Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Letters to the Editor

John E. Harding

To cite this article: John E. Harding (1993) Letters to the Editor, Oncology Issues, 8:1, 6-6, DOI: 10.1080/10463356.1993.11904404

To link to this article: https://doi.org/10.1080/10463356.1993.11904404

Published online: 18 Oct 2017.

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Review and corrections

Articles will be reviewed by two or more editorial review board members. Authors will be informed of acceptance, rejection, or need for revision within 6 to 8 weeks, but at times longer delays may be unavoidable. All articles are subject to copy editing. Author corrections and revisions should be kept to a minimum and must be received within seven days of receipt; after this time, no further changes may be made by the author.

Articles should be submitted to: Managing Editor, *Oncology Issues*, 11600 Nebel St.,Suite 201, Rockville, MD 20852, 301/984-9496

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Authors will receive two free copies of the issue in which their article appears. Additional copies of *Oncology Issues* and/or the article are available upon request for a fee.

LETTERS TO THE EDITOR

Off-label Drug Use

The letters of Drs. Adamson and Wade in the Fall 1992 issue pinpoint the problem of off-label drug use. As a Medicare Carrier Medical Director, Dr. Adamson has the responsibility to determine the medical necessity of any service that his carrier is billed for. When there is no scientific evidence to justify the treatment, there is no justification for payment.

I hope Dr. Wade does not advocate approval of the use of any drug that any physician wishes to use under any circumstance. This flies in the face of quality health care, as well as cost-effective health care, and should not be acceptable to oncologists or third-party payers. There is a potential solution. In New York, our carrier uses the oncology society as a resource in determinations on off-label chemotherapeutics. This has resulted in a better understanding of the issues by both parties. Our carrier is able to make more accurate coverage decisions and oncologists understand (and often concur!) with our reasons for doing so.

There will never be a universal consensus, but reasonable people have a better chance of resolving a problem. Better communication, understanding the other party's position, and development of criteria for off-label coverage would seem the logical solution to this problem.

—John E. Harding, M.D., Medical Director, Upstate Medicare Division, Blue Shield of Western New York, Binghamton, NY.

James L. Wade, III, MD, Decatur (IL) Memorial Hospital and Chair of ACCC's Governmental Affairs Committee, responds:

I applaud Dr. Harding's suggestion that third-party payers work with state oncology societies to research and make recommendations on coverage decisions. My own state society, the Illinois Medical Oncology Society, has an excellent relationship with our insurers. We maintain an ongoing dialogue on difficult issues and the society is willing to review any issue with which our insurers would like assistance. The ACCC encourages the type of arrangement Dr. Harding describes and has assisted state societies, including all of the current ACCC chapter members, in setting up systems that assure a thorough and timely review. The societies see this as beneficial both to its members and the insurers in the state.

President's Corner

(Continued from page 4)

Will all interest in quality evaporate? No, but it will slide down the ladder for awhile. How else is the new Administration going to cut the budget deficit while it adds access? While the proposed cut in Medicare and Medicaid is $66.5 billion over five years, universal access could add between $30 and $90 billion each year to the federal budget!

What does all of this mean for oncology programs? Here are some initial guesses. First, the PO will attempt to deliver chemotherapy in the lowest cost way, with the maximum feasible control of expenditures. So, there will be significant interest in employing medical oncologists. Second, the PO will be interested in using primary care physicians for patient triage and to manage patient follow-up with guidelines for the follow-up interval and appropriate tests. Third, the PO will be interested in using highly trained nurses to supplement the oncologist in any way possible. POs will consider the shortage of oncologists and attempt to find ways to minimize their use. Freestanding radiation therapy centers will be perceived as an uncontrollable cost and will be replaced or purchased. New technology will be discouraged, unless it is more cost effective. Capital expenditures for any kind of new venture, new technology or upgrades are very likely to be discouraged in the near term when the price competition is going to be at its worst. Fourth, experimental procedures, unless they are fully reimbursed, are unlikely to be allowed. Patient satisfaction is likely to out pace typical physician satisfaction interests. Minimum care is likely to be the byword. Guidelines will be necessary to assure that malpractice is abrogated.

Doesn't sound like the old system at all does it?

As times change, we must change. But we must also hold true to our basic standards for quality cancer patient care.

Robert T. Clarke, M.H.A.