

Adapting to Changes in Medicare 2008

Today's Topics

- Medicare Physician Fee Schedule 2008
 - PQRI
- Hospital Outpatient Prospective Payment System 2008
- Medicaid & NDC Numbers
- MACs & RACs
- Clinical Trials
- ESAs
- Oncology Coding Update
- Resources

Medicare Physician Fee Schedule 2008

- Annual Update
 - Final rule reported 10.1% decrease in conversion factor (CF)
 - Congressional action on 12/18/07 increases CF by 0.5% for 6 months (January 1 - June 30, 2008)
 - For dates of service on and after July 1, 2008, the -10.1% update will go into effect unless there is additional Congressional action

Medicare Physician Fee Schedule 2008

- Participation
 - Since there is a change to the 2008 CF and PFS rates, CMS is extending the participation decision period for an additional 45 days
 - Decision period now runs through February 15, 2008; all participating status changes will be effective January 1, 2008
 - Changes in participation status should be sent to your local contractor and postmarked by February 15, 2008

Physician Fee Schedule 2008: RVUs

- Relative Value Units (RVUs)
 - Some changes to RVUs for physician work
 - 2008 is second year of transition to new method for calculating practice expense RVUs
 - CMS estimates a 1% reduction in Medicare payments to physicians in hematology/oncology specialties due to changes in physician work RVUs
 - Net total effect of changes for 2008 is -1%

Physician Fee Schedule 2008: IVIG

- IVIG
 - CMS will continue the extra payment for G0332, “pre-administration services” related to intravenous immune globulin
 - RVUs in 2008 are the same as 2007
 - Bill this code in addition to appropriate drug administration code and J-code for the IVIG

Physician Fee Schedule 2008: ASP

- ASP Calculation
 - Proposed rule included methodology to determine ASP for drugs sold in “bundled” arrangements; CMS did not finalize this proposal
 - Drugs administered in the physician office will continue to be paid at ASP + 6%

Physician Fee Schedule 2008: CAP

- Competitive Acquisition Program
 - CAP vendor now allowed to bill Medicare after it ships drug but before drug has been administered to patient
 - Law requires post-payment reviews to determine that drugs have been administered to patients
 - Physicians may be asked for medical records as part of this process

Physician Fee Schedule 2008: CAP

- CAP vendor may not bill beneficiary for coinsurance until drug is administered
 - Voluntary agreement between CAP vendor and physician to provide info to vendor, or
 - CAP vendor may call physician office to verify drug administration
- Time limit for physicians to file claims has increased from 14 days to 30 days

Physician Fee Schedule 2008: CAP

- CMS will now allow a physician who has elected the CAP program to revoke that decision based on “exigent circumstances” in first 60 days of participation
 - “Exigent circumstances” not defined; will be evaluated on a case-by-case basis
- Termination at any time also possible if “a circumstance not previously known to the practice” becomes a burden
 - Change in personnel or computer system, vendor behavior

Physician Fee Schedule 2008: CAP

- Clinical Trials
 - If a standard-of-care drug used in the control group of a clinical trial is on the CAP drug list, CMS says physicians may order the drug from the CAP vendor
 - If not on the CAP drug list, physicians may buy and bill for it in usual manner
 - CMS has asked for any information that CAP prevents participation in clinical trials; says it will address issues if it receives such comments

Physician Fee Schedule 2008: CAP

- CMS has announced an additional physician election period from 1/15 – 2/15/08 for physicians who have not already elected to participate in CAP for 2008
 - Effective dates will be 4/1 – 12/31/08
- CMS also re-opening vendor bidding for new 3-year contract, 1/1/09 – 12/31/11
- Additional information on CAP is available at http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

Physician Fee Schedule 2008: Reporting Hemoglobin/Hematocrit Levels

- Effective January 1, 2008, physicians must report hematocrit or hemoglobin levels on any claim for treatment of anemia in connection with cancer treatment
 - Not limited to erythropoiesis stimulating agents (ESAs) but also applies if other drugs are used
- Instructions on how to report have not yet been issued by CMS

Physician Fee Schedule 2008: Reporting Hemoglobin/Hematocrit Levels

- Physician must report the “most recent” hemoglobin or hematocrit
 - CMS is not specifying when that level must have been determined
 - CMS recognizes that multiple claims may be submitted with the same hematocrit or hemoglobin
- CMS has released new modifiers for use in 2008; instructions have not yet been released
 - EA, EB, EC, ED, EE

