most oncologists in clinical practice possess a limited knowledge of the structure and function of the American Society of Clinical Oncology (ASCO). Other than the Annual Meeting, clinicians have had minimal exposure to ASCO. The Clinical Practice Committee (CPC) was created by the ASCO Board to provide a 2-way conduit of information concerning legislative, business and scientific issues which impact the vast majority of American oncologists. The CPC is composed of the Presidents of all the State medical oncology societies as well as ASCO Board members and physicians appointed by the Chairman of the CPC. The State Affiliate Working Group subcommittee of the CPC was created by the CPC to focus on the activities of all the State Affiliate Societies.

In 2006, the ASCO Board of Directors approved funding for the State Affiliate Working Group to offer grants of up to \$10,000 to State Societies. This competitive grant system was created to foster innovative programs at the State level to enhance the scope of State Societies and allow them to further their mission. The only restrictions on grant applications were that they not be to fund ongoing Society operations or any commercial operation.

Successful grant applications have covered a wide array of State functions. Since its inception four years ago, the Grant program has awarded almost 30 grants. Several awardees used their grants to hold statewide meetings when the State societies were endeavoring to broaden their base membership. Florida used 2 grants to create a statewide research program. With the anticipated awarding of Medicare Administrative Contractors (MAC) jurisdictions, several societies were able to fund meetings of all the member states in the new MAC to facilitate an understanding of this new entity and to create familiarity between these member societies and discover areas of common interest. Massachusetts (MSCO) and the consortium of Maine, New Hampshire and Vermont (NNECOS) developed programs to allow medical oncology fellows to present original research at their meetings. The Medical Oncology Association of Southern California (MOASC) created a form (to be given to patients) which described their treatment to facilitate care in a medical emergency such as Hurricane Katrina or an earthquake. These are just a few of the successful grant awards. Hawaii was awarded a grant to create appropriate medical information pamphlets in Tagalog to reach out to their largest minority group.

WSMOS has been awarded three grants in 4 years. In 2005, the WSMOS grant allowed us to reach out to our colleagues in Alaska who were not represented by anyone at the CPC level. Through our efforts, the Denali Oncology Group was transformed from an informally structured group which previously only held an annual summer educational forum into a fully functioning legal entity which became a fully accredited State Affiliate Society.

In 2006, in light of what was felt to be the imminent awarding of MAC Jurisdiction 2, WSMOS used a grant to hold a joint meeting at Salishan with the Oregon State Medical Oncology Society (OSMOS), the Idaho State Society and the Denali Oncology Group. Due to multiple appeals, our MAC has yet to be awarded. However, the initial meeting has provided the groundwork to allow these 4 State Societies to communicate more readily when we finally know who our Medicare carrier will be.

In 2008, the WSMOS grant sought to survey practices within the state regarding their employment of medical personnel with special attention being given to the roles of Advanced Nurse Practitioners (ANPs) and Physician Assistants (PAs). We also endeavored to create a directory of practices' experience in training personnel from medical assistants up to ANPs and PAs.

A parallel survey was made of teaching institutions within the State. The goal of the educational component of these two surveys was to create a cross-linked directory to enhance communication between practices and teaching institutions in order to attract more personnel to the field of medical oncology. The results of these surveys can be found on the WSMOS website. As this is an ongoing process which requires updating to reflect practices current needs, we encourage practices to participate in this survey again. In addition to the results posted on our website, this data is to be published in the near future in the Journal of Oncology Practice.

## WSMOS New Physician Members

*Welcome!*

Hosne Begum, MD  
 Andrew Coveler, MD  
 W. Welby Cox, MD  
 Sheldon Goldberg, MD  
 Kathryn F. McGonigle, MD  
 Howard Muntz, MD

## Another President's Report

### *We Have Met the Enemy*

As oncologists we rely on the resiliency of our patients. We anticipate bone marrow recovery in the chemotherapy regimens we give. We rely on an emotional resilience to carry them through the ups and downs of grief and hope that comes with a so consciously terminal disease. And we learn from our patients. We too are a pretty resilient lot... unfortunately that has become a problem of sorts.

Healthcare reform came early to oncology's neck of the healthcare woods. It has only been 6 years since MMA (Medicare Modernization Act) was enacted, but it seems like we have been buffeted endlessly by wave after wave of declining reimbursement. It has eroded our confidence and our bottom line. We have had to face the fragility of our existence and we hope for miracles. But like our patients, we have learned to cope with and adapt to a new reality.

