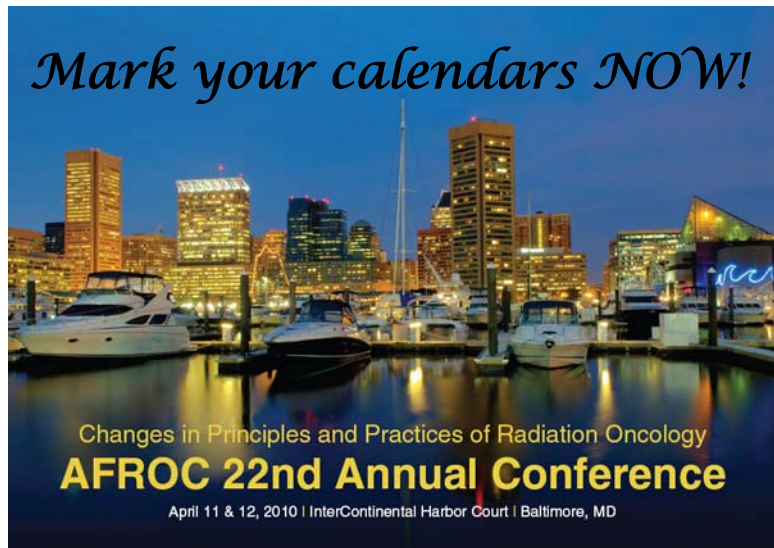


*January/February 2010*

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Visit the website for full conference details as well as Exhibit and Sponsorship opportunities. See the registration page on Page 6 of this newsletter. *Look forward to seeing you in Baltimore!!*

**2010 DUES**

Second notice for 2010 AFROC dues were mailed in mid-January. To assure that your name will remain on our mailing list, please let us hear from you.

It is estimated that 95% of your dues can be taken as a business expense.

**LEGISLATIVE NEWS**

**MedPAC Holds January Meeting to Discuss Payment Recommendations**

On January 14 and 15, the Medicare Payment Advisory Commission (MedPAC) held a session regarding payment adequacy across a number of provider groups. MedPAC recommended that Congress should update payments for physicians in 2011 by 1%.

MedPAC also discussed potential changes to the “in office ancillary services” exception (generally known as the “group practice” exception) to the Stark federal self-referral law. Under the current scheme, this is the Stark Law exception that enables medical oncology, urology, and other non-radiation oncology practices to establish freestanding radiation oncology centers. While the MedPAC staff’s presentation did detail some benefits of this exception, the presentation emphasized the negative impact that the

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exception may have on utilization and on physicians' judgment regarding the diagnostic and treatment options available to their patients.

MedPAC considered three options for addressing the group practice exception:

1. Excluding certain services from the IOAS exception, such as outpatient therapy and radiation therapy and diagnostic tests that are not usually provided at the time of the office visit.
2. Payment tools such as reducing payments for self-referring physicians, packaging services, and bundling services. It was acknowledged, however, that reducing payments for self-referred services could increase volume.
3. Establishing a prior authorization program for physicians who self-refer for advanced imaging. This prior authorization program could focus on self-referring physicians who either order more studies than their peers or order services that are typically not provided on the same day as the office visit.

There did not appear to be any consensus on what direction, if any, the Commission should take with respect to this issue. The Chairman of the Commission noted that he personally was not convinced that changing the self-referral rules was the best way to address the escalation in certain services. However, many Commissioners did appear to agree that radiation therapy services should be excluded from the group practice exception.

### **FDA Released Recommendations on Radiation Exposure from CT Scans**

The Food and Drug Administration recently released interim recommendations to imaging facilities, radiologists and radiologic technologists regarding exposure to radiation during CT perfusion imaging of the brain. The recommendations are part of an ongoing investigation into cases of excess radiation during the imaging procedure; the agency has identified

patients in Los Angeles and Alabama who had been exposed to excess radiation during the scans. Some of the patients were exposed to excess radiation of up to eight times the expected level.