Physician Fee Schedule 2008: Anti-Markup Provision

- When a physician bills for a purchased diagnostic test or a diagnostic test for which the professional or technical component was performed at a site other than the physician's office, the Medicare payment cannot exceed the net charge that the physician paid for it
 - If either the technical component or the professional component was furnished outside the physician's office, this anti-markup provision applies to that component
- Expanded anti-markup provisions have been delayed until Jan. 1, 2009, except for certain anatomic pathology diagnostic tests

Physician Fee Schedule 2008: Drug Compendia

- By statute, Medicare must cover off-label uses of drugs used in anticancer chemotherapy regimens if the uses are supported by citations in:
 - U.S. Pharmacopoeia – Drug Information (and successor publications)
 - American Hospital Formulary Service
- CMS has authority to recognize other authoritative compendia as well

Physician Fee Schedule 2008: Drug Compendia

- CMS will continue to recognize the compendium called USP-DI after its name change to DrugPoints “if it is...a successor publication rather than a substitute publication.”
- CMS has not yet announced the status of DrugPoints

Physician Fee Schedule 2008: Drug Compendia

- CMS has developed an annual process to review compendia
 - CMS will receive requests for changes in the list of recognized compendia for a 30-day period beginning each January 15
 - Requests will be posted each March 15 for a 30-day public comment period
 - CMS will make a decision within 90 days of close of comment period

Off-Label Uses Not in the Compendia

- Medicare statute authorizes carriers to cover off-label uses of cancer drugs not in the compendia based on studies in peer-reviewed publications specified by CMS
- CMS's current list of 15 journals had not been updated since legislation was passed in 1993
- ASCO recommended that additional journals be added to the CMS list
- CMS recently announced that an additional 11 journals will be recognized effective October 22, 2007

Recently Added Journals

- Annals of Oncology
- Biology of Blood and Marrow Transplantation
- Bone Marrow Transplantation
- Gynecologic Oncology
- Clinical Cancer Research
- Int'l Journal of Radiation, Oncology, Biology, and Physics
- Journal of NCCN
- Radiation Oncology
- Annals of Surgical Oncology
- Journal of Urology
- Lancet Oncology

PQRI 2008

- CMS will continue the Physician Quality Reporting Initiative (PQRI) with minor modifications for calendar year 2008
- PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program
 - CMS says payment bonus for 2008 will be 1.5%
- Note that this program applies only to the traditional Medicare fee-for-service and is not applicable to Medicare Advantage Plans

PQRI 2008: Measures

- 119 PQRI quality measures available in 2008
- 2007 oncology-related measures to be used in 2008, with some coding and specification changes
 - NOTE: Coding and specifications for breast cancer hormonal therapy (#71), colon cancer chemotherapy (#72) and chemotherapy planning (#73) measures have been changed
 - 2007 G codes cannot be submitted for these measures in 2008

PQRI: Measures

- NOTE: Reporting for measures 71 (breast cancer hormonal therapy) and 72 (colon cancer chemotherapy) is more burdensome in 2008
 - New CPT II staging codes require use of instructions for interpretation and reporting
 - ASCO requested changes to CPT II codes but AMA declined to make changes for 2008 because of time constraints

PQRI 2008: Measures

- CMS has also added measures developed by AMA's Physician Consortium for Performance Improvement (PCPI):
 - Series of new prostate cancer measures
 - Breast cancer patients who have a pT and pN category and histologic grade for their cancer
 - Colorectal cancer patients who have a pT and pN category and histologic grade for their cancer

PQRI 2008

- Eligible professionals will
 - Report a designated set of quality measures on claims for dates of service 1/1 – 12/31/08
 - Includes physicians (MD, DO, others); practitioners (physician assistant, nurse practitioner, clinical nurse specialist, clinical social worker, clinical psychologist, registered dietician, nutrition professional, others); therapists (physical therapist, occupational therapist, qualified speech-language therapist)

PQRI: Reporting

- Eligible professionals participate by reporting appropriate quality measures on the claim form; there is no separate enrollment process
- Eligible professionals will select and report measures that are applicable to their practice

PQRI: Reporting

- Certain reporting thresholds must be met
 - When no more than 3 measures are applicable, each measure must be reported in at least 80% of appropriate cases
 - When four or more measures are applicable, the 80% threshold must be met on at least three of the measures