This resilience is both our saving grace and our Achilles heel. Our saving grace because we are still here, most of us in the same communities we started in, quietly and efficiently providing care to our patients. Our Achilles heel because that is exactly what Congress, CMS, insurers, hospital administrators and the pharmaceutical industry expect us to do. Whether we are preconditioned by the diseases we treat to accept our fate as inevitable or we truly are so busy saving our patients to save ourselves matters not, "we have met the enemy and he is us."

Walt Kelly first coined his famous parody of Commodore Perry's "We have met the enemy and he is us" in an attack on McCarthyism. His creation, Pogo, later used it in an Earth Day cartoon that made it famous.



Pogo would remind oncologists that though there is plenty of reason to view the aforementioned Gang of five as the enemy, we are enablers, and the enemy is us.

The enemy is us when we are less than transparent about a broken healthcare system, obscene costs, and perverse incentives built into a reimbursement scheme that we did not create. Our patients and our colleagues need to implicitly appreciate that we will make decisions and recommendations that are scientifically and ethically sound in spite of the system. We do not need to apologize for it, nor defend it. We do need to acknowledge it.

The enemy is us when we fail to engage in the political process. There is no way we can match the pharma or insurance lobby in D.C., and we don't provide local jobs in the numbers hospitals do, but we do have credibility. We have credibility with our patients (who vote) and with our elected representatives. And we cannot assume that ASCO, ACCC or COA carry the same credibility. It wasn't long ago that when one of our Senators was approached by a national organization about an issue of great importance, the response was that until the Senator heard from oncologists in Washington State, it was not important enough. Just putting our elected representatives' websites in our favorites, and opening and heeding the emails from our national organizations to contact our friends in Congress would go a long ways towards being heard.

And the enemy is us when we allow the buffetings from without to divide us within. It is an unfortunate reality that "oncologist" is often preceded by academic, multispecialty group, community, solo, or hospital, but it is our fault that we let it divide us.

The enemy that is us is apathy, discouragement and despair. Walt Kelly also said, "Traces of nobility, gentleness and courage persist in all people, do what we will to stamp out the trend." When we think of those patients we have most admired they are those who, live or die, overcame their cancer. If we will cast off apathy and discouragement, recognize the nobility of the work that we do, continue to be gentle with our patients, and muster the courage to insist on being heard, being a healthcare reform player instead of a bystander, we will overcome the enemy. If we don't, we will defeat ourselves.

WSMOS wants to facilitate the players. If you are not a member join us. If you are, support us with your involvement. It is time to do more than just soldier on. We need you. If we are not meeting your needs, tell us what they are. It is our goal to give voice to your concerns and goals. Come to the Spring Meeting in March. Make the enemy ours.

## CAC Report

**Health Care Reform:** At the time of this writing, healthcare reform is too fluid and incomplete to spend time on in a newsletter. Suffice it to say that “it will happen.” It will change the way we do business. You can try to ride the wave or you can get drowned by it. Stay tuned to ASCO, COA, and ACCC reports. If you read all three you will get some sense as to what is happening and what it all means.

**Physician Fee Schedule 2010:** This, on the other hand is something to sink your teeth into. Bottom line, reimbursement for oncology is estimated to drop, on average, 1%, and it could have been much worse.

**SGR**, that 21.2% cut projected by a faulty sustainable growth rate formula imposed by Congress as part of the Balanced Budget Act of 1997 has been patched through February. The House had the guts to pass a bill that would nix it and fix it. The Senate didn't and won't for the foreseeable future. Of historical side note, the Balanced Budget Act went into cloture with both Senate and House versions of the bill with a formula that was SGR + 1-2% and somehow the leadership came out with a bill that was SGR + 0%. Meaning that no one ever really thought that SGR was a reasonable target to begin with, and that Republicans and Blue Dog Democrats who now insist that every doctor needs to write a \$100,000 check to the government for ill-gotten gains are being more than a bit disingenuous. Nevertheless, expect another patch and a growing SGR deficit that Congress will continue to put on the books as if they were going to collect it.

