Adapting to Changes in Medicare for 2010

January 7, 2010

Hosted by The American Society of Clinical Oncology
Topics Covered Today

• Legislative Update
• Highlights from the Medicare Physician Fee Schedule (PFS) and Hospital Outpatient Prospective Payment System Rule (HOPPS)
• PQRI and e-Prescribing incentive programs
• Billing, coding and coverage issues
• Recovery Audit Contractors
ASCO’s Legislative Update
Sustainable Growth Rate (SGR)

- SGR Patch through Feb. 28 passed as part of the Defense Appropriations bill
- House passed SGR repeal (H.R. 3961) and replaces with a formula based on Medicare Economic Index (MEI)
- Senate failed to invoke cloture on their version of the SGR repeal, S. 1776
- In Senate Health Reform bill, there is a one year patch, with a rate of +0.5%
Health Reform

• Clinical Trials
  – Senators Sherrod Brown (D-OH) and Kay Bailey Hutchison (R-TX) were able to include a provision that requires routine care costs to be covered by insurers in the Manager’s Amendment to the Senate Health Reform Bill, which passed the Senate on Christmas Eve.
  – Also applies to FEHBP enrollees.
  – Does not preempt states that already have similar clinical trials laws.
Health Reform

• ASCO attempted to include the following provisions in the Health Reform bills:
  – Prompt Pay
    • This was initially included in the House Energy and Commerce version, but was stripped out when the bills were merged.
    • Efforts are under way to include this in the conference committee that will finalize the Health Reform bill.
  – Consult Codes
    • Ongoing push to restore these codes in the final Health Reform bill.
Fee Schedule Highlights
Physician Fee Schedule

- Conversion Factor
  - Final rule included conversion factor update of 21.2%
    - Published conversion factor of $28.4061; later corrected to $28.3895
  - On 12/21 President Obama signed legislation with a short term patch for the SGR; conversion factor is frozen at 2009 rate through 2/28/10
    - Technical corrections result in conversion factor of $36.0846 (slight change from 2009)
Sustainable Growth Rate

• Barring other changes, beginning in 2010 CMS will no longer include drug costs in calculating the SGR
  – CMS projects that this change is more likely to result in subsequent annual updates that are positive, rather than the yearly cuts that have been the subject of annual Congressional intervention
Practice Expense Updates

- CMS used AMA’s Physician Practice Information Survey (PPIS) to determine practice expenses and malpractice expenses.
- ASCO fought hard to have CMS use the Gallup survey data for oncology rather than AMA PPIS data; CMS agreed and updated the Gallup data for inflation using the Medical Economic Index (MEI).
  - Practice expenses still understated.
Practice Expense Updates

- Medical oncology
  - 6% cut transitioned in over the next 4 years
  - 1% cut for medical oncology in 2010

- Radiation oncology
  - 5% overall cut to be transitioned in over 4 years
  - 1% cut for radiation oncology in 2010
Competitive Acquisition Program

• Started by CMS in 2005, put on hold in 2009
• Final rule did not indicate when CAP will resume but did include several new provisions
  – Quarterly drug payment adjustments
  – Narrows CAP drug list to 41 items
  – Limits geographic area to 48 contiguous states and the District of Columbia
  – Allows participating physicians to store nominal amounts of CAP drugs in the office and furnish from that stock using electronic transactions
  – Eases transportation restrictions between offices
Medicare Claims Hold

• CMS has instructed contractors to hold claims for physician fee schedule services for up to the first 10 business days of January (1/1 – 1/15) for 2010 dates of service
  – All claims for services delivered on or before 12/31/09 will be processed and paid under normal procedures
• Claims hold is to allow contractors time to receive the new, updated payment files and perform testing before paying claims at the new rates
• CMS has instructed contractors to begin processing claims at the new rates no later than 1/19/10
Participation Enrollment

• CMS has extended the 2010 Annual Participation Enrollment Program end date from January 31, 2010 to March 17, 2010
  – Enrollment period 11/13/09 – 3/17/10
• Effective date for any change in participation status remains January 1, 2010 and will be in force for the entire year
HOPPS

• Increases payments to hospital outpatient departments by inflation adjustment of 2.1%
  – 0.1% for hospitals that do not participate in quality reporting

• Drug payments
  – Separately billable drugs paid at ASP+4%
  – Continue paying separately for drugs costing more than $65 per day; drugs costing less than $65 are not reimbursed separately
  – CMS will no longer exempt the 5-HT3 antiemetic products from standard packaging methodology
Physician Supervision

