



FLORIDA SOCIETY OF CLINICAL ONCOLOGY FAX BLAST – November 7, 2007

LEGISLATIVE COMMITTEE UPDATE: Lowell Hart, MD, Chairman

This week, on behalf of FLASCO, Dr. Robert Cassell, President, has sent a letter to all US Congressmen encouraging them to support HJR 54 (Eshoo-Rogers) to help our patients with symptomatic chemotherapy induced anemia. Likewise, a similar letter was sent to our Two US Senators asking them to join Senators Burr, Dole, Hutchinson, Inhofe and Coburn in supporting SJR 22 (Baucus-Crapo) to help our patients with symptomatic chemotherapy induced anemia. Likewise, a communication was sent to all FLASCO members requesting that you write a similar letter to our two US Senators and to your local Congressman. A special thanks is extended to Dr. Gerald Robbins, FLASCO Vice President, for drafting these letters and for pursuing this very important FLASCO initiative.

CLINICAL PRACTICE COMMITTEE UPDATES: Thomas Gaddis, MD, Chm.

New J Codes effective January 1, 2008

New information from CMS around the new J codes recently issued to IGIV (non-lyophilized) or liquid products. A chart appears below. CMS had issued Q codes that will now be converted to permanent J codes. Until 12/31/2007, the current Q codes remain in effect. Gamunex(Q-4092), Octagam (Q-4087), Gammagard (Q-4088), Flebogamma (Q-4091)

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	Minimum Unadjusted Copayment
J1561	Gamunex Injection	NI	K	0948		32.06	6.41
J1562	Vivaglobin Injection		K	0804		7.01	1.40
J1568	Octagam injection	NI	K	0943		33.19	6.64
J1569	Gammagard liquid injection	NI	K	0944		31.06	6.21
J1572	Flebogamma injection	NI	K	0947		32.27	6.45

DRUG & INDUSTRY UPDATES

Ixempra for Metastatic or Locally Advanced Breast Cancer (Source: Michelle Smith Flowers (OMF))

For those of you waiting for pricing for Bristol Myers drug Ixempra for metastatic or locally advanced breast cancer, listed below are the Medicare allowables for both the 15mg kit and the 45mg. kit.

According to Medicare regulations the payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Drug Pricing file or Not Otherwise Classified Pricing files are based on 106 percent of the WAC, or invoice pricing if the WAC is not published. The allowance for the 15mg kit which includes the diluent will be \$977.28 (par) or \$928.41 (non-par), the allowance for the 45mg kit which includes the diluent will be \$2,9318.81 (par) or \$2,785.25 (non-par) and is only payable when used for the FDA indicated reasons.

Tasigna for Treatment of Philadelphia Chromosome Positive Chronic Myeloid Leukemia

The U.S. Food and Drug Administration (FDA) has approved Tasigna (nilotinib) capsules for treatment of Philadelphia chromosome positive chronic myeloid leukemia (CML) in adult patients whose disease has progressed on or who cannot tolerate other therapies that included imatinib. Imatinib (Gleevec) is approved for the treatment of new diagnosed patients with Philadelphia chromosome positive CML. FDA's approval of Tasigna includes a black box warning for possible life-threatening heart problems that may lead to an irregular heartbeat and possible sudden death.

ASCO UPDATES:

Four new ASCO Clinical Practice Guidelines

Four new ASCO Clinical Practice Guidelines are now available:

1. "Update of Recommendations for the Use of Tumor Markers in Breast Cancer,"
2. "Adjuvant Chemotherapy and Adjuvant Radiation Therapy for Stages I-III A Resectable Non-small Cell Lung Cancer Guideline."
3. "Update on the Use of Epoetin and Darbepoetin."
4. "Recommendations for Venous Thromboembolism Prophylaxis and Treatment in Patients with Cancer."

For more information, contact ASCO's Cancer Policy & Clinical Affairs Department at 703-299-1050 or guidelines@asco.org

ASCO Member Volunteers Needed

Applications for the ASCO Committee appointments for the terms beginning June 2008 will be accepted through December 2007. To be eligible for a committee appointment, **you must be an ASCO member.**

ASCO committees oversee specific activities and projects for the Society. Members serve on a rotating basis as volunteers on committees for which they have relevant experience. On every committee, a Chair Elect, a Chair, and an Immediate Past Chair each serve a consecutive one-year term. Committee members are limited to one three-year term (some committees have shorter terms), after which they may be re-appointed following a one-year break in service. Committees report to the Board of Directors and meet at least once a year.

[Brief descriptions of ASCO Committees](#) are available online to assist you in selecting Committees on which you would like to serve. Please note that seats on the Nominating Committee are filled as part of the annual ASCO election process; therefore, this Committee should not be included as one of the three on which you are interested in serving.

If you are interested in Volunteering to be considered to serve on an ASCO Committee for 2008, please visit their website at: www.asco.org and follow the links below:

Home> About ASCO> Board & Committees> Committee Volunteers

PLEASE CONSIDER VOLUNTEERING FOR AN ASCO COMMITTEE – IT WOULD BE GREAT TO SEE ADDITIONAL FLORIDA FLASCO MEMBER PARTICIPATION WITH ASCO.