**Consult Codes** are history as far as Medicare is concerned. If you haven't followed the tit for tat between CMS and OIG for the last few years, it goes something like this: The definition of a consult per Medicare guidelines has never mirrored physician understanding. Medicare and its contractors ignored this fact for the longest time. However the OIG, that is Office of Inspector General, decided a few years ago that Medicare was paying at the higher rate of a consult fee for all kind of new patient visits and began to ride Medicare about it. They may have chosen to ignore it, but with the RAC (Recovery Audit Contractors) now entering the arena, it was time to fix it. The simple solution, get rid of consults altogether. This creates a windfall of savings that by all rights should have been put into new patient visits. But the administration is eager to find ways to buoy primary care and the only way to do it is to take from the specialists, so the savings have been spread across all E&M fees. If your patient load is heavy in consults, this

translates into real money. If you are not tuned into this and have been continuing to bill Medicare consultation codes, they will be denied and you will have to rebill as new patients. For the moment, commercial insurers still pay for consult codes.

Nowhere was the desire of the administration to divert fees from specialists to primary care more overt than in CMS original proposal to rebalance **Practice Expense Relative Value Units**. The AMA did a 2009 survey for CMS to update practice expense. However, by statute, CMS is required to use the Gallup data paid for by ASCO in 2002. Thus the AMA data on oncology was half-baked, incomplete, and statistically unsound, suggesting that our practice expense has actually decreased significantly over the last eight years. Cardiology was in a similarly implausible circumstance. CMS liked what they saw in the AMA data however and attempted to use it to slash cardiology and oncology RVUs while increasing it for other specialties and primary care.

The result would have been a 6% hit on physician and admin fees. CMS ultimately agreed to take the Gallup data and update it by a medical expense inflation calculation, however the AMA survey still resulted in dramatic increases in some specialty and primary care expenses, a result that ASCO also believes is flawed, and it only improved the hit to 4%. CMS further softened this blow by staging it in over 4 years, 1% in 2010. Cardiology, for their part has chosen to sue CMS. Dismissed on their first foray before a judge, they may choose to appeal. ASCO, true to form, has chosen to forego this, “burn your bridges” approach. It is hoped that CMS or Congress can reach an accommodation to repeat the Gallup Survey; a move that it is anticipated would at least stop further RVU cuts.

CMS also decreased **Malpractice RVUs** for oncology. Their awkwardly contrived assumption is that since you are not physically doing the work in the treatment room, there is no liability either. In the final rule it was a smaller decrease than the initial proposal and it is not a lot of money, but it all adds up.

If all the percentages have your head wondering how it adds up to only a 1% decrease on revenues, remember that if you are a private clinic based oncologist you have three revenue streams, physician E&M, chemo admin fees, and drug revenue. This year, we took multiple hits on the first two, but drug revenue was unchanged.

**Competitive Acquisition Program (CAP):** No MMA's, poorly conceived specialty pharmacy isn't back, not yet. However it isn't dead. CMS tweaked the rules a bit and

could choose to rebid it and start up any time they choose. Word on the street is that in some parts of the country, small practices with cash flow problems have started brown-bagging drugs that are underwater. A resurrected CAP may not be far behind.

### **Hospital Outpatient Prospective Payment System**

**(HOPPS):** It is increasingly clear that what happens in the hospital impacts an ever increasing number of oncologists. An ever-enlarging number of us now practice in this setting and regardless of the compensation formula used to calculate their paychecks, ultimately the profitability of a hospital's cancer program will impact oncologists' salaries. Further, many private practices are relying on hospital infusion centers for uninsured and underinsured patients, such as Medicare patients without supplements and Medicaid. This will only work as long as hospitals are adequately paid. This is not the forum to explain the nuances of hospital outpatient reimbursement. One of the offerings at this year's Spring Meeting will be a primer on this subject. If the following is a foreign language to you please attend. You will be glad you did.

When Medicare changed hospital outpatient reimbursement to a DRG like system called Ambulatory Payment Classifications (APCs) a number of years ago, they tried to bundle chemotherapy into set tiered payments. It didn't work. The fall back has been to pay for chemotherapy and biologics above \$65 at ASP + 4%. Expensive supportive care, including 5-HT3 inhibitors were paid at ASP + 4% as well. ASCO has contended from the get go that CMS has miscalculated the costs of hospital pharmacy overhead and that the true value should match the ASP + 6%. There really is no excuse for the differential except that it is a thinly veiled reduction in hospital payments on the assumption that they get better drug prices and can absorb an inadequate payment for pharmacy overhead.

This year, with the advent of generic 5-HT3s, CMS has chosen to bundle or package the entire class back into a single payment. This may have an impact on the availability of Aloxi on some hospital formularies. On the other hand, CMS has acquiesced to ASCO's longstanding contention that therapeutic radiopharmaceuticals should be moved from packaged drugs to ASP + 4%, correcting a longstanding error that resulted solely from Zevalin and Bexxar sticker shock nearly a decade ago. Unfortunately diagnostic radiopharmaceuticals, a drug category with a wide range of costs, continues to be packaged.