• Physician Supervision
  – CMS finalized proposal to allow “certain non-physician practitioners” to directly supervise all hospital outpatient therapeutic services that they may perform themselves within state scope of practice and hospital-granted privileges
    • NPPs may not supervise diagnostic services
Physician Supervision

- For on-campus hospital outpatient therapeutic services, “direct supervision” means
  - The physician or NPP must be present anywhere on the hospital campus and
  - Immediately available to furnish assistance and direction throughout the performance of the procedure/service
  - Supervising physician or NPP must have the ability to perform the services or procedure being performed
- State scope of practice and hospital-granted privileges
Physician Supervision

• For services furnished in an off-campus provider-based department, “direct supervision” continues to mean
  – The physician or NPP must be present in the off-campus provider-based department and
  – Immediately available to furnish assistance and direction throughout the performance of the procedure/service
PQRI & ePrescribing Incentive Programs
Physician Quality Reporting Initiative (PQRI) 2010

• Voluntary reporting program that provides incentive payment to eligible professionals (EP) who satisfactorily report data on specific quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries and paid under the Medicare Physician Fee Schedule
  – Eligible professionals (EP) include physicians, nurse practitioners, physician assistants, clinical nurse specialists (and others)
PQRI 2010

• 2010 incentive payment is 2.0% of the EP’s estimated total allowed charges for Medicare Part B covered professional services provided during the reporting period

• Two participation/reporting periods
  – January 1 – December 31, 2010
  – July 1 – December 31, 2010

• 179 measures and 13 measure groups
Reporting Options

• Claims-based reporting
• Measure groups
  – None specific to oncology
• Registry reporting
• Group practice reporting
  – For practices with 200 or more individual eligible professionals; groups must self-nominate to CMS
  – Group practices that report at group level cannot report at the individual level
Changes for 2010

• New oncology measure
  – Measure 194: Oncology: Cancer Stage Documented

• Reporting options indicated for each measure (claims, registry)

• Registry Only reporting
  – Measure #136: Melanoma: Follow-up Aspects of Care
  – Measure #137: Melanoma: Continuity of Care – Recall System
  – Measure #138: Melanoma: Coordination of Care
  – Measure #143: Oncology - Medical and Radiation: Pain Intensity Quantified
  – Measure #144: Oncology - Medical Plan of Care for Pain

• Review all measures for edits, changes from previous years
Claims-based Reporting

• Must report on at least 3 measures unless fewer than 3 measures apply to the patients in your practice
• Report for 12 months (1/1 – 12/31/10) or for 6 months (7/1 – 12/31/10)
• Report for at least 80% of applicable patients (at least 3 measures)
Measures

• In general the quality measures consist of
  – a unique denominator that describes the eligible cases for a measure and
  – numerator that describes the clinical action required by the measure for reporting and performance

• Measures address various aspects of care: prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination
Measures

• Select measures that apply to services most frequently provided to Medicare patients by the EP/practice
  – Do not choose measures that do not or infrequently apply to services provided to Medicare patients by the EP/practice
• Identify and report on all eligible cases for the measures selected by the practice
• Quality-Data Codes (QDCs) are used to report
  – CPT Category II codes and/or G codes
Billing and Claims Processing

• QDCs must be reported on the same claim as the denominator billing code(s)
  – For the same beneficiary
  – For the same date of service
  – By the same EP (individual NPI) who performed the covered service (denominator codes)

• QDCs must be submitted with a line-time charge of zero dollars ($0.00)
  – If billing system does not allow $0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount
Billing and Claims Processing

- QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis.
- EPs will receive remittance advice with a standard remark code (N365) and a message that confirms that the QDCs passed into the National Claims History (NCH) file.
  - N365 does NOT indicate whether the QDC is accurate for that claim or for the measure.
- Claims may not be resubmitted for the sole purpose of adding or correcting QDCs.
Measure Groups

• Report on one or more measure groups
• 13 measure groups
  – Choose a measure group only if ALL the measures within the group are applicable to services provided to Medicare patients by the EP
• Review the 2010 PQRI Measures Group Specifications Manual to determine if a particular measures group is applicable for your practice
  – http://www.cms.hhs.gov/PQRI/15_MeasureCodes.asp#TopOfPage
Registry Reporting

