NJSOM MISSION STATEMENT

NJSOM is committed to keeping our members informed through quarterly educational conferences, networking, and continuous updates to our website. As part of our responsibility we strive to create an environment of constant learning and improvement in the Oncology/Hematology arena. NJSOM works hard to foster a network of growth, support and collaboration among our members.

NJSOM is committed to the highest standards of ethics and integrity and strongly believes that we are responsible to our members, stakeholders, and to the community we serve. We believe that through education and commitment, NJSOM can improve the practice of Oncology in the State of New Jersey and subsequently improve the lives of cancer patients and their families.

This Newsletter is made possible by support from:

Oncology Supply
AmerisourceBergen Specialty Group

New Jersey Society of Oncology Managers
P.O. Box 95
Florham Park, New Jersey 07932

Phone: 800.658.5011
E-mail: info@njsom.org

NJSOM
New Jersey Society of Oncology Managers

Reimbursement E-News ISSUE: 54 May 2017

Welcome to this Publication of the Monthly Newsletter!!

The ***New Jersey Society of Oncology Managers Reimbursement E-News*** is a monthly publication focused on the latest reimbursement news for your Oncology Practice. You can scroll through the document a page at a time or you can use the links along the bottom to assist in quick navigation.

Please feel free to submit any questions, comments, suggestions, stories and/or questions to Michelle Weiss, editor, at Michelle@weissconsulting.org

Report Calls for Adding Shared Decision Making to CMS' Oncology Care Model

A new report published by the Urban Institute suggests that CMS' Oncology Care Model (OCM) could be substantially improved by incorporating a formal framework for shared decision making (SDM) between patients and oncologists. Read the full article in AJMC here.

Republicans finalize new Obamacare repeal proposal

The White House, top House conservatives and a key moderate Republican have finalized a new Obamacare repeal and replace plan they hope will break a month-long logjam on a key priority for President Donald Trump. READ MORE

Clinical Laboratory Fee Schedule 60 Day Reporting Extension

Under the new private payer, rate-based Medicare Clinical Laboratory Fee Schedule (CLFS), entities are required to report applicable laboratory data to CMS by March 31, 2017. Industry feedback indicates many reporting entities will not be able to submit a complete set of applicable information to CMS by the March 31, 2017 deadline and these entities require additional time. CMS is adopting a 60-day enforcement discretion period (through May 30, 2017) to provide additional reporting item for these entities. To see the announcement, CLICK HERE.

Front Page News | Novitas Solutions Inc. | CMS Medicare | Other Payer Updates | Other News | Patient Assistance | Frequently Asked Questions

Front Page News

The Process of Prior Authorization

Change Request (CR) 9940 (revised) updates the Centers for Medicare & Medicaid Services Program Integrity Manual permitting MACs to conduct prior authorization processes as directed through individualized operational instructions. Make sure your billing staff is aware of these changes. READ MORE

SAVE THE DATE

June 22-23, 2017

NJSOM Annual Conference

Water Club Atlantic City NJ

1 Borgata Way
Atlantic City, NJ 08401

October 20, 2017
8:30AM-4:30PM

NJSOM Conference

Hyatt Regency Princeton

102 Carnegie Center
Princeton, New Jersey, USA, 08540
Tel: +1 609 987 1234

For more information…CLICK HERE

Attention New Jersey Licensed Clinical Laboratory Owners and Directors:

On January 9, 2017, Governor Christie signed P.L.2016, Chapter 86 Senate, No. 976 enacted by the New Jersey Senate and Assembly that revised certain sections of the New Jersey Clinical Laboratory Improvement Act (Act), N.J.S.A. 45:9-42.26 et seq. the statute that authorizes the Department of Health to promulgate rules for the operation of clinical laboratories at N.J.A.C. 8:44-2.1 et seq.

In response to the adoption of P.L.2016, Chapter 86 Senate, No. 976, the New Jersey Department of Health's Clinical Laboratory Improvement Services (CLIS) is issuing this guidance memorandum to explain this new law, its requirements, and what is being implemented by the New Jersey Department of Health (NJDOH) immediately to comply pending official changes to the rules at N.J.A.C. 8:44-2.1 et seq. The guidance is attached.

Please review the P.L.2016, Chapter 86 Senate, No. 976 at http://www.njleg.state.nj.us/2016/Bills/PL16/86_.HTM care fully to ensure your laboratory's compliance. If you have any questions or comments please e-mail joan.mikita@doh.nj.gov. and be sure to list your CLIS ID# and name of your laboratory.

Joan Mikita, M.S.
Manager, NJ State Licensure/PT Review Program
New Jersey Department of Health, Clinical Laboratory Improvement Services, Public Health and Environmental Laboratories
PO Box 361, Trenton, NJ 08625-0361, Phone: 609-406-6830
www.nj.gov/health/phel/clinical-lab-imp-services

Novitas Solutions Inc.