Understanding the Measures

Clinical action required for
reporting and
performance

*CPT II or
Temporary
G Codes*

Eligible cases for a measure
(the eligible patient
population associated
with the clinical action)

=

*ICD-9-CM and
CPT Category I Codes*

Understanding the Measures

Key to Successful Reporting:
Understand the applicable
patient population

PQRI: Analysis and Payment

- Reporting and analysis is based on individual NPI numbers
 - The individual NPI of the participating professional must be properly used on the claim
 - Participants will have access to a CMS analysis of their reported data at the end of the program
- Bonus payments will be made to the holder of the Taxpayer Identification Number (TIN)

PQRI: Analysis and Payment

- The potential 1.5% bonus is based on the total allowed charges paid under the Physician Fee Schedule, subject to a cap
- The cap is meant to encourage more instances of measure reporting
 - More instances of reporting make the cap less likely to apply
 - The cap also promotes rough equity between those who report relatively few instances and those who have reported many instances

PQRI: Ensuring Success

- Start reporting early to increase the probability of achieving the 80% rate of reporting required
- Report on as many eligible patients as you can to decrease the probability of being subject to the bonus cap
- Ensure that quality codes are reported on the same claim as the diagnosis or CPT I codes

PQRI Tools

- ASCO Table: “2008 PQRI Measures for Consideration by Oncology Providers”
 - Includes oncology-specific measures of interest to pathologists, oncologists/hematologists, and radiation oncologists
 - Also includes general measures which may be applicable to oncology practices
 - Includes links to AMA tools
- Available with audiocall materials and on ASCO website at www.asco.org/pqri

PQRI Tools

- www.cms.hhs.gov/pqri
 - Statute, regulations, program instructions
 - Technical specifications
 - Measures, codes
 - Educational resources
 - Coding Handbook
- www.ama-assn.org/go/toolsMedicarePQRI
 - Participation tools including description, data collection sheets, specifications

Hospital Outpatient Prospective Payment System (HOPPS) 2008

- Payment for drugs
 - Separately billable drugs now paid at ASP + 5%
 - No separate payment for pharmacy overhead
 - CMS states that it believes that adequate payment for drugs is ASP + 3%; refers to 2008 as “transition” year
 - Medicare will pay separately for drugs costing more than \$60 per day; drugs costing less than \$60 are not reimbursed separately
 - Anti-emetics are reimbursed separately regardless of their daily cost in 2008

HOPPS 2008

- IVIG
 - CMS is continuing payment for G0332, pre-administration services for IVIG; payment is now based on claims data and will be approximately \$37 in 2008
- Drug Administration
 - CMS now recognizes all active CPT codes for drug administration in HOPD but will continue to package payment for 90768 (concurrent infusions)