- ASCO is advocating for the use of registries for PQRI and for processes that would allow ASCO’s current data efforts to comply with PQRI
  - For now there are no oncology-specific registries
- CMS “Qualified Registries for 2010 PQRI Reporting”
  - There are a number of registries that say they can report on “all measures”
  - Check with individual registries for details about submitting data, cost, etc.
  - [http://www.cms.hhs.gov/PQRI/Downloads/QualifiedRegistriesPhase1Rvsd120709_1.pdf](http://www.cms.hhs.gov/PQRI/Downloads/QualifiedRegistriesPhase1Rvsd120709_1.pdf)
PQRI Help Desk

• General CMS PQRI & E-Prescribing Information
• PQRI Portal Password Issues
• PQRI feedback report availability and access
  – 7:00 am – 7:00 pm CST
  – Phone: 1-866-288-8912
  – Email: Qnetsupport@sdps.org
PRQI: For more information...

- [http://www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI)
- “Satisfactorily Reporting 2010 PQRI Measures”
  - How to get started with PQRI reporting
- “2010 Physician Quality Reporting Initiative Implementation Guide”
  - Includes PQRI Participation Decision Tree
PRQI: For more information...

- CMS National Provider Conference Call on PQRI and the eRx Incentive Program
  - Tuesday, January 12, 2010, 1:30 – 3:30 pm EST
  - Register for the call by 1/9/10 at 1:30 pm EST at http://www.events svc.com/palmettogba/011210
e-Prescribing Incentive Program

- Medicare incentive program started in 2009
- Do not need to participate in PQRI to participate in the eRx Incentive Program
- No sign-up or pre-registration is necessary
eRx Requirements

1. Eligible professional (EP) must have and use a qualified eRx system and report on his or her adoption and use of the eRx system.

2. EP must meet the criteria for successful electronic prescriber specified by CMS for a particular reporting period.

3. At least 10% of a successful electronic prescriber’s Medicare Part B covered services must be made up of codes that appear in the denominator of the eRx measure.
Qualified eRx System

• Capable of ALL of the following:
  – Generate a complete active medication list with data received from applicable pharmacies and pharmacy benefit managers if available
  – Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts
  – Provide information related to lower cost, therapeutically appropriate alternatives (if any).
  – Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available).
eRx in 2010

• 4 possible reporting mechanisms
  – Claims-based reporting
  – Registry-based reporting
  – EHR-based submission
  – Group practice reporting option
eRx Claims-based Reporting

• To report this measure in 2010, a qualified eRx system that meets the requirements (slide 26) must have been adopted

• Measure is to be reported for patient visits that meet the denominator coding criteria and for which an EP has electronically prescribed at least one prescription

• There is no specific diagnosis code required for this measure
Successful Reporting

• To be considered a successful electronic prescriber for the 2010 eRx Incentive Program and potentially qualify to earn a 2.0% incentive payment, an individual EP must report the eRx measure for at least 25 unique electronic prescribing events during 2010.
Numerator

• A qualified eRx system has been adopted and the following G-code applies to the patient visit
  – G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system
Denominator

• Any patient visit for which one (or more) of the following codes applies and is included on the claim

<table>
<thead>
<tr>
<th>Codes 1</th>
<th>Codes 2</th>
<th>Codes 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801 – 90802</td>
<td>96150 – 96152</td>
<td>99341 – 99345</td>
</tr>
<tr>
<td>90804 – 90809</td>
<td>99201 – 99205</td>
<td>99348 – 99350</td>
</tr>
<tr>
<td>90862</td>
<td>00211 – 99215</td>
<td>G0101</td>
</tr>
<tr>
<td>92002</td>
<td>99304 – 99310</td>
<td>G0108</td>
</tr>
<tr>
<td>92004</td>
<td>99315 – 99316</td>
<td>G0109</td>
</tr>
<tr>
<td>92012</td>
<td>99324 – 99328</td>
<td></td>
</tr>
<tr>
<td>92014</td>
<td>99334 – 99337</td>
<td></td>
</tr>
</tbody>
</table>
Claims Submission

• The eRx G-code must be reported:
  – On the same claim as the denominator billing code
  – For the same beneficiary
  – For the same date of service
  – By the same EP who performed the covered service

• Claims may not be resubmitted for the sole purpose of adding or correcting an eRx code
Claims Submission

• The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed
  – The submitted charge field cannot be blank
  – The line item charge should be $0.00
    • A nominal amount can be substituted – beneficiary is not liable for this nominal amount
    • Total charge for the claim cannot be $0.00 (claim will be rejected)
Claims Submission

- eRx line items will be denied for payment but are passed through the claims processing system to the National Claims History (NCH) database, used for eRx claims analysis.
- EPs will receive a Remittance Advice which includes standard remark code N365:
  - “This procedure is not payable. It is for reporting/information purposes only.”
  - This does not indicate whether the eRx G-code is accurate, only that the G-code passed into NCH.
eRx: For more information...