NJSOM
New Jersey Society of Oncology Managers

Novitas Self-Service Tools

View all Self-Service Tools

Home Prothrombin Time/International Normalized Ratio Monitoring for Anticoagulation Management

Please read our article on physician billing for the review, interpretation, and patient management of home Prothrombin Time (PT)/International Normalized Ratio (INR) monitoring for anticoagulation management (G0250). READ MORE

Incorrect Payment Reduction Values Reported on Remittances

Payment reduction values were reported incorrectly on remittances for claims processed from January 1, 2017 through February 9, 2017. For details, please review our article. READ MORE

Automated Claim Correction Changes

Effective May 4, 2017: Claim corrections which cannot be processed via Novitasphere or Interactive Voice Recognition will need to be submitted using the Part B Redetermination and Clerical Error Reopening Request Form. Please review our article for further information. READ MORE

Frequently Asked Questions (FAQs)

Have questions and not sure where to turn? Check out our FAQs for answers to your questions. READ MORE

Are You Ready for the Social Security Number Removal Initiative?

We have created an article to help you prepare for the upcoming changes to the Medicare beneficiary's Health Insurance Claim Number. READ MORE

New Medicare Insights Podcast now available

In this Medicare Insights Podcast episode, we encourage our listeners to subscribe to our email lists and stay up-to-date on Medicare news. READ MORE

Novitas Solutions Inc.

Oncology Related Medical Policy

The following JL Local Coverage Determinations have been revised:

- Intravenous Immune Globulin (IVIG) (L35093)

The following JL Local Coverage Articles have been revised:

- NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

Part B Top Claim Submission / Reason Code Errors

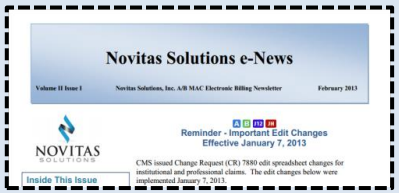
The Top Claim Submission / Reason Code Errors and resolutions for March 2017 are now available. Please take time to review these errors and avoid them on future claims. READ MORE

Part B Top Inquiries Frequently Asked Questions (FAQs)

Our Part B Top Inquiries FAQs have been reviewed for March 2017. Please take time to review these FAQs for answers to your questions. READ MORE

Novitas Solutions e-News Electronic Billing Qtly Newsletter

Current Qtly Issue Available … CLICK HERE



Medicare Part B - H O T L I N K S !

Medicare JL Part B Fee Schedule
2017 Physician Fee Schedule Final Rule
2017 Physician Fee Schedule Final Rule Fact Sheet
Current Active Part B LCD Policies
Quarterly Update to CCI Edits
Current Average Sales Price (ASP) Files

On-Demand Education

- Weekly Audio Podcasts
- Training Modules
- Medicare Reference Manual
- Specialty Guides
- Acronyms & Abbreviations
- Frequently Asked Questions
- Evaluation & Management (E/M) Center
- Comprehensive Error Rate Testing (CERT) Center

CMS Education

- Open Payments (Physician Payments Sunshine Act)
- Medicare Learning Network
- National Provider Training Program
- Internet-Only Manual
- Provider Specialty Links
- Safeguarding Your Medical Identity

State of New Jersey
Department of Human Services

Information for Providers:

- Provider Resources
- Medicaid Managed Care Contract
- Dual Eligible Special Needs Plan Contract
- Accountable Care Organizations
- Public Notices
- New Jersey Medicaid State Plan

Novitas Solutions Inc.

Listed are Novitas training events an oncology practice should consider!

DATE	TIME	EVENT	LOCATION
5/5/17	8:00a-11:00a	Accuracy Matters – J.C. Blair Memorial Hospital in Huntingdon, PA	In Person
5/5/17	11:00a-12:00p	Hydration and Infusion Therapy Services **IMPORTANT**	Webinar
5/9/17	8:00a-4:30p	2017 Novitas Solutions Medicare Symposium -Camp Hill, PA	In Person
5/11/17	8:00a-4:30p	2017 Novitas Solutions Medicare Symposium - Monroeville, PA	In Person
5/12/17	11:00a-12:00p	Novitasphere Provider Portal Enrollment Overview	Webinar
5/15/17	9:00a-12:00p	Accuracy Matters - Allentown, PA	In Person
5/17/17	2:00p-3:00p	Novitasphere Claim Submission Overview	Webinar
5/18/17	10:00a-11:00a	JL Part B Ask-the-Contractor	Webinar
5/23/17	11:00a-12:00p	Novitasphere Claim Correction Overview	Webinar
5/25/17	10:00a-11:00a	Part B How to Avoid Top Claim Errors - Second Quarter 2017	Webinar
5/25/17	2:00p-3:00p	Novitasphere Hot Topics and Frequently Asked Questions	Webinar
5/31/17	9:30a-12:30p	Accuracy Matters - Edison, NJ	In Person
5/31/17	2:00p-3:00p	Novitasphere Claim Correction Overview	Webinar