**PQRI:** If you haven't ever tried it, or if you tried and gave up, it may be time to take another look. Sooner or later

this will be a play or pay program, before that happens it will need to be easier to be a successful participant. To that end, there are more oncology measurements, 13 of them, and they are more meaningful. Eventually ASCO would love to get QOPI certification to substitute for PQRI, but it won't happen anytime soon.

**Off Label and Compendia:** Two issues of which to be aware. First is self-evident to any of you that have tried to access the compendia. There are four of them and they are all proprietary and prohibitively expensive. Further, since it is off-label, the pharmaceutical industry can only share them with you if you expressly ask by both drug and indication. There are work arounds to get to NCCN for many of us, but the other three are inaccessible. Most of us have been using only NCCN. This will at times, however, limit our patient's options for treatment.

The second issue is embedded in the first. The statute reads, "*Off-label, medically accepted indications are supported in either one or more of the compendia or in peer-reviewed medical literature. The contractor may maintain its own subscriptions to the listed compendia or peer-reviewed publications to determine the medically accepted indication of drugs or biologicals 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.*" Then it further reads: "*If a use is identified as not indicated by the Centers for Medicare and Medicaid Services (CMS) or the FDA, or if a use is specifically identified as not indicated in one or more of the compendia listed, or if the contractor determines, based on peer reviewed medical literature, that a particular use of a drug is not safe and effective, the off-label usage is not supported and, therefore, the drug is not covered*" The salient facts are underlined. In summation, a Medicare Contractor is not required to have the compendia, may require you to submit it, and if a drug is identified as not indicated in any one compendia, it is off limits.

Trailblazer has revised its LCD on off label use. Initially they required billing for off-label use to include copies of all four compendia. Now they are only strongly encouraging it, but the threat is that if you haven't seen and read all four of them you may be at risk of a denial. It is expected that other contractors will, to one degree or another, follow suit, and since they have developed a penchant for revising LCDs instead of redoing them, it may not require CAC input.

ACCC has been working for some time now on resurrecting something akin to the Drug Bulletin we used to use to navigate the compendia. It is anticipated that as early as second quarter it could have navigated all the legal hurdles necessary and be made available. However, it will come with an instruction manual. There will be no thumbs up or down listing this time. It will be stage specific and drug specific. It will not be compendia specific. You will know that a drug is indicated for a particular stage of a disease in at least one of the four compendia, but not how many or which one. It will give you manufacturer information, however, from who you can, ostensibly, request specific compendia information. In other words this time the Drug Bulletin will not be a stopping point, but a starting point in accessing compendia information.

**Erythropoiesis Stimulating Agents:** Over the past year, a number of our hospital based practices have been subjected to denials of ESAs and audits of your practices that have been, at the least, overzealous. Without going into detail, regardless of whether a patient's anemia was being caused by iron, folate, or B12 deficiencies, patients receiving these supplements, oral or parenteral, were, as a matter of course, deemed ineligible for ESAs. Further, Noridian in a letter to all physicians last fall, explicitly stated that to give these supplements and not code deficiencies as a basis for administering them would be construed to be fraud.

This month Noridian revised their LCD. Again, this is not a new LCD and did not go through the CAC process. It is effective retroactively to 10/1/2009, but should certainly bolster those claims currently in the denial process from before that date. Rather than paraphrase, this is from the revised LCD, [click here](#).

*“Anemia of CRF as well as certain other anemias may respond to supplemental erythropoietin administration despite adequate erythropoietin levels. Following the establishment (e.g., correction of any iron deficiency, vitamin deficiency, occult or other blood loss, etc.) and documentation of an erythropoietin-associated anemia, supplementation with synthetic drugs with structures identical to or similar to naturally occurring erythropoietin has been accepted as safe and effective in correcting anemia in certain groups of patients...*

*For all conditions, prior to the initiation of any treatment with an ESA, the patient's iron, folate, and B-12 must be assessed with appropriate studies and the patient repleted as appropriate. Patients with hemolysis, bleeding, or bone marrow fibrosis are not candidates for treatment with ESAs.*

*Because the NCD and its associated edit exclude ESA treatment where there is a **current** anemia resulting from one of these conditions, coding any of these anemias will result in a NCD denial of reimbursement for the ESA. The ICD-9-CM codes 281.0-281.9 should not appear on a claim for a patient receiving ESA therapy when these conditions do not underlie and/or are not responsible for the **current** anemia.*