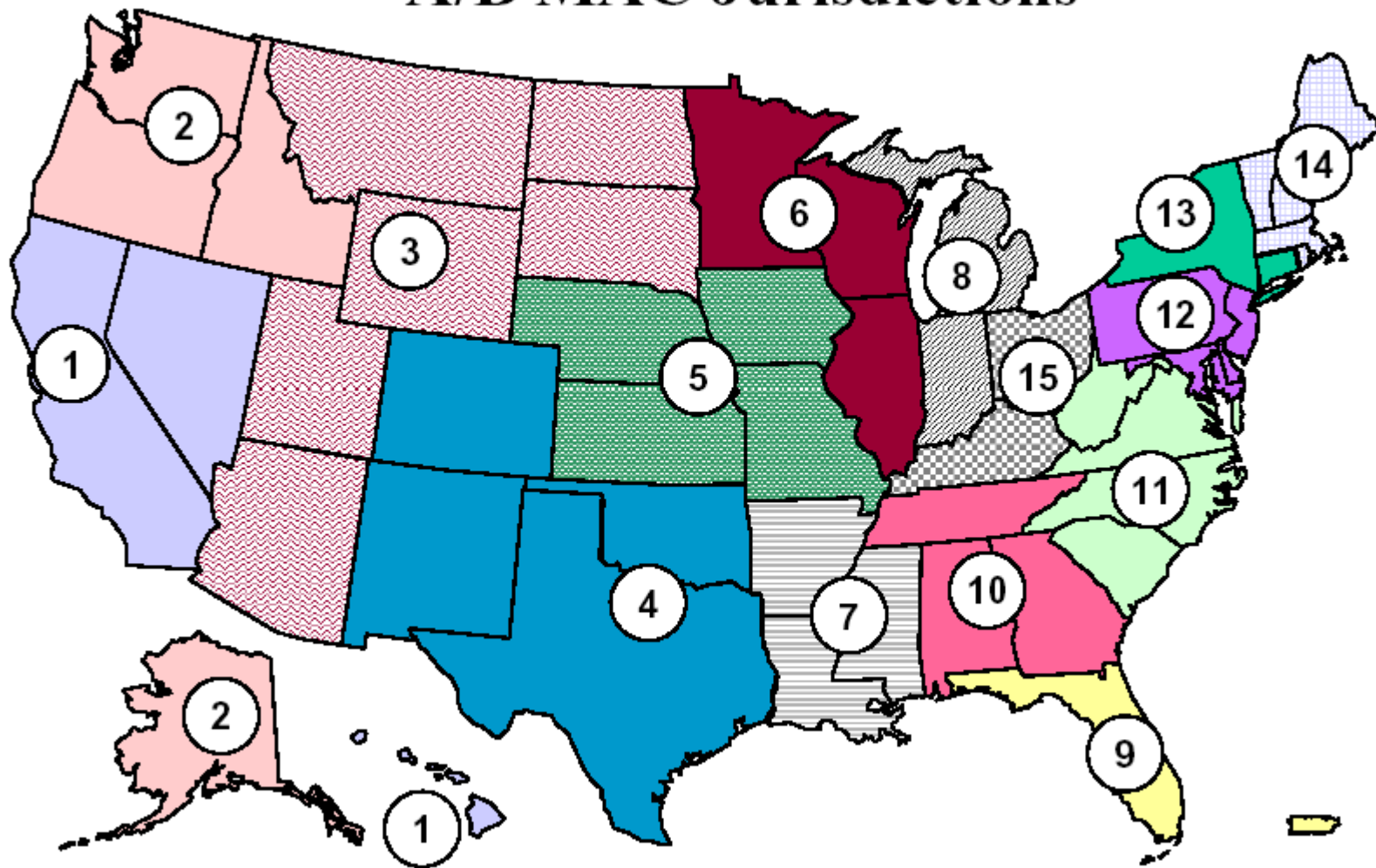
Medicaid Claims & National Drug Code Numbers

- Effective 1/1/08, state Medicaid programs are required to collect rebates for the top 20 multisource drugs administered in the office in order to receive matching federal funds
- These drugs cannot be identified using J-codes
- The Deficit Reduction Act of 2005 (DRA) contained language that requires physicians to submit Medicaid claims using NDC numbers
 - Some states implemented this requirement early; all states are expected to require NDC numbers in 2008

Medicare Administrative Contractors

- Under a competitive bidding process, Medicare is replacing fiscal intermediaries and carriers with new entities called MACs
- Will be two types of MACs
 - Part A/Part B MACs
 - Specialty MACs (covering durable medical equipment, home health, and hospice)
- 15 Part A/Part B MAC regions

A/B MAC Jurisdictions



MACs

- Three A/B MACs awarded so far:
 - Jurisdiction 3 - Noridian Administrative Services (Awarded July 2006)
 - Jurisdiction 4 – Trailblazer Health Enterprises (Awarded August 2007)
 - Jurisdiction 5 – Wisconsin Physician Services (Awarded September 2007)
- More jurisdictions to be awarded in 2008
- For more information on MACs go to <http://www.asco.org/ASCO/Legislative+%26+Regulatory/Medicare+Coverage/What+is+a+CAC%3F>

Recovery Audit Contractors

- Under the Medicare Modernization Act, CMS was directed to explore the concept of recovery audit contractors (RACs)
- Goal of this directive was to ensure that Medicare dollars are being spent appropriately
- RACs are independent companies or entities that are separately contracted
 - Due to a conflict of interest, existing companies who are currently contracted to process claims for Medicare (carriers, fiscal intermediaries, MACs) are ineligible to bid on RAC contracts

RACs

- CMS created a 3-year RAC demonstration project in May 2005
 - Project included/covered California, Florida, and New York
 - RAC responsible for identifying underpayments and overpayments and collecting overpayments
- Demonstration project was scheduled to end March 2008; however, the Tax Relief and Health Care Act (TRHCA) expanded the program to all states

