

March 2011

A PUBLICATION OF THE WASHINGTON STATE MEDICAL ONCOLOGY SOCIETY

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## President's Update

Vincent J. Picozzi, Jr., MD

Colleagues and friends,

This decade will see an unprecedented transformation of how health care is delivered in the United States. Access, cost and quality all are central challenges for American medicine. Nearly 50,000,000 Americans lack adequate insurance. Health care now consumes a record percentage -17%, or fully one-sixth of our GNP-at a time that both federal and state governments face massive levels of debt. Despite our quantity of expenditure on medical care, our medical outcomes frequently are no better than those seen in other Western countries.

The challenges facing oncology are, if anything, greater than those facing medicine as a whole. Demand for oncology services, owing to both increased cancer incidence and longevity, continues to grow. At the same time, oncology manpower continues to decline- presently a 15% shortage of oncologists exists nationwide. Despite the above, reimbursement is threatened in every conceivable way. The (potential) implementation of the Affordable Care Act will force the development of new care systems, which may or may not advantage cancer patients and their providers. Our therapeutic opportunities have never been greater, but our ability to test and pay for new medications has never been more challenged. Indeed, we are unable to be assured of an adequate supply of mainstay pharmaceuticals such as leucovorin and cytosine arabinoside.

Where are the answers to these challenges? Having attended clinical practice meetings for ASCO, ASH and the ACCC in the last several months, I can tell you that our national organizations are no closer to understanding the future optimum pathway for oncology than we are. The answers to the challenges must come from within us.

At our initial meeting of the year on March 11, we are fortunate to have recognized experts on both national and state health care policy. We will also begin a systematic examination of the accounting metrics ("Oncology Economics 101") useful for oncology practice from both hospital- and community-based perspectives. This economic curriculum will continue over the next several years. As an added value to our members, we will be offering to our members access to 2 additional meetings besides our annual fall meeting (presently scheduled for Nov. 4) a meeting in conjunction with the Seattle Blood Club (May 5) and a meeting during the Best of ASCO review to be held in Seattle this year (August 5-6).

More importantly, the fundamental goal of our society over the next 2 years is to establish the relationships necessary in the state of Washington to advocate effectively for the future well-being of our patients

*Continued on page 2*

**Corporate Members****In Appreciation to Our 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:

**Diamond Members**

Amgen  
 Celgene Corporation  
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 Eisai, Inc.  
 McKesson Specialty Care Solutions  
 Merck  
 Oncology Supply/ION  
 OSI

**Silver Member**

Allos Therapeutics  
 GlaxoSmith Kline

**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

and our practices. In this regard, no relationship is more important than that which we have with each other. To this end, WSMOS will be reaching out to each and every oncologist and oncology administrator in the state so that we can accurately understand both your concerns and needs in order to help you address them. It is our goal to make every oncologist in the state a WSMOS member, and to be a knowledgeable, effective spokesperson for our state's oncology community.

**CAC Report**

*Jeffery Ward, MD*

This will be my last CAC letter. At times I would have hated to admit it, but I have enjoyed the last ten years representing WSMOS to our Medicare Contractor. I have learned a thing or two along the way, things that I might never have learned keeping my head down, gaining a perspective that has kept me going through a very turbulent period for our profession. Before I get to the mundane and frightening, forgive me for waxing nostalgic, and perhaps a bit sappy.

Being a CAC Rep is about developing friendships. We have been very fortunate to have Noridian Medical Directors, in Dick Whitten and Bernice Hecker, who very much care about doing a good job and developing open relationships with providers. Not to say we always have agreed, and sometimes our relationship has been adversarial, but I am pleased to count them as friends. As I have compared notes with CAC reps around the country it is clear that we could do much worse (I don't mean that in a back handed compliment kind of way). Believe it or not, there are also good people in the pharmaceutical industry that I count as friends, and though I appreciate the value in regulatory changes that keep them at arm's length, there is continuing value in partnering and collaborating with them to maintain access to care for our patients.

But more than anything else, I value the friendships that I have gained in the oncology community. ASCO and ASH have fostered a CAC network, bringing us together annually to compare notes, strategies, and tactics. I hope that I have conveyed to you over the years that we are not alone. ASCO and ASH really do work on our behalf. It has been an honor to be able to rub shoulders with the other CAC Reps and ASCO leadership and staff. It has given me a national perspective that sustains me when I am in my trench. Finally, I am grateful for the support and friendships that I have made within our oncology community here in Washington. In particular, I have gained an appreciation for the job that our practice administrators do.