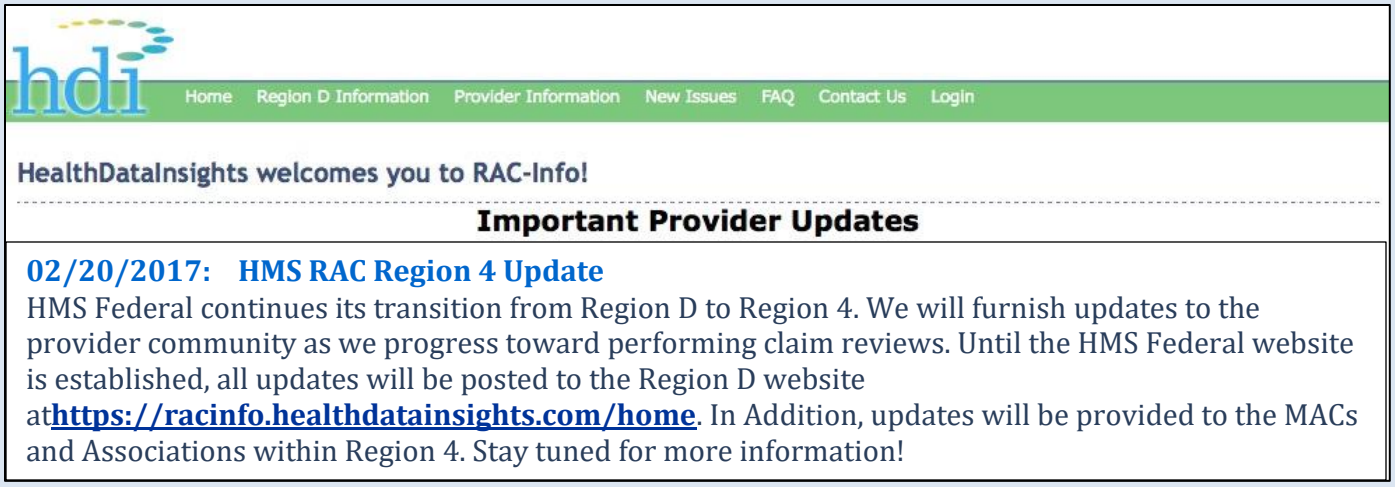
CLICK HERE

to access the educational area of the Novitas website!

CMS Medicare

REGION 4 RAC – HMS Federal Solutions

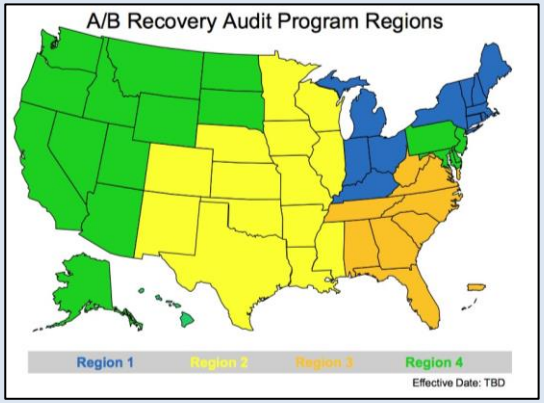
Temporarily all information found on HDI website



To visit the website CLICK HERE

October 31, 2016 – CMS has awarded the next round of Medicare Fee-for-Service Recovery Audit Contractor (RAC) contracts to:

Region 1 – Performant Recovery, Inc.
Region 2 – Cotiviti, LLC
Region 3 – Cotiviti, LLC
Region 4 – HMS Federal Solutions
Region 5 – Performant Recovery, Inc.



Grassley Drops Gloves on Alleged Medicare Advantage System Gaming

By Mark Spivey – A powerful U.S. Senator is demanding answers regarding the perceived ineffectiveness of Centers for Medicare & Medicaid Services (CMS) efforts to address apparently sizeable overpayments to Medicare Advantage plans. READ MORE

RAC Monitor continued on next page…

CMS Medicare

Who's Auditing the RACS?