ACCC UPDATES: Jeffrey Bubis, DO, FLASCO Liaison

2008 Final Hospital Hospital Outpatient Prospective payment System;

On Nov. 1, 2007, the Centers for Medicare & Medicaid Services (CMS) released the 2008 Final Hospital Outpatient Prospective Payment System (HOPPS) rule. ACCC is currently evaluating the rule and its impact for ACCC members. Key highlights include:

Drug Payments. CMS has lowered payment for separately paid drugs without pass-through status to ASP+5 percent. Further, the agency states that it believes that adequate payment for drugs is ASP+3 percent. Drugs with pass-through status will continue to be reimbursed at ASP+6 percent. For all drugs and biologicals with average per day costs less than \$60, CMS will package payment for the drug in with their administration payment; however, CMS will continue to make separate payment for anti-emetics.

Administration Payments. Some administration payments increased slightly; other administration payments decreased. ACCC is preparing a detailed look at these codes. CPT code 90768 (intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion) will remain a packaged service.

Pharmacy Costs and Overhead. Once again, CMS did not accept the three-phase plan for reporting pharmacy overhead costs that was put forward by ACCC, the APC Panel, and other key stakeholders. In addition, the agency will not require hospitals to remove pharmacy overhead costs from drug acquisition costs and report these costs in an uncoded revenue code line.

Quality Measures. Similar to this year, hospitals must report on 7 quality measures in order to receive the full market basket increase of 3.3 percent in 2008. Hospitals that do not report quality data will have their annual update reduced by 2 percentage points.

Increased Packaging or "Bundling." As proposed, CMS is increasing the number of services to be packaged in 2008. For more on the final HOPPS rule, go to ACCC's website.

On Nov. 1, 2007, the Centers for Medicare & Medicaid Services (CMS) released the 2008 Physician Fee Schedule (PFS) final rule. ACCC is currently analyzing the rule, which becomes effective Jan. 1, 2008. Key highlights include:

Physician Payments. The conversion factor will be set at \$34.0682, a 10.1 percent reduction from the 2007 level of \$37.8975. Congress could reverse this reimbursement cut through legislation, as it has done in the past. CMS continues to phase-in the new methodology for practice expense RVUs, which causes the practice expense RVUs for many services to change in 2008.

Off-label Drug Use. CMS does not revise the list of compendia used to determine covered off-label uses of drugs used in anticancer chemotherapeutic regimens. The final rule does, however, create a new process for considering requests for changes to the list. *DrugPoints®* was not specifically named a successor publication to USP-DI. This does not mean it will not be a successor publication, but the issue was not implicitly discussed in the final rule.

IVIG Payment. CMS will continue to pay for preadministration services for IVIG furnished in physicians' offices in 2008 at rates based on the practice expense RVUs established in 2007.

ESAs. CMS will provide implementing instructions for the new requirement to report hemoglobin or hematocrit levels for cancer patients receiving anti-anemia drugs.

Quality Reporting. The 2007 Physician Quality Reporting Initiative (PQRI) is extended for all of 2008. In addition, the rule designates the fund that will pay for the bonus payment.

For more on the final Physician Fee Schedule, go to ACCC's website.

With the release of the 2008 HOPPS final rule, hospitals face a decrease in drug payments to ASP+5 percent in 2008.

CMS UPDATES:

Release of 2008 Healthcare Common Procedure Coding System (HCPCS) code set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the “Alpha-Numeric HCPCS” list at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHPCPS/list.asp> . All changes are effective January 1, 2008, unless otherwise indicated in the effective date column.

Medicare Announces a New “Key” NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare Administrative Contractors (MACs), and DME MACs Using an Electronic Claim Form (ASC X12 837P) or Paper Claim Form (CMS-1500).

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a National Provider Identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully crosswalking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Medicare Informational Warnings to Those Who Are Not Submitting NPIs On Claims

Since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called “Provider Identification Code Qualifier Invalid Value” messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value. The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value. The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

The Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet (July 2007 version), which provides information about payment for physician services in teaching settings and general documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at <http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf>.

CORPORATE MEMBERSHIP/SPONSORSHIP: (January 1 – December 31, 2007)

FLASCO Members extends a big thanks to all of our 2007 Corporate Members/Sponsors

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FLASCO EVENTS:

November 9-10, 2007 – FLASCO Fall Meeting – Rosen Shingle Creek – Orlando

March 7-8, 2008 – FLASCO Spring Meeting – Tampa Airport Marriott Hotel

November 7-8, 2008 – FLASCO Fall Meeting – Tampa Airport Marriott Hotel

OTHER EVENTS:

The Florida Association of Pediatric Tumor Programs will hold its 30th Anniversary Annual Seminar at the Hyatt Regency Grand Cypress in Orlando from November 15-17, 2007. To register please visit the following Web Site: www.faptp.org

FLASCO Contact Information:

Dorothy Green Phillips, Executive Director - 3709 W. Jetton Ave., Tampa, Florida 33629
Tel: 800.444.1410, Ext. 4410 - Cell Phone: 813.294.2620 - Fax: 813.254.5857 or 813.349.4472
Email: Dorothy.Green@cancer.org