- **ePrescribing Incentive Program**
  - [http://www.cms.hhs.gov/ERxIncentive/](http://www.cms.hhs.gov/ERxIncentive/)

- **Claims-based reporting**
  - [http://www.cms.hhs.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf](http://www.cms.hhs.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf)

- **Group practice reporting option**

- **Alternative reporting mechanisms (Registry-based submission, EHR-based submission)**
  - [http://www.cms.hhs.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage](http://www.cms.hhs.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage)
Billing, Coding and Coverage Issues
HCPCS code changes

- J9155 – injection, degarelix, 1 mg (Firmagon)
- J9171 – injection, docetaxel, 1 mg
  - Code J9170 (injection, docetaxel, 20 mg) has been deleted
- J9328 – injection, temozolomide, 1 mg (Temodar)
- J2562 – injection, plerixafor, 1 mg
- C9257 – injection, bevacizumab, 0.25 mg (for HOPPS billing)
ICD-9 code changes

- Some general language revisions to 190, 196, 197, 198, 199, 202, and 209
  - 238.72 has been revised to include, “Refractory anemia with excess blasts-1 (RAEB-1).” This was deleted from code 238.73

- New codes include
  - V10.90 Personal history of unspecified malignant neoplasm
    - V10.91 Personal history of malignant neuroendocrine tumor
  - 209.31 Merkel cell carcinoma of the face
    - 209.32 Merkel cell carcinoma of the scalp and neck
    - 209.33 Merkel cell carcinoma of the upper limb
    - 209.34 Merkel cell carcinoma of the lower limb
    - 209.35 Merkel cell carcinoma of the trunk
    - 209.36 Merkel cell carcinoma of other sites
ICD-9 code changes (cont.)

- 209.70 Secondary neuroendocrine tumor, unspecified site
  209.71 Secondary neuroendocrine tumor of distant lymph nodes
  209.72 Secondary neuroendocrine tumor of liver
  209.73 Secondary neuroendocrine tumor of bone
  209.74 Secondary neuroendocrine tumor of peritoneum
  209.75 Merkel cell carcinoma, unknown primary site
  209.79 Secondary neuroendocrine tumor of other sites
- 239.81 Neoplasms of unspecified nature, retina and choroid
  239.8 Neoplasms of unspecified nature, other specified sites
- 285.3 Antineoplastic chemotherapy induced anemia

* Some additional language changes for 285.2, 285.22
Drug Administration

- No major changes this year to drug administration codes
- New instructions in preamble language of drug administration section describing how “initial” service code should be determined
- There is a variance between physician office setting and facility setting
Drug Administration

- When reported by a physician, initial code should best describe the key or primary reason for the encounter.

- When reported by a facility:
  - Chemotherapy is primary to therapeutic, diagnostic, prophylactic.
  - Therapeutic, diagnostic, prophylactic is primary to hydration.
  - Infusions are primary to pushes.
  - Pushes are primary to injections.
Consultation Codes

• Effective January 1, 2010, CPT consultation codes (99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment

• For services furnished to Medicare beneficiaries on or after 1/1/10, providers should use an evaluation and management (E/M) code that represents
  – where the visit occurs, and
  – identifies the complexity of the service provided

• MM6740 released on 12/14/09
Office Setting

• If consultation is provided in the office setting
  – Report either a new patient (99201 – 99205) or established patient (99212 – 99215) visit code
  – If you bill Medicare for a consultation code after 1/1/10, you will receive a denial

• A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years
Inpatient Hospital Setting

• If a consultation is provided in the inpatient hospital setting
  – Report the initial hospital care codes (99221 – 99223)

• For subsequent visits in the hospital
  – Report the subsequent hospital care codes (99231 – 99233)
Inpatient Hospital: Modifier -AI

- To distinguish between the admitting physician and consulting physicians
  - The principal physician of record (admitting physician) will use modifier “-AI” with the E/M code
  - This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care
  - All other physicians (consultants) who perform an initial evaluation will bill only the E/M code for the complexity level of the service performed
Nursing Facility Setting