By Ronald Hirsch, MD, FACP, CHCQM

The first five years of the Recovery Audit Contractor (RAC) audit program created nightmares for many in the provider community. Deadlines were routinely missed at every step of the way. The appeal backlog at the Administrative Law Judge (ALJ) level exceeded three years and does not seem to be getting any better. Read the full story »

*****

Field Report: OIG Compliance Program Effectiveness Guide

By Nancy J. Beckley, MB, MBA, CHC

Indeed, it was another "Dantastic" Monday as Inspector General Dan Levinson took the podium to deliver the keynote at the 21st Annual Compliance Institute in National Harbor, Maryland. Read the full story »

*****

Participant Describes Role in Recent HCCA OIG Roundtable

By Donna Thiel, CHC

EDITOR'S NOTE: Donna Thiel, former chief compliance officer and now director of the ProviderTrust compliance integrity division, participated in a roundtable conducted by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). Read the full story »

IMPORTANT

MIPS Participation Status Letter Being Sent to Practices

CMS is reviewing claims and letting practices know which clinicians need to take part in MIPS. In late April through May, more than 200,000 practices will get a letter from their MAC. This letter will tell the participation status of each NPI for qualifying clinician associated with the TIN in a practice, based on Medicare participation during the period from September 2015, through August 2016. (Please note, this is a sample letter and clinicians will receive individualized letters.) For clinicians participating under multiple TINs, a separate notification will be sent to reflect each TIN.

CMS is advising clinicians to use the letters to determine if they will participate in the program as a group on individual, noting that the participation status based on the low volume threshold may change based on group versus individual participation. Others who are exempt from participation will include newly enrolled Medicare providers and those participating in advanced alternative payment models. To see a sample of the letter, CLICK HERE.

CMS Medicare

2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 thru 31

On May 1, 2017, CMS will begin accepting Notices of Intent to Apply (NOIA) for the January 1, 2018 start date. You must submit a NOIA if you intend to apply to the Medicare Shared Savings Program, Skilled Nursing Facility 3-Day Rule Waiver, and/or Medicare Accountable Care Organization Track 1+ Model. NOIA submissions are due no later than May 31, 2017 at noon ET.

A NOIA submission does not bind an organization to submit an application; however, you must submit a NOIA to be eligible to apply. See the NOIA Guidance Document and How to Apply webpage for eligibility requirements and detailed instructions on the submission process.

MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30

The registration period for groups who choose CMS Web Interface or Consumer Assessment of Health Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey as their data submission method is April 1 through June 30, 2017.

- For individual or group participation, registration is not required for any other submission method
- If your group registered for the Group Practice Reporting Option Web Interface in 2016, you are automatically registered to use the CMS Web Interface in 2017

For More Information:

- Quality Payment Program website
- CMS Web Interface and CAHPS for MIPS Survey Registration Guide
- MIPS: CMS Web Interface Fact Sheet
- CAHPS for MIPS Survey via CMS-Approved Survey Vendor Reporting Fact Sheet

Medicare Shared Savings Program Call: Audio Recording and Transcript

An audio recording and transcript are available for the April 6 call on the Medicare Shared Savings Program. During this call, find out how to prepare to apply for the January 1, 2018, program start date, including the Medicare Accountable Care Organization Track 1+ Model and Skilled Nursing Facility 3-Day Rule Waiver.

Save the Dates:
ASCO QPP/MIPS Educational Webinars on Quality Reporting

The Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act (MACRA), launched in January 2017 and is being implemented in oncology practices across the country. 2017 is a transition year, but practices still have to report some quality data in order to avoid financial penalties in 2019. This transition year offers practices an opportunity to test the QPP reporting system before 2018, when quality reporting will require a significantly heavier lift to avoid financial penalties in 2020. Does your practice have a plan in place to successfully navigate QPP over the next few years?

As your partner in practice transformation, ASCO is releasing a series of webinars to guide oncology practices to successful quality reporting:

- Monday, May 15 - Quality Payment Program: Scoring the Quality Measures
- Monday, June 19 - Quality Payment Program: Scoring for Advancing Care Information and Improvement Activities
- Monday, July 10 - Quality Payment Program: Optimizing your MIPS Score

All webinars are scheduled for 4:00 PM ET. Registration is open now.

More QPP resources and updates are available in ASCO's online MACRA and QPP toolkit at www.asco.org/macra. Visit ASCO in Action for all the latest cancer policy news.

New Quality Payment Program Resources Available

Learn more about Merit-based Incentive Payment System (MIPS) participation and the Improvement Activities Performance Category. CMS recently posted three new resources to the Quality Payment Program Educational Resources webpage to help clinicians successfully participate in the first year of the program:

- MIPS Participation Fact Sheet: Who is eligible to participate in MIPS, and how clinicians might be able to participate voluntarily in the program
- MIPS Improvement Activities Fact Sheet: Choosing and submitting improvement activities, reporting criteria, and scoring
- 2017 CMS-Approved Qualified Registries: Qualified registries that will be able to report data for the Quality, Advancing Care Information, and Improvement Activities performance categories in 2017

For More Information:

- Visit the Quality Payment Program website
- Contact the Quality Payment Program at QPP@cms.hhs.gov, or 866-288-8292 (TTY 877-715- 6222), Monday through Friday, 8 am to 8 pm ET

CMS Medicare

Next Generation ACO – All Inclusive Population Based Payment Implementation MLN Matters Article

An MLN Matters Special Edition Article on Next Generation Accountable Care Organization (ACO) – All Inclusive Population Based Payment Implementation is available. Learn about alternate payment mechanism for certain services for Medicare beneficiaries.