Nevertheless, I have an opportunity to do something new that I am very excited about and that I hope will allow me to contribute in a new way as an associate editor with the Journal of Oncology Practice. I was introduced to ASCO's Clinical Practice Committee during my term as WSMOS President and will continue to serve there, but must relinquish my role with the CAC. The board will be responsible for my replacement and a CAC alternate. If you have a penchant for getting involved, or just think it is time to do your part, please let Dr. Picozzi know. Now onto the stuff you started reading this for.

**Healthcare Reform:** I doubt that the game being played out in Congress has escaped anyone and nobody really knows what will come of it. The recent elections and Republican control of the House is really just act II and act III won't be written until after the 2012 elections. If Republicans retain the House and take the Senate and/or the White House in 2012, the healthcare reforms passed a year ago will most

## New WSMOS Members

Thomas Baker, MD  
 Daniel Byrd, MD  
 John Fitzharris, MD  
 Michael Harris, MD  
 Saifuddin Kasubhai, MD  
 Matthew Lonergan, MD  
 Andrea Rose, MD  
 Hiu Wang, MD  
 Carolyn Wild, MD

Welcome!

certainly go by the wayside and we will start all over again. It is possible, I guess, that both parties could decide that any attempts at a major reform is a path of political suicide and do nothing until public opinion is overwhelmingly clamoring for it, but that seems unlikely right now. In the short term, the House will try to limit implementation of reforms by refusing to fund them. Their biggest targets are likely to be the IPAC and CMI (see below).

**CMS and CMI:** In the meantime, CMS has a new acronym for us. The CMI (Center for Medicare and Medicaid Innovation), unless their funding is stripped, will press forward in examining alternative reimbursement schemes. Unfortunately, the Republicans seem much more willing, as seen with MMA, to treat healthcare reform with unproven therapies. Accountable Care Organizations (ACO) remains the most popular said beast. ACOs are, as best can be ascertained, HMOs in sheep's clothing and the financial risks inherent in bundled payments (formerly called capitation) will require large organizations with lots of lives. At least 5000 lives will be required and that will most certainly be insufficient. By that measure alone, it is clear that in our neighborhood most ACOs will be hospital based organizations. You can reach your own conclusions about what it means to the dwindling number of oncologists in our state that remain independent.

ACOs are not the only game in town. Look for an article coming to a journal near you in the month of March by Peter Bach of Memorial Sloan Kettering. He makes a case for episodic bundled payments in outpatient oncology as a vehicle to pay oncologists fairly and drive down the cost of high priced pharmaceuticals and

radiation therapy modalities at the same time, noting that the NCCN guidelines have six or seven first line therapies with a six times cost differential. And that is nothing compared to prostate cancer therapies.

**SGR:** Everybody is giving lip service to fixing SGR for good. But no rubber has hit the road and is unlikely to do so. The Republican fix would be to dismantle healthcare reform and use the money budgeted for it to fix SGR. Then they pretend it is budget neutral. Since that fix would be vetoed anyway, expect another last minute reprieve at the end of the year that is likely to take us to sometime past the 2012 elections.

**ASP and Prompt Pay Discounts:** I don't believe we appreciate how close we got to removing prompt pay discounts from ASP last year. Everybody gets it and ASCO, COA, and USON continue to press for it. It just needs the proper legislative vehicle. CAC reps and CPC members from Southern California, where most oncologists are in solo practice or very small groups of 2 or 3, tell me that many practices are in arrears to drug suppliers, and that some have turned to "white bagging" where they have developed a relationship with a particular pharmacy and write prescriptions for chemotherapy that patients pick up and bring into the clinic where it is infused when the supplier will no longer float them a line of credit.

**Medically Unlikely Edits:** MUEs are units of billing that are considered most likely to be error or fraud. An example would be a billing of more than two episodes of radiation therapy on a given day or three orchiectomies in a given patient. Recently, Medicare Central (not Noridian) decided to begin developing MUEs for the drugs we use. ASCO has protested that MUEs on cancer drugs is administratively impractical and a barrier to access to care, but it is clear that Medicare plans to continue this effort for the time being.