• If a consultation is provided in a nursing facility
  – Report initial nursing facility codes (99304 – 99306)
  – Admitting physician will use the –AI modifier

• For subsequent visits in a nursing facility
  – Report the subsequent nursing facility care codes (99307 – 99310)
Same Group Practice

• Medicare may pay for an inpatient initial hospital visit or an office or other outpatient visit if one physician or NPP in a group practice requests an E/M service from another physician in the same group practice when the consulting physician or NPP has expertise in a specific medical area beyond the requesting professional’s knowledge.
Documentation

• Bill the code that most appropriately describes the level of the services provided and follow appropriate medical documentation standards

• Documentation must always meet the level of service that is billed

• Follow the E/M documentation guidelines available on the CMS website (1995 and 1997)
Medicare secondary payments

- Medicare will no longer recognize the consultation codes for purposes of determining MSP.
- If the primary payer for the service continues to recognize consultation codes, there are 2 options:
  1. Bill the initial care codes which will “preserve the possibility of receiving a secondary payment from Medicare”; OR
  2. Bill the consultation codes which will result in a denial of payment from Medicare.
Prolonged Service Codes

- MM6740 also included information about prolonged service codes

- Prolonged service coding has not changed
  - Add-on codes; used for prolonged service time beyond the usual service
  - Use codes 99354 and 99355 for office or other outpatient setting
  - Use codes 99356 and 99357 for inpatient setting
  - Appropriate documentation is required to support the billing of prolonged visit codes
Private Payers

• Remember that the consultation codes still exist in the CPT manual, even though they are no longer recognized by Medicare

• Determine private payer policies
  – Some payers will continue to recognize and pay for consultation codes
  – Some payers may adopt or follow CMS’ rules
Compendia, Off-label

- CMS recognizes off-label uses published in specified compendia for Medicare Parts B, D:
  - Thomson DrugDex
  - NCCN Drugs & Biologics Compendium
  - AHFS Drug Information
  - Clinical Pharmacology

- “On and after 1/1/10, no compendia may be included...unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.”
  - Final rule includes implementation requirements
Recovery Audit Contractors
Recovery Audit Contractors

• RACs program is required in all states as of January 1, 2010
• Purpose of RAC is to identify potential overpayments and underpayments made to providers
• Initial RAC demonstration project showed significant advantages to Medicare so program was expanded to all states via statutory language
Recovery Audit Contractors

• Four permanent contractors for initiative
  – Diversified Collection Services, Inc.
  – CGI Technologies and Solutions, Inc.
  – Connolly Consulting Associates, Inc.
  – HealthDataInsights, Inc.

• Each contractor is responsible for a designated geographic region
Recovery Audit Contractors

Proposed 2008 RAC Jurisdictions
## Recovery Audit Contractors

<table>
<thead>
<tr>
<th>RAC</th>
<th>Website</th>
<th>E-mail</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A: Diversified Collection Services</td>
<td><a href="http://www.dcsrac.com">www.dcsrac.com</a></td>
<td><a href="mailto:info@dcsrac.com">info@dcsrac.com</a></td>
<td>1-866-201-0580</td>
</tr>
<tr>
<td>Region B: CGI</td>
<td><a href="http://racb.cgi.com">http://racb.cgi.com</a></td>
<td><a href="mailto:racb@cgi.com">racb@cgi.com</a></td>
<td>1-877-316-7222</td>
</tr>
<tr>
<td>Region C: Connolly Consulting</td>
<td><a href="http://www.connollyhealthcare.com/RAC">www.connollyhealthcare.com/RAC</a></td>
<td><a href="mailto:RACinfo@connollyhealthcare.com">RACinfo@connollyhealthcare.com</a></td>
<td>1-866-360-2507</td>
</tr>
</tbody>
</table>
RAC Audits

Oncology-related RAC audits

- Region A – No specific audits, most relate to wheelchair services

- Regions B, C & D
  - Blood transfusions – Should be billed with a max of 1 unit per patient per date of service
  - IV hydration – Should be billed with a max of 1 unit per patient per date of service (initial code)
RAC Audits

• Regions B, C & D (continued)
  – Neulasta – Looking for claims submitted with total number of milligrams instead of 1 unit per 6 mgs

• Region D (additional item)
  – Skilled Nursing Facility (SNF) services – Services billed to the MAC by providers that are considered part of SNF consolidated billing and should have been billed by the SNF itself
ASCO Resources
Cancer Policy Today