RACs

- CMS must have RAC program implemented in all states by January 2010
- CMS is proposing to have 4 RAC regions and one RAC contractor per region
- CMS expanded demo project in Spring 2007 by adding part A providers in South Carolina, Massachusetts, and Arizona along with states that are serviced by Mutual of Omaha
 - CMS states that the demonstration project expansion is limited to Part A inpatient and outpatient hospital claims

RACs

- CMS has proposed an expansion plan beginning in March 2008; however, no specific details on the expansion are available at this time
- Current RAC contractors under demo project will expire and must re-bid under the new bidding process
- CMS has begun the open bidding process for the 4 permanent RACs

Medicare Coverage of Clinical Trials

- In 2000, CMS issued a National Coverage Decision (NCD) announcing coverage for routine costs of clinical trials
- July 2007, CMS issued proposed revisions
 - To eliminate automatic coverage for federally funded or FDA-reviewed trials and
 - require self-certification of trials with CMS according to 13 standards
- October, 2007: CMS decided not to proceed with proposed revisions

ESAs: What's New

- The CMS NCD still stands
- FDA updated ESA labels (November 2007)
- Two new reports of negative outcomes in ESA studies (November/December 2007)
- Sponsors in continued talks with FDA, more label revisions possible
- ODAC meeting planned for first quarter of 2008* to review ESA safety data

*According to the FDA Web site, it appears this meeting will take place in March 2008.

FDA Label Changes: Synopsis

- 12 g/dL is now the “upper safety limit” for an ESA-treated Hb target
- Added language stating that ESAs have not been shown to improve symptoms of anemia, quality of life, fatigue, or patient well-being
- Do not use with “therapeutic biologic products” unless administering concomitant chemotherapy

FDA Label Changes: Synopsis (cont.)

Dosage and Administration

- OLD: “...the dose should be adjusted...to maintain the lowest Hb level sufficient to avoid the need for RCB transfusion and not to exceed 12 g/dL”
- **NEW**: “...the dose should be adjusted...to maintain the lowest Hb level sufficient to avoid the need for RBC transfusion and not to exceed *the upper safety limit of 12 g/dL*”

FDA Label Changes: Synopsis (cont.)

Dosage and Administration

- OLD: “If the rate of Hb increase is >1 g/dL per 2-wk period or when the Hb *exceeds 11 g/dL*, the dose should be reduced by 40% of the previous dose.”
- **NEW**: “If the rate of Hb increase is >1 g/dL per 2-wk period or when the Hb *reaches a level needed to avoid transfusion*, the dose should be reduced by 40% of the previous dose.”

FDA Label Changes: Synopsis (cont.)

Dosage and Administration

- **OLD:** If Hb >12 g/dL, ESA should be temporarily withheld until Hb *falls to 11 g/dL*. At this point, therapy should be reinitiated at a dose 40% below the previous dose.
- **NEW:** If Hb >12 g/dL, ESA should be temporarily withheld until Hb *approaches a level where transfusions may be required*. At this point, therapy should be reinitiated at a dose 40% below the previous dose.

ESAs: ASCO Activities

- Added language on FDA dosing changes into recent ASCO/ASH guideline
 - Available online and in print
- Ongoing dialogue relating to the implementation of the national coverage decision

Oncology Coding in 2008

- ICD-9-CM
- CPT
- HCPCS

NOTE: This information is not all inclusive; practices should check the coding books for additional new codes and/or changes.

ICD-9 Code Changes

Effective 10/1/07

- New codes and codes now requiring 5th digit
 - Anemia, aplastic, acquired 284.81
 - due to chronic systemic disease 284.89
 - drugs 284.89
 - infection 284.89
 - radiation 284.89
 - Anemia, aplastic, red cell (acquired) (adult) (with thymoma) 284.81
 - Anemia, aplastic, specified type NEC 284.89
 - Anemia, aplastic, toxic (paralytic) 284.89

ICD-9 Code Changes

- Anemia, hypoplasia, red blood cells 284.81
- Anemia, pure red cell 284.81
- Anemia, postoperative due to acute blood loss
285.1
- Anemia, postoperative, chronic blood loss 280.0
- Anemia, toxic 284.89

ICD-9 Code Changes

- Ascites 789.59
 - abdominal NEC 789.59
 - cancerous 789.51
 - malignant 789.51
- Complications
 - Chemotherapy (antineoplastic) 995.29
 - Drug NEC 995.29