We recently began hearing reports of odd denials of Faslodex, 5FU, and Procrit. As soon as societies heard from their membership, ASCO heard from CAC reps, and shortly ASCO staff and CPC chair met with CMS. MUE limits are secret, but it was clear that the MUE for Faslodex was set at 250 mg and then the FDA changed the label. CMS notified ASCO that an appropriate change in the MUE will be made on April 1 and initially suggested that all billings and/or appeals for it wait until then. With pushback, they agreed that providers may submit their claims prior to April 1 by reporting 10 units of J9395 on each of two lines of a

*Continued...*

claim, utilizing modifier 59 with the code on one claim line, and be paid for the 500 mg dose of Faslodex.

5FU was a little more difficult to figure out. As best we can ascertain, the MUE was set somewhere around 1000 mg. This was based on the package insert label for IVP 5FU and gave no allowance for CIV therapy that may be billed as much as a week at a time. CMS has admitted their error in this regard as well, and it too will be corrected on April 1. Claims for fluorouracil may be held until April 1 or may be submitted using the -59 modifier. It is important to note that if claims are submitted using the -59 modifier, documentation should be submitted that supports the dose.

I surmise, based on the denials that I have seen, that the MUE for Procrit is anything above 40,000 units, but Medicare will not release the MUE in belief that it invites fraud. Where it creates a problem is in MDS patients who may respond to significantly higher levels. At this time, you will need to expect a denial in these patients. Be prepared to support your appeal vigorously and follow the LCD for MDS to the letter if you expect success.

**Critical Drug Shortages:** As I suspect many are aware, we are currently experiencing a severe shortage of cytarabine arabinoside. Last spring it was L-asparaginase. We have had on and off issues with Leucovorin availability for nearly a year. The considered rationales for this have been ingredient shortages, manufacturing limitations, low profits and incentives to get into the market, aggressive FDA activities that shut down factories and exacerbate shortages, and hoarding of drugs in short supply. Most of the shortages we have dealt with have been interruptions in raw materials.

ASCO and other impacted providers called a summit in November and met with representatives from the FDA and other regulatory agencies, pharmaceutical manufacturers, and supply chain entities to explore the issue. 21 recommendations were made to include expanding FDA authority to require manufacturer notification of shortages and market withdrawals, tax credits to manufacturers who produce critical drug products in exchange for a guarantee of continued production, require manufacturers to report to the FDA when they are dependent on an single ingredient or manufacturing source, and to establish a modified or reduced user fee program and an expedited approval pathway for drugs deemed to be critical therapies. ASCO has since worked with Senators Amy Klobuchar (D-Minnesota) and Bob Casey (D-Pennsylvania) who have submitted legislation incorporating many of these ideas. As always, it will be looking for a vehicle to get to the floor, and no one knows what the Republican

# Save the Date!

## WSMOS Fall Membership Meeting

November 4, 2011

8:00 am - 4:00 pm

## Cedarbrook Conference Center & Lodge

18525 36<sup>th</sup> Avenue South

SeaTac, WA 98188

## Meeting Agenda Soon!

Questions? -Please contact Liz Cleland at 360-258-0443, via [email](#) or check out or [website](#).

controlled House will choose to do with bills that come from the Democratic controlled Senate.

**ASCO Clinical Guidelines and Tools:** Buried a couple of not so intuitive pages into ASCO's busy website is a page worth highlighted at the recent ASCO CPC meeting and worth bringing to your attention. Check out the [Clinical Tools](#). They are a well done set of bedside (kind of an antiquated term, but you know what I mean) education tools certain to improve the detail and efficiency of informing and assisting your patients in decision-making. My favorite is the Adjuvant Endocrine Therapy for Hormone Receptor Positive Breast Cancer Decision Aid Tool shown [HERE](#).

**PQRI and EHR incentive bonuses:** PQRI is now PQRS (substitute system for initiative). For 2011, 1% bonuses are still being paid for participation in these quasi-P4P programs. Soon they will morph into penalties if you don't play. PQRS continues to be tweaked to try and entice/allow more oncology participation/success. If you haven't played before, or just not recently, you might wish to take a second look.

**MD Signatures and Lab Requisitions:** Somebody not thinking too straight at CMS developed a policy to require that a doc's signature be on every paper requisition for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule. CMS finalized

it last November and it went into effect in January. If you don't believe me, check it out [HERE](#). This doesn't mean that you identify a signed order somewhere in the chart, it really means on the requisition form. Yes, this is ridiculous. Yes, it makes no sense. But when did CMS ever make sense. The bottom line is that they are convinced that there are numbers of docs who have automatic labs that are ordered with each patient visit with no forethought. They want you to think about what you order. That makes sense, but this rule does not. There is an out. This does not apply to electronic requisitions. If you are thinking of ignoring this rule, think RAC first.