*In those patients who have a history of one of these conditions but where the condition has been corrected and no longer the cause of anemia, the following codes should be used if and when ongoing replacement therapy is required concurrently with ESA therapy.*

- *Iron deficiency due to ESA therapy alone. V58.69: Long-term (current) use of other medications may be used to describe a previous iron deficiency that developed in response to ESA therapy alone and remains corrected with ongoing iron replacement provided in addition to the ESA.*

- *Other conditions requiring long-term replacement after resolution of initial anemia. When it is necessary to administer continuing supplements (e.g. folate or B12), do **not** code this administration to an anemia diagnosis (281.0-281.9, which causes the ESA claim to deny); rather, code the underlying absorptive, bowel or other disorder or diagnosis that necessitates supplementation.”*

There is more and it requires close reading by each physician and practice. For example, *“Providers may use either hemoglobin (Hb) or hematocrit (Hct) determinations for therapeutic decision-making. To convert measured Hct to Hb, divide by 3. To convert measured Hb to corresponding Hct, multiply the Hb value by 3 and round to the nearest whole number. For example, if Hb = 8.4, Hct conversion calculation is: 8.4 X 3 = 25.2, rounded down to 25.”* The example not given is for a Hb = 9.9, where 9.9 X 3 = 29.7 and rounds up to 30. Epo will be denied in this example if the Hct is not <30.

Resources:

[Noridian Revised ESA LCD Effective 10/01/2009](#)  
[Noridian Revised ESA Coding Article Effective 10/01/2009](#)  
[Noridian ESA Article Posted 12/22/2009](#)  
[Noridian Consultation Services Article Posted 1/07/2010](#)

All in all though, it is a vast improvement, one that will get many of our practices and a Medical Director out of an impasse that has threatened the collegiality that we have been so fortunate to have in Washington State.

**WSMOS Spring Membership Meeting**

March 12, 2010

Cedarbrook Conference Center

SeaTac, WA

# Agenda

**Time**

**Session**

8:00 a.m. 9:00 a.m.

Breakfast with Exhibitors  
Cedars Room

9:00 a.m. 9:15 a.m.

**Welcome & Introductions**  
*Jeffery Ward, M.D., President*  
Summit Room

9:15 a.m. 10:15 a.m.

**Washington DC Update:  
The Health of Oncology**  
*Michael Neuss, M.D., ASCO CPC Chair*  
Summit Room

10:15 a.m. 10:30 a.m.

Break with Exhibitors

10:30 a.m. 11:30 a.m.

**Physician Documentation and RAC Update**  
*Stephen D. Rose, JD*  
*Bob Perna, FACMPE, WSMA*  
Summit Room

11:30a.m. 1:00 p.m.

**Hospital Based Cancer Centers: The Business  
Model & Case Studies**  
*Max Reiboldt, Coker Group*  
Summit Room

1:00 p.m. 2:00 p.m.

Lunch with Exhibitors  
Cedars Room

2:00 p.m. 3:00 p.m.

**Financial Counselors in the Oncology Office**  
*Elaine L. Towle, CMPE*  
Summit Room

3:00 p.m. 4:00 p.m.

**Medicare Update**  
*Bernice Hecker, M.D., Noridian*  
Summit Room

4:00 p.m. 6:00 p.m.

Networking Reception  
& Diamond Member Awards Ceremony



**WSMOS**

Washington State  
Medical Oncology Society

MEETING REGISTRATION FORM  
**Friday March 12, 2010 8:00am-4:00pm**

Cedarbrook Conference Center  
18525 36th Avenue South  
SeaTac, Washington, 98188

Be sure to include all outlined information for all attendees. **PRINT CLEARLY**

**NO REGISTRATION FEE for Physicians Members or Staff.**

***Please join us at the same location after the Membership Meeting  
From 4:00pm-6:00pm for the WSMOS Networking  
Cocktails and hors d'oeuvres Reception!***

Yes, I will attend the evening reception with \_\_\_\_\_ guests.

Name of guest for reception: \_\_\_\_\_

**Meeting Registrant Information**

Institution: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Special Dietary Needs: \_\_\_\_\_

PLEASE FAX REGISTRATION TO LIZ AT: 360.695.6937  
FOR MORE INFORMATION CONTACT LIZ @ 360.258.0443 OR [wsmos@comcast.net](mailto:wsmos@comcast.net)