ICD-9 Code Changes

- Complications
 - Infection and inflammation due to
 - catheter NEC 996.69
 - central venous 999.31
 - Hickman 999.31
 - peripherally inserted central (PICC) 999.31
 - triple lumen 999.31
- Disorder
 - bleeding 286.9

ICD-9 Code Changes

- * Lymphoma (malignant) 202.8
 - large B cell 202.8
 - large cell 200.7
 - anaplastic 200.6
 - mantle cell 200.4
 - marginal zone 200.3
 - extranodal B-cell 200.3
 - nodal B-cell 200.3
 - splenic B-cell 200.3
 - peripheral T-cell 202.7
 - Primary central nervous system 200.5
 - T-cell 202.1
 - peripheral 202.7

*lymphoma codes require 5th digit

ICD-9 Code Changes

- Neoplasms
 - 5th digit now required for many codes
 - Malignant Secondary
 - Malignant Ca in situ

HCPCS Code Changes

- **Codes of Interest (either new or revised)**
 - J1561 Immune globulin, (Gamunex), intravenous, nonlyophilized, 500 mg
 - J1562 Immune globulin, (Vivaglobin), 100 mg
 - J1566 Immune globulin, intravenous, lyophilized, not otherwise specified, 500 mg
 - J1568 Immune globulin, (Octagam), intravenous, nonlyophilized, 500 mg
 - J1569 Immune globulin, (Gammagard liquid), intravenous, nonlyophilized, 500 mg
 - J1571 Hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml

HCPCS Code Changes

- J1572 Immune globulin, (Flebogamma), intravenous, nonlyophilized, 500 mg
- J1573 Hepatitis B immune globulin (Hepagam B), intravenous, 0.5 ml
- J3487 Zoledronic acid (Zometa), 1 mg
- J3488 Zoledronic acid (Reclast), 1 mg
- J9306 Panitumumab, 10 mg (new code for Vecibix)
- J9226 Histrelin implant, 50 mg (Supprelin LA)

CPT Code Changes

- Medical Team Conferences (99366-99368)
 - Medical Team conference with interdisciplinary team of health care professionals with or without direct patient/family contact
 - Not separately payable by Medicare
 - Services are “bundled” as CMS believes these counseling services are covered by existing E & M services

CPT Code Changes

Non Face-to-Face Physician Services

- Telephone Services (99441-99443)
 - Services are considered “non-covered” by Medicare because
 - they are not face-to-face services and
 - contain language that would recognize services provided to individuals other than the beneficiary (which would not be covered by Medicare)
- On-Line Medicare Evaluation (99444)
 - Services are considered “non-covered” by Medicare for the same reasons listed above

CPT Code Changes

Non Face-to-Face Non-physician Services

- Telephone Services (98966-98968)
 - Services are considered “non-covered” by Medicare because
 - they are not face-to-face services and
 - contain language that would recognize services provided to individuals other than the beneficiary (which would not be covered by Medicare)
- On-Line Medical Evaluation (98969)
 - Services are considered “non-covered” by Medicare for the same reasons listed above

CPT Code Changes

Preventive Medicine Services

- CPT contains a new “Behavior Change Interventions” section
- Includes smoking and tobacco use cessation counseling (99406 & 99407)
 - Face-to-face codes
 - Services are covered by Medicare

Other Coding Issues

- Consultations
 - Reminder that follow up visits to a consultation are reported using established patient codes in the office/outpatient setting; subsequent hospital care codes in the inpatient setting
 - No further clarification from CMS regarding “transfer of care” and continues to be an area of confusion

Other Coding Issues

- Medical genetics counseling by a genetics counselor
 - 96040
 - Considered to be bundled by Medicare in 2007 and 2008 as CMS believes this counseling is covered by existing E & M services

New Drug Administration Services

- New administration codes for subcutaneous infusions
 - Codes to describe the administration of immune globulin into the subcutaneous tissues
 - Distinct services not related to intravenous infusions
 - New codes follow same structure of existing drug administration codes
 - Include an “initial” service, add-on code for each additional hour, and an add-on code for additional subcutaneous pump set-ups

Subcutaneous Infusion Codes (90769 – 90771)

- **90769** – Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)
 - An “initial” service code
 - Code not to be reported more than one time per encounter
 - Infusions of 15 minutes or less should be reported as subcutaneous or intramuscular injections with 90772