**Incident To Rules:** It has been a year or so since CMS decided that a physician must provide direct supervision of procedures, to include chemo administration, in hospital and hospital owned outpatient facilities. Freestanding clinics have dealt with this for some time. CMS has modified the definition to be applied to all outpatient incident to procedures, regardless of the setting. For now, "direct supervision means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be present in the room when the procedure is performed."

"Immediately available" is no longer defined by specified physical boundaries, but this is not intended to be a relaxing of the requirement. It remains the intent of CMS that the supervisory practitioner be physically present and interruptible and leaves the burden of proof on the hospitals, clinics, and physicians to be accountable to each individual circumstance of incident to services in an outpatient setting. Dr. Hecker described it as something akin to the availability of a code team. Ultimately, CMS plans to establish an independent review process to assess appropriate supervision levels for specific services. Watch out!

**My Swan Song, Not:** My kids will remind me how far I am from keeping up with the street vernacular. Nobody says 'not' like that anymore, I guess. Never the less, though this is my last CAC letter, I promise not to go away.

**See you soon at the WSMOS Spring Meeting.**

## UnitedHealthcare Changes Report Submission Requirements for Erbitux & Vectibix

On Friday March 4, WSMOS received the following letter from Dr. Lee Newcomer, Senior Vice President, UnitedHealthcare:

Dear State Societies:

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

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

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

### Other entities

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

If you have any questions or comments, please contact us at [unitedoncology@uhc.com](mailto:unitedoncology@uhc.com).

Sincerely,

*Lee Newcomer, MD*

The WSMOS *Update* newsletter is distributed in electronic format only. To receive your newsletter VIA email, please send a message to [WSMOS@comcast.net](mailto:WSMOS@comcast.net)

You can also view current and back issues of this newsletter on the WSMOS web site at [www.WSMOS.org](http://www.WSMOS.org)

WSMOS

# Top 10 Reasons to Come to WSMOS Spring 2011

Jeffery Ward, MD

**#10:** Enjoy Cedarbrook Lodge, winner of the TripAdvisor Traveler Choice Awards #1 Hotel in the entire United States and #17 in the world. And you can afford to stay overnight if you like since it is also #2 in Bargain Hotels. Enjoy the free parking, a great restaurant, and complimentary Haagen Dazs and Malted Milk Balls in the lounge.

**#9:** Everybody who is anybody can measure it and quantify it. Hospital's and private practice groups are missing out if they don't survey it and benchmark it. You can bet that if you aren't monitoring it and assessing it, your competitor is. You may be ahead of the game if you have appraised, analyzed, broken it down, and dissected it. But none of it means diddly-squat if you haven't thereby improved it. Come listen to Teri Guidi, CEO and President of Oncology Management Consulting Group share the secrets of Financial Performance.

**#8:** Get the Big Picture from Dr. Hecker. Drug companies, hospitals, and insurance companies, along with some still wet behind the ears aides wrote the thing. Congress passed the thing. The Republicans are trying to undo the thing, and Obama is defending the thing. You and I are paying for the thing. But when all the dust settles it is CMS that will figure out Health Care Reform and write the rules for the Noridians of our world to implement. So get the real deal from Bernice.

**#7:** Ever wonder why film critics always love those thought provoking films with depressing endings? Well it is two thumbs up for the performance of Jonathan Seib, Executive Policy Advisor to Governor Gregoire. Healthcare reform is coming to a theatre near you and Mr. Seib is going to give us a sneak preview on what is coming our way from Olympia. We will bring popcorn, but this premiere is BYOK (bring your own Kleenex).

**#6:** That thorn in your side may only be a small percentage of the patients you see, but boy does it love to fester and sting. Remember all those patients that will now be covered under healthcare reform? They will double the Medicaid roles. That festering wound may be on its way to cellulitis and sepsis. That is why we are giving Dr. Jeffrey Thompson, DSHS Medical Director, a podium of his very own this meeting. Sure to be opinionated and probably provocative, Dr. Thompson has a way of debriding the wound without anesthetic. Please be kind.

**#5:** If you've forgotten that the real target of healthcare reform was private payers, you can bet that they haven't. Join Alicia Scalzo, Kibble and Prentice's in-house benefits counsel, in reminding us that it isn't the government payers that keep our doors open. Will reforms close the door or open it wider? Alicia knows.