Updated Advance Beneficiary Notice

In March 2017, the Office of Management and Budget approved the Advance Beneficiary Notice (ABN) (Form CMS-R-131) for another 3 years. There are no changes to the form, except the new expiration date of March 2020. Starting June 21, 2017, you must use the most recent version of the CMS-R-131 to deliver a valid ABN; however, you may begin using the new form immediately. For more information, visit the FFS ABN webpage.

Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course

With Continuing Education Credit A new Quality Payment Program in 2017: Pick Your Pace Web-Based Training course is available through the Learning Management System.

Learn:

- If your medical practice needs to participate
- How to participate
- How to pick a pace in the program

Comparative Billing Report on Transitional Care Management Webinar — June 21

Wednesday, June 21 from 3 to 4 pm ET
Join us for a discussion of the comparative billing report on Transitional Care Management (TCM) (CBR201704), an educational tool for providers who submit claims for TCM services for Medicare beneficiaries using Current Procedural Terminology (CPT®) codes 99495 and 99496. During the webinar, providers interact directly with content specialists and submit questions about the report. See the announcement for more information and find out how to participate.

CMS Medicare

Advocacy Groups Urge MedPAC to Reconsider Medicare Part B Proposal

(ASCO in Action) Apr 18, 2017 - ASCO recently joined more than 180 patient and provider advocacy groups in signing a letter to the Medicare Payment Advisory Commission (MedPAC), urging the congressional advisory group to reconsider proposed changes to Medicare Part B drug reimbursement. READ ARTICLE

Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Revised

A revised Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet is available. Learn about:

- Payment for physician services in teaching settings
- General documentation guidelines
- Evaluation and Management (E/M) documentation guidelines
- Exception for E/M services furnished in certain primary care centers

Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised

With Continuing Education Credit A revised Diagnosis Coding: Using the ICD-10-CM Web-Based Training course is available through the Learning Management System. Learn about:

- International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) coding tips, information, and resources
- ICD-10-CM structure, format, and features
- How to find correct ICD-10-CM codes

Open Payments Call: Audio Recording and Transcript

An audio recording and transcript are available for the April 13 call on Open Payments: Prepare to Review Reported Data. During this call, find out how to access the Open Payments system to review the accuracy of the data submitted about you before it is published on the CMS website.

CMS Medicare

Provider Compliance Products Fact Sheet — Revised

A revised Provider Compliance Products Fact Sheet is available. Learn:

- How to avoid common billing errors and other erroneous activities when dealing with the Medicare Program
- Provider-specific compliance tips

Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 3] Educational Tool

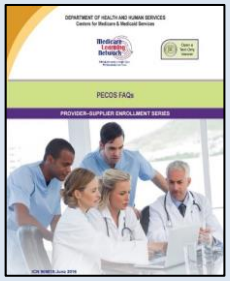
A new Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 3] Educational Tool is available. Learn about:

- How to avoid common billing errors and other erroneous activities
- How to address and avoid the top issues of this quarter

PECOS FAQs Booklet — Reminder

The PECOS FAQs Booklet is available. Learn about:

- Information you need before you begin enrollment via the Provider Enrollment, Chain and Ownership System (PECOS)
- Enrollment application issues
- Revalidations



Questions about Medicare Enrollment Revalidation?

What's ahead for your next Medicare enrollment revalidation? View CMS resources to help you stay on top of the process every step of the way:

- MLN Connects® Video slideshow
- Frequently Asked Questions
- Revalidations website
- Find Your Revalidation Due Date

PECOS for Physicians and Non-Physician Practitioners Booklet — Reminder

The PECOS for Physicians and Non-Physician Practitioners Booklet is available. Learn about:

- Enrollment application submission options for the Provider Enrollment, Chain and Ownership System (PECOS)
- How to complete an enrollment application
- User ID and password helpful hints

Administrative Simplification: New Fact Sheet and Infographic

Administrative Simplification standards apply to entities who exchange health care information electronically, including health plans, health care providers, and clearinghouses. New CMS resources:

- Fact sheet explains how these standards streamline day-to-day tasks like billing; verifying patient eligibility; and sending and receiving payment
- Infographic explains how health care providers can streamline paperwork

CMS Medicare

CMS New Mailbox Announcement

Effective April 13, 2017, questions regarding any of the Fee For Service Beneficiary Notice Initiative (BNI) notices may be sent to our new mailbox: BNImailbox@cms.hhs.gov.