Subcutaneous Infusion Codes (90769 – 90771)

- **90770** – each additional hour
 - Add-on code
 - Reported when subcutaneous infusion is above and beyond one hour and 30 minutes
 - Reported in conjunction with 90769
- **90771** – additional pump set-up with establishment of new subcutaneous infusion site(s)
 - Add-on code
 - Reported in conjunction with 90769
 - To be reported for additional pump set-up
 - Not to be reported more than one time per encounter

Updates on Drug Administration Services

- Continued refinements to drug administration services in 2008
- Most changes made to assist facilities in reporting drug administration services
- The refinements provide clarification of
 - physician reporting versus facility reporting
 - a hierarchy of administration services so facilities can appropriately determine the “initial” service
 - Subsequent and sequential services

Updates on Drug Administration Services

- Some new language appears in the preamble of the hydration, therapeutic/diagnostic and chemotherapy administration sections
 - “These codes are not to be reported by the physician in the facility setting.”
- The facility reports the administration services when provided in the facility setting, not the individual physician

NOTE: If the services are performed in an office-based setting, then the individual physician would report the administration services

Updates on Drug Administration Services

- CPT provides language that clarifies the hierarchy of drug administration services
 - Language was added to provide specific guidance for facilities to assist in determining the “initial” service
 - Chemotherapy services are primary to therapeutic/diagnostic services which are primary to hydration services
 - Infusions are primary to pushes
 - Pushes are primary to injections
- Hierarchy does not apply to physician reporting!

Updates on Drug Administration Services

- New parenthetical notes added to clarify “subsequent” services
 - Administration services provided through the same intravenous line/access
 - Appear after add-on codes 90761, 90767, 90775
 - Also appear after initial chemotherapy administration code 96413
- Instructional note added after 90768 to clarify when concurrent code can be used

Updates on Drug Administration Services

- New parenthetical note for 90772
 - Can not report 90772 without direct physician supervision
 - Directs physicians to bill 99211
 - This may be stated coding policy; however, under Medicare a physician can not bill 99211 as an incident-to service without direct physician supervision
 - Facilities can report 90772 when the physician is not present

Updates on Drug Administration Services

- Code description for 90760 (first hour of hydration) was revised
 - Intravenous infusion, hydration; initial, 31 minutes to one hour
 - Intravenous hydration infusions of 30 minutes or less should not be reported

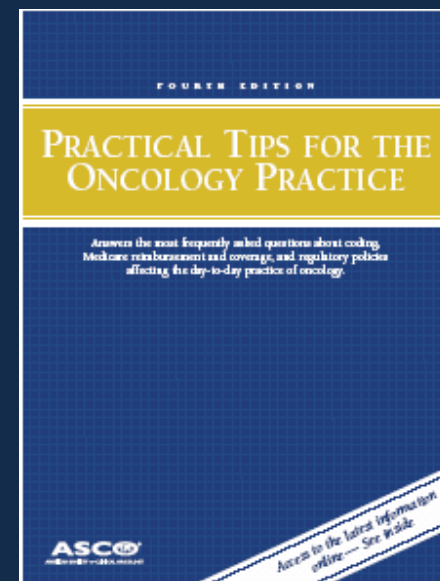
Note: This revision is specific to hydration services.

Updates on Drug Administration Services

- New sequential push code (90776)
 - Established to address reporting issues in the facility setting
 - Code can only be reported by facilities and is used only in the facility setting
- Used to report sequential intravenous pushes of the same substance or drug
- Add-on code
- Push of the same substance/drug must be 30 minutes apart in order to bill 90776

ASCO Resources

- *Practical Tips for the Oncology Practice, 4th Edition*
 - Detailed information about coding, billing, Medicare coverage guidelines
 - Includes excerpts from Medicare coverage manuals



ASCO Resources

- Ask a Coding Question
 - Call 703-299-1054 or
 - Email practice@asco.org
- *Cancer Policy Today*
 - E-newsletter for ASCO members; available by request for administrators
 - Email practice@asco.org

ASCO Resources

- *Journal of Oncology Practice*
 - Focus on Quality
 - Practical Tips
 - For Your Patients
 - Legal Corner
 - Research in Practice
 - Business of the Business
 - Original Research
- Manuscripts and letters to the editor may be sent to jopsubmissions@asco.org



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 - www.cms.hhs.gov/manuals/
- Drug pricing page
 - <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>