**#4:** After all that, we will all need to get up and take a 7th inning stretch. Recognizing that, the WSMOS board considered a number of stress relievers. We considered a session on meditation and yoga. Maybe strive for a therapeutic release through art therapy or a poetry reading, "chemo haiku." Then Dr. Picozzi hit on the perfect idea. If we needed a stretch, what better than some time on a RAC. Once it was a medieval torture device, but now it is just what we need to help us refocus at the end of a long day. So join us for a mock RAC audit led by the ever entertaining David Glaser, JD, who when he isn't a regular feature at WSMOS meetings, defends physicians who get sideways of the RAC.

**#3:** Let me quote my 18 year old in a rare introspective moment, before he heads off into the world on his parent's dime. "Maybe it's because I'm a kid and haven't gotten to the level where I actually enjoy work, an idea that seems completely somewhat foreign to me, but I certainly know the value of taking time off from our busy lives. And I don't just mean going and hanging out with my friends." Of course, we aren't kids and we all enjoy our work..., true? True. However, we still need some time to catch up with old friends and make some new ones too. WSMOS meeting attendance has been at an all-time high. Come hang out with us.

**#2:** WSMOS is poised to become the advocate that oncology practices and patients really need. Financially we have never been stronger. We have expanded our board with the addition of young, motivated, and energetic leaders. We are getting notice locally and nationally for the strong work that we do, but there is much more we can do. Don't just hang with us. "United we hang" brings a depressing visual. Stand with us and help us be a society that makes a difference for its membership.

**#1:** Dr. Picozzi, our new WSMOS President is in charge. This guarantees a much more relaxing and enjoyable meeting for at least one of us.

## **Register Now!**

WSMOS Spring Meeting March 11, 2011  
Cedarbrook Convention Center Seattle, WA

[www.wsmos.org](http://www.wsmos.org) is up and running! Check out the events page to register online and view the agenda for the meeting. Alternatively, complete the attached registration form and fax or email the complete form to [wsmos@comcast.net](mailto:wsmos@comcast.net) or 360.326.1733

If you are not currently a WSMOS member but are interested in attending a meeting, we would be happy to let you come check it out for free. Please contact [me](#) for details.

**WSMOS Spring Membership Meeting**

March 11, 2011

Cedarbrook Conference Center

SeaTac, WA

# Agenda

- |                |  |
|----------------|--|
| 8:00-8:45 am   | <b>Breakfast with Exhibitors</b>   |
| 8:45-9:00 am   | <b>Welcome &amp; Introductions</b><br>Vince Picozzi, M.D., MMM, President WSMOS  |
| 9:00-10:00 am  | <b>National Legislative Update</b><br>Alicia Scalzo-Wilmoth, J.D., Benefits Counsel, Kibble & Prentice                                   |
| 10:00-11:00 am | <b>Medicare Update</b><br>Bernice Hecker, M.D., Noridian   |
| 11:00-11:30 am | <b>Break with Exhibitors</b>   |
| 11:30-12:30 pm | <b>Oncology Economics 101</b><br>Teri Guidi, CEO Oncology Management Consulting Group  |
| 12:30-1:30 pm  | <b>State Legislative Update</b><br>Jonathan Seib, J.D., MPA, Executive Policy Advisor<br>Health Care Reform, Office of Governor Gregoire |
| 1:30pm-2:30 pm | <b>Lunch with Exhibitors</b>   |
| 2:30-3:30 pm   | <b>DSHS Update</b><br>Jeffery Thompson, M.D., MPA, Chief Medical Officer   |
| 3:30-4:30 pm   | <b>Mock RAC Audit</b><br>David Glaser, J.D., Health Care Fraud & Compliance<br>Fredrikson & Byron  |
| 4:30-6:00 pm   | <b>Networking Cocktail Reception</b><br>Recognition of Diamond Members   |



*Spring Membership Meeting*  
**March 11, 2011**

Cedarbrook Convention Center  
18525 36th Avenue South  
Seattle, WA 98188-4967

Please join us at the same location after the Membership Meeting  
From 4:30pm-6:00pm for the WSMOS Networking  
Cocktails and hors d'oeuvres Reception!

Yes, I will attend the evening reception.

Meeting Registrant Information

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

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

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

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

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

Email or fax the completed registration form to [wsmos@comcast.net](mailto:wsmos@comcast.net) or 360.326.1733