The BNI notices are FFS Advance Beneficiary Notice of Noncoverage (FFS ABN), FFS Hospital-Issued Notices of Noncoverage (FFS HINNs), and more. There is an exception for the Medicare Outpatient Observation Notice (MOON). Continue to send questions regarding the MOON to MOONMailbox@cms.hhs.gov.

Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement

GAO-17-290, March 10

- Report: http://www.gao.gov/products/GAO-17-290
- Highlights: http://www.gao.gov/assets/690/683314.pdf

HHS's Price Urges Doctors to Submit Ideas for Medicare Pay Models

April 13, 2017 - Doctors should step up and recommend more payment alternatives to fee-for-service Medicare, the HHS secretary said April 11.

Read the full article on Bloomberg here.

CMS Proposes 2018 Payment and Policy Updates for Medicare Hospital Admissions, Releases a Request for Information

Proposed rule seeks transparency, flexibility, program simplification and innovation to transform the Medicare program.

- Full text of this excerpted CMS press release (issued April 14)
- CMS fact sheet

Recent LearnResource & MedLearn Matters Articles

- Implementation of New Influenza Virus Vaccine Code
- Improvements to the Adjudication Process of Serial Claims
- Next Generation Accountable Care Organization (NG ACO) - All Inclusive Population Based Payment (AIPBP) Implementation
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.2, Effective July 1, 2017
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.2, Effective July 1, 2017
- April 2017 OPPS Pricer File
- New Waived Tests
- July 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revision to Prior Quarterly Pricing Files
- Provider Enrollment Revalidation - Cycle 2

Horizon Payer Updates

Recent Horizon Articles that may be of interest to an oncology practice

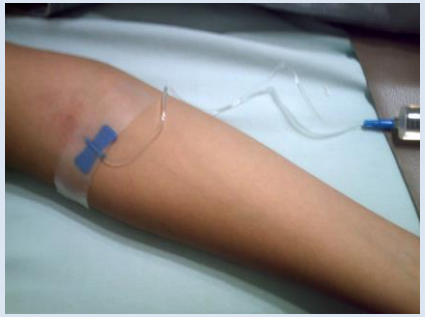
Quarterly Update to Injectable Medication Fee Schedule: Q3 2017

Horizon Blue Cross Blue Shield of New Jersey will update our fee schedule for injectable medications on August 1, 2017. SEE THE LIST AND READ MORE

ONCOLOGY RELATED MEDICAL POLICY UPDATES

- NEW - Olaratumab (Lartruvo)
- NEW - Fulvestrant (Faslodex)
- REVISED - Granulocyte Colony Stimulating Factor (G-CSF - Neupogen, Neulasta, Granix, Zarxio) and Granulocyte-Macrophage Colony Stimulating Factor (GM-CSF - Leukine)
- REVISED - Omalizumab (Xolair)

Medical Injectables Program Updates: Additional Medications and INFLECTRA



As previously announced, effective May 1, 2017, additional injectable medications will be included as part of our Medical Injectables Program (MIP) administered by Magellan Rx Management[SM].
READ MORE

Medical Policy Revision: Computer-Aided Evaluation of Malignancy with MRI of the Breast

Effective **August 1, 2017**, Horizon Blue Cross Blue Shield of New Jersey will change the way we consider claims for the use of computer-aided evaluation (CAE) for interpretation of magnetic resonance imaging (MRI) of the breast. READ MORE

Other Payer Updates

AmeriHealth.

Four drugs added to the Dosage and Frequency Program

Effective May 5, 2017, vedolizumab (Entyvio®), octreotide acetate (Sandostatin® LAR Depot), ustekinumab (Stelara®), and omalizumab (Xolair®) will be added to the AmeriHealth Dosage and Frequency Program. Medical policies for each of these drugs already include the dosage and frequency requirements. READ MORE

AmeriHealth.

Updated policy on Modifier 25 reporting and reimbursement

Posted May 1, 2017 - AmeriHealth has updated its policy on Modifier 25 reporting and reimbursement. Claim Payment Policy #03.00.06n: Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service was posted as a Notification on May 1, 2017, and will go into effect **August 1, 2017**.

As part of the update, there are two scenarios outlined within the policy where a payment **reduction of 50 percent** will be applied to certain services when appropriately billed with Modifier 25. This applies to all professional Modifier 25 claim submissions with a date of service on or after August 1, 2017, that fall into these two scenarios: READ MORE

AmeriHealth.

Updated Claims Resolution Matrices Now Available

Posted April 12, 2017 - The Claims Resolution Matrix is to be used as a reference tool to troubleshoot rejected institutional and professional claims that have been submitted electronically (i.e., submitted via 837I/837P transaction). READ MORE

AmeriHealth.