• Cancer Policy Today
• Bi-weekly e-newsletter
• Updates on legislative and regulatory issues
• Updates on CMS initiatives
• Links to important resources, tools, and legislation
Alerts & Breaking News

- Alerts
- Breaking news or issues affecting oncology
- Sent to ASCO members
- Available on ASCO site

---

**CLINICAL ALERT—LEUCOVORIN SHORTAGE**

January 8, 2008

**Why is there a shortage of leucovorin?**

There is currently a nationwide shortage of injectable racemic leucovorin, available only as a generic drug and only from two manufacturers in the US (Knoll Pharmaceutical and Teva Pharmaceuticals). According to the FDA and the American Society of Health-System Pharmacists (ASHP), the companies have not provided information on how long this shortage, caused by unspecified “manufacturing delays,” is expected to last.

**What about using levo-leucovorin?**

Levo-leucovorin is the levo isomeric form of racemic (-)-leucovorin, and is the pharmacologically active isomer of leucovorin. Levo-leucovorin is available under the brand name “Fusilev” (Spectrum Pharmaceuticals). According to the FDA website, limited supplies of levo-leucovorin continue to be available (the ASHP does not list a shortage of this drug). Unlike leucovorin, levo-leucovorin is not FDA-approved for use in colorectal cancer or other malignancies (with the exception of use for rescue after high-dose methotrexate therapy in colorectal cancer). However, it has been used off-label in the treatment of malignancies, as a substitute for leucovorin, though noninferiority in terms of efficacy has not been tested either for metastatic disease or adjuvant therapy.

If clinicians and patients are considering the use of levo-leucovorin, they should note the following:

- The dose for levo-leucovorin is 50% of the usual dose of racemic leucovorin.
- Levo-leucovorin is not FDA-approved for malignancy indications (except as noted above).
- The cost of levo-leucovorin may be significantly higher than for leucovorin.
- For the time being, you may wish to check with your Medicare contractor and private insurance carriers for coverage determinations.


**What about using oral leucovorin?**

According to the ASHP, leucovorin tablets are still available. Oral leucovorin is not FDA-approved for use in treatment of malignancies (except for methotrexate rescue in colorectal cancer), although its use has been evaluated in that setting. The use of oral leucovorin may be limited by the large number of tablets needed and by the fact that oral absorption of leucovorin is saturable and highly variable.

**What about using capecitabine to substitute for the combination of 5FU/leucovorin?**

Capecitabine is an oral pro-drug of 5FU. For some treatment regimens, for some malignancies, substitution of capecitabine for the combination of 5FU/leucovorin is supported based on high quality randomized clinical trials. However, such data are not available for all 5FU/leucovorin containing regimens.
• For Practice Managers and Executives
• Highlights on key issues
• Resources for you, the practice, and staff
• To subscribe, email practice@asco.org
Journal of Oncology Practice

http://jop.ascopubs.org

• Regular features
  – Original Research
  – Practical Tips
  – Practice of Research
  – Business of the Business
  – Ethics Vignettes
  – Strategies for Career Success

• Manuscripts and letters to the editor may be sent to jopsubmissions@asco.org
Practical Tips for the Oncology Practice

• Your guide on the coding, billing, and coverage of oncology services and the regulatory policies affecting the day-to-day practice of oncology.
Electronic Health Records

ASCO Electronic Health Record Initiatives at www.asco.org/ehr

• Social networking site
  – http://ehr.ascoexchange.org

• EHR Lab at 2010 ASCO Annual Meeting

• The Oncology Electronic Health Record Field Guide: Selecting and Implementing an EHR
Why are we talking about Health Information Technology?

- Patients
- Payers
- Practice

The Premier, Oncology-Specific Guide to EHRs

The Oncology Electronic Health Record Field Guide: Selecting and Implementing an EHR addresses core functionalities desired in an oncology-specific EHR and includes the following topics:

- Identifying an EHR project team
- Making a selection
- Building a budget
- Supporting quality of care and patient safety
- Implementing and post-management

An indispensable tool for selecting and implementing oncology-specific EHRs
Available in print or as an electronic download

Order Now!
Visit www.asco.org/ehrfieldguide
Clinical Tools & Guidelines

- Clinical tools and guidelines
- Executive summaries
- Flow sheets
- Patient guides

www.asco.org/guidelines
Contact Us

• ASCO’s Cancer Policy & Clinical Affairs Department
  – 571-483-1670

• Coding & Reimbursement Assistance
  – practice@asco.org
  – For ASCO members and their staff