The interim recommendations apply to all CT perfusion images, including brain and heart, and include recommendations that:

- Facilities assess whether patients who underwent CT perfusion scans received excess radiation.
- Facilities review their radiation dosing protocols for all CT perfusion studies to ensure that the correct dosing is planned for each study.
- Facilities implement quality control procedures to ensure that dosing protocols are followed every time and the planned amount of radiation is administered.
- Radiologic technologists check the CT scanner display panel before performing a study to make sure the amount of radiation to be delivered is at the appropriate level for the individual patient.

### **Exemption to Pay-Go Rules for Doc Fix Tacked Onto Debt Measure by Senate**

By a vote of 60-40 on strict party lines, the Senate recently passed an amendment to the debt ceiling increase legislation that paves the way for a five-year Medicare physician payment fix that would be exempt from the pay-as-you-go rules. The underlying debt ceiling legislation was subsequently passed by a party-line 60-39 vote.

The vehicle to be used to enact the actual physician payment fix is not yet clear. There has been some discussion of including the "fix", which would avert a 21.5% reduction in Medicare payment for physicians' services, in legislation extending unemployment insurance; however, Senate and House leaders remain unclear about whether this or some other legislative vehicle will be used. The current reprieve from the 21.5% reduction will expire at the end of the month,

unless further legislation is enacted. At this stage, however, it appears unlikely that 2010 will bring a permanent solution to the problems posed by the SGR.

### **Fate of Health Care Reform Unclear in Aftermath of Massachusetts Election, Shift in Presidential Priorities**

Health care reform, if not dead, appears to be on life support, with no treatment plan in sight. In the aftermath of the upset election in Massachusetts, the path to health care reform is unclear. At this stage, it appears that the House is unwilling to enact the Senate version of reform, and the Senate wants a reprieve from further health care reform negotiations at least until the dust of the Massachusetts election settles.

At the same time, the President's State of the Union address signals a shift in priorities towards jobs and the economy as the primary focus of the Administration. While not abandoning health care reform, the President acknowledged responsibility for failing to communicate the reform effort clear to the American people. Based on all of these factors, it appears likely that whatever health care reform legislation is enacted is likely to be incremental, enacting substantially smaller scale changes in the current system.

### **Proposed Electronic Health Records Regulations: Q&A**

The stimulus bill enacted in 2009 included provisions to provide Medicare and Medicaid incentive payments to physicians who adopted health information technology, or more specifically, to physicians who are "meaningful users" of "certified" EHR (electronic health record) technology. Physicians are eligible for payments beginning in calendar year 2011 (some States may adopt Medicaid incentive payments as early as this year.)

How Much Am I Eligible to Receive? A physician who uses EHR technology in 2011 and 2012 is eligible for \$44,000 in increased Medicare payments over 5 years, with decreasing amounts payable to physicians who begin using EHR technology in 2013 and 2014. Beginning in 2015, physicians who aren't using EHR will be subject to

Medicare payment penalties. To be eligible for Medicaid payments, physicians have to show that at least 30% of their patients are Medicaid patients. Medicaid payments to a physician who begins using EHR by 2016 total \$63,750. There are no penalties under the Medicaid provisions. Physicians who are eligible for both programs must choose one.

How do I know if I am Eligible? Hospital-based physicians are not eligible for payments under either program. Physicians who receive Medicare e-prescribing incentive payments are not eligible for the Medicare EHR incentive, but can receive the Medicaid EHR incentive.

CMS issued proposed rules on January 13 to implement the meaningful use criteria and the Office of the National Coordinator for Health Information Technology (ONC) issued an interim final rule on the same day to describe "certified" technology. Among the issues addressed by CMS in its proposed rule is the meaning of "hospital-based physician", which CMS is defining as a physician who provides 90% or more of his or her services in a hospital inpatient, outpatient or emergency room. CMS also describes the clinical quality indicators that physicians will have to report to be considered "meaningful users." The ONC rule is designed to comport with the CMS proposed rule, and ONC says that it will be issuing another rule shortly that will implement a certification program for EHR technology. Comments on the rules are due March 15, 2010.

In the interim, physicians are cautioned to check out the financial viability of companies from whom they purchase HIT software since they can be locked out of their patient information if the company fails. Also, they need to determine whether the programs have a history of causing errors. While the companies and their software may not perform, the physicians are left holding the bag in the event of system failures.

### **Administration Budget Requests Substantially Increased Funding for Fraud and Abuse Enforcement Activities**

With respect to HHS, the President's FY 2011 recently released Budget totals \$911 billion in outlays, an increase of \$51 billion over FY 2010.