NaviNet® Claim Investigation: Best Practices When Submitting A Claim Review Request

Posted April 10, 2017 - When using the Claim Investigation Submission transaction on the NaviNet web portal, please be specific when describing the reason for the claim review. Note: You must first perform a Claim Status Inquiry to locate the claim. A detailed user guide is available in the NaviNet Resources section. READ THE STEPS

Notice NJSOM Members…

If there is a specific Payer you would like included in this newsletter, please email the editor, Michelle Weiss at Michelle@weissconsulting.org

Other Payer Updates

NJSOM
New Jersey Society of Oncology Managers

NEW!

UnitedHealthcare
NetworkBulletin
An important message to health care professionals and facilities
Please route as appropriate to UnitedHealthcare contracted physicians and health care professionals in your office.

A Few Articles You Won't Want to Miss:

- **Front & Center**
  - New and Enhanced Link Apps
  - New Prior Authorization and Notification App Launching on Link
  - Revisions to Evaluation and Management Policy
  - UnitedHealthcare Commercial and Medicare Advantage Claims Editing System Is Being Upgraded
- **UnitedHealthcare Commercial**
  - UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates
- **UnitedHealthcare Commercial Reimbursement Policies**
  - Procedure and Place of Service Policy Revision
- **UnitedHealthcare Community Plan**
  - UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates
- **UnitedHealthcare Medicare Solutions**
  - UnitedHealthcare Medicare Advantage Plan Reimbursement Policies – New Procedure to Modifier Policy
- **UnitedHealthcare Affiliates**
  - Oxford Medical and Administrative Policy Updates

And Much More…
MAY Monthly Issue Available HERE

NEW!

UnitedHealthcare
Medical Policy Update
Bulletin
Medical Policy, Drug Policy & Coverage Determination Guideline (CDG) Updates

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates
- Revised:
  - Genetic Testing - Effective May 1, 2017

Medical Benefit Drug Policy Updates
Updated:
- Actemra® (Tocilizumab) Injection for Intravenous Infusion - Effective May 1, 2017.
- Orencia® (Abatacept) Injection for Intravenous Infusion - Effective May 1, 2017
- Simponi Aria® (Golimumab) Injection for Intravenous Infusion - Effective Jun. 1, 2017
- Stelara® (Ustekinumab) - Effective Jun. 1, 2017

Revised:
- Entyvio® (Vedolizumab) - Effective Jul. 1, 2017
- Lemtrada (Alemtuzumab) - Effective Jun. 1, 2017
- Oncology Medication Clinical Coverage Policy - Effective Jun. 1, 2017
- Spinraza™ (Nusinersen) - Effective May 1, 2017

Utilization Review Guideline Updates
Revised:
- Site of Service Guidelines for Certain Outpatient Surgical Procedures - Effective Jul. 1, 2017

MAY Monthly Issue Available HERE

aetna℠

A Few Articles You Won't Want to Miss:

- Updates to our national participating provider precertification list
- Proposed updates to 2018 Aexcel program
- How to add providers to the network
- How to update data about your office
- Coverage determinations and UM
- Use our new form for Medicare member authorization appeals
- ABNs aren't valid for Medicare Advantage members
- Changes to commercial drug lists begin on July 1, 2017

And Much More….
MARCH
Mid-America Region
Qtly Issue Available HERE

Other News

DRUG SHORTAGES –

If you are looking for a complete list of Drug Shortages from the FDA CLICK HERE.

RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- FDA granted accelerated approval to durvalumab (IMFINZI, AstraZeneca UK Limited) for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or who have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. More Information. May 1, 2017

- FDA granted accelerated approval to brigatinib (ALUNBRIG tablets, Takeda Pharmaceutical Company Limited, through its wholly owned subsidiary ARIAD Pharmaceuticals, Inc.) for the treatment of patients with metastatic anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib. More Information. April 28, 2017

- FDA approved midostaurin (RYDAPT, Novartis Pharmaceuticals Corp.) for the treatment of adult patients with newly diagnosed acute myeloid leukemia (AML) who are FLT3 mutation-positive (FLT3+), as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. More Information. April 28, 2017

- FDA expanded the indications of regorafenib (STIVARGA, Bayer HealthCare Pharmaceuticals Inc.) to include the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib. More Information. April 27, 2017

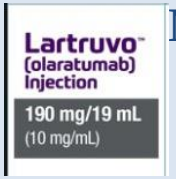
- FDA approved Renflexis (infliximab-abda) for multiple indications. Renflexis is administered by intravenous infusion. This is the second FDA-approved biosimilar to U.S.-licensed Remicade. For more information, see the approval letter and the labeling at Drugs@FDA. April 21, 2017