The Budget proposes \$81 billion in discretionary budget authority, an increase of \$2.3 billion over FY 2010 on a comparable basis.

The following are a number of the highlights of the President's budget proposal, with respect to Medicare and Medicaid issues:

- **Enhancing Medicare and Medicaid Program Integrity:** The Budget includes \$561 million in discretionary resources, an increase of \$250 million, to strengthen Medicare and Medicaid program integrity activities.
- **Strengthening the Centers for Medicare & Medicaid Services (CMS):** The Budget includes \$3.6 billion, an increase of \$186 million. Specifically, \$110 million of CMS' increase is for a new, comprehensive Health Care Data Improvement Initiative to transform CMS's data environment from one focused primarily on claims processing to one also focused on state-of-the art data analysis and information sharing.
- **Health Care Professionals Shortages:** The Budget includes \$995 million, an increase of \$33 million, to address the shortage of health care providers in underserved areas.
- **Health Care Center Services:** The Budget includes an increase of \$290 million for further expansions of health center services, including the creation of 25 new access points in communities without access to a health center.

## Practice Platinum, Gold & Silver Members

As of January 20, 2010:

### Platinum Members:

- Minneapolis Radiation Oncology  
Minneapolis, Minnesota

### Silver Members:

- Centennial Radiation Oncology/  
Poudre Valley Radiation Oncology  
Denver, Colorado
- RadiantCare Radiation Oncology  
Lacey, Washington
- Radiation Medical Group, Inc  
San Diego, California
- Tacoma Valley Radiation Oncology Center  
Tacoma, Washington
- Tri State Regional Cancer Center  
Ashland, Kentucky

- The Budget includes nearly \$5.4 billion, an increase of \$354 million, that will enable the Indian Health Service (IHS) to focus on reducing health disparities.
- **Technology (Health IT):** The Budget includes \$78 million, an increase of \$17 million, for the Office of the National Coordinator for Health Information Technology (ONC) to advance the President's health IT initiative by accelerating health IT adoption and electronic health records (EHRs) utilization as essential tools to modernizing the health care system.
- **Extension of Medicaid Matching Funds:** The Budget includes a proposal to extend by an additional six months, through June 2011, the temporary Federal Medical Assistance Percentage (FMAP) increase provided by the Recovery Act. The extension will result in an additional \$25.5 billion to States for maintaining support for children and families helped by Medicaid.
- **Outcomes Research:** The Budget includes an additional \$261 million, including program support costs, in the Agency for Healthcare Research and Quality (AHRQ) to support new research projects.

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**AFROC Office**

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FOR MORE INFORMATION,  
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Check out the website for updated information:  
[www.afroc.org](http://www.afroc.org)

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**22<sup>nd</sup> ANNUAL CONFERENCE**  
 Sunday and Monday, April 11 and 12, 2010

*InterContinental Harbor Court Baltimore*  
 Baltimore, MD

**Registration Form**

Full name: \_\_\_\_\_ Title: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Non-attending guest's full name: \_\_\_\_\_

Registration includes: All conferences, continental breakfasts, refreshment breaks, lunches, and reception. Guest fee for breakfasts, lunches and reception – see below.

**Two Day Registration**

	Registration fees	Payment
<input type="checkbox"/> AFROC member	\$475	\$ _____
<input type="checkbox"/> Additional AFROC members*	\$450	\$ _____
<input type="checkbox"/> Non-Member	\$550	\$ _____
<input type="checkbox"/> Guest	\$175	\$ _____

**One Day Registration**

<input type="checkbox"/> AFROC member	\$300	\$ _____
<input type="checkbox"/> Additional AFROC members*	\$275	\$ _____
<input type="checkbox"/> Non-Member	\$325	\$ _____

*Any member organization paying a \$475 registration fee will be granted a \$50 reduction in registration fees per additional attendee. Please return forms for multiple attendees together.*

**Payment Information**

Total \_\_\_\_\_

Enclosed is check # \_\_\_\_\_ (Payable to AFROC)

VISA     MasterCard    Card #: \_\_\_\_\_    Exp date: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Authorized signature: \_\_\_\_\_