- FDA has granted Genentech's Tecentriq (Atezolizumab) Accelerated Approval as Initial Treatment for Certain People with Advanced Bladder Cancer. First and only cancer immunotherapy approved in advanced bladder cancer as initial treatment for those unable to receive cisplatin chemotherapy. More Information. April 17, 2017

- FDA has granted marketing authorization to ipsogen JAK2 RGQ PCR Kit, manufactured by QIAGEN GmbH., to detect mutations affecting the Janus Tyrosine Kinase 2 (JAK2) gene. This is the first FDA-authorized test intended to help physicians in evaluating patients for suspected Polycythemia Vera (PV). More Information. March 27, 2017

Other News

New Vial Size - LARTRUVO (olaratumab) injection, 10 mg/mL solution



Starting the week of March 6, 2017, a new smaller vial size for LARTRUVO was made available. In addition to the 500 mg/50 mL vial, this 190 mg/19 mL vial can reduce waste by an average of 88% compared with the 500 mg/50 mL vial alone. Please visit CLICK HERE for more information.

FDA News - ESA Risk Evaluation and Mitigation Strategy (REMS) - No Longer Necessary

In 2017, the FDA determined that the ESA Risk Evaluation and Mitigation Strategy (REMS), which was limited to the use of Epogen/Procrit and Aranesp to treat patients with anemia due to associated myelosuppressive chemotherapy is no longer necessary to ensure that the benefits of Epogen/Procrit and Aranesp outweigh its risks of shortened overall survival and/or increased risk of tumor progression or recurrence in patients with cancer. READ MORE

65 Products That Are Fraudulently Claiming to Prevent, Diagnose, Treat or Cure Cancer

The FDA has issued warning letters addressed to 14 U.S companies illegally selling more than 65 products that are fraudulently claiming to prevent, diagnose, treat or cure cancer. The products are marked and sold without approval by the FDA and can be seen through various websites and social media channels. The products have not be reviewed by the FDA for safety and efficacy and can be dangerous. CLICK HERE to see the list of illegally sold cancer treatments.

COA Lauds the Introduction of the Prescription Drug Price Transparency Act

(Targeted Oncology) Apr 18, 2017 - Representative Doug Collins (R, Georgia) has proposed a bill that would increase the transparency of payment methodologies to pharmacies. READ ARTICLE

COA White Paper Exposes Delay, Waste, and Cancer Treatment Obstacles Imposed on Patients by Pharmacy Benefit Managers

(COA) Apr 27, 2017 - A new white paper released today by the Community Oncology Alliance (COA) and the Community Oncology Pharmacy Association (COPA) exposes the negative impact pharmacy benefit managers (PBMs) have on the care cancer patients receive. READ PRESS RELEASE

ASCO Opposes Payer Utilization Management Approaches that Curb Access to High-Quality, High-Value Cancer Care

(ASCO) Apr 18, 2017 - The American Society of Clinical Oncology (ASCO) opposes payer-imposed utilization management policies that restrict patient access to high-quality, high-value cancer care. READ PRESS RELEASE

Patient Assistance

THE MERCK ACCESS PROGRAM

KEYTRUDA (pembrolizumab) Injection 100 mg

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Contact The Merck Access Program Mon-Fri at **855-257-3932**

Ask to be contacted by a Reimbursement Associate by calling **855-257-3932**

THE MERCK PATIENT ASSISTANCE PROGRAM

The Merck Access Program representatives can refer patients to the Merck Patient Assistance Program.

Who is the program for?

Patients who do not have insurance or whose insurance does not cover KEYTRUDA may be eligible for free product, including product replacement, from the Merck Patient Assistance Program if they meet certain financial and medical criteria.

For more information on the program's eligibility requirements, please visit **www.merckhelps.com**.

Getting started is simple

1. Download and complete the appropriate sections of the enrollment form OR use the electronic enrollment form.
2. Print and fax the completed form to **855-755-0518**.
3. A program representative will contact your patient and your office.

Download Enrollment Form

Use Electronic Enrollment Form

Use Online Portal

Download the Merck Patient Assistance Program Product Replacement Form

This form is to be completed by health care professionals only.

To request an appointment with a Nurse Educator, please call **855-257-3932.**

NJSOM Featured Corporate Sponsor Assistance Program

(NJSOM will profile a different Corporate Sponsor Assistance Program each Newsletter)

To get more information and visit their website CLICK HERE

Frequently Asked Questions

Reimbursement Questions & Answers

If you have reimbursement questions you need answers to, please submit them to njsombilling@gmail.com.

Question: I've been told that we need to put the ORDERING provider name on our claim form where the referring provider name goes. I guess we don't use the referring provider like we used to when we billed consults. Anyway, where do I find the claim form instructions for filling out the CMS1500?

Answer: Yes, the ordering provider's information goes in box 17 and 17b on the claim form. MS provides the CMS-1500 claim form instructions in the Internet-Only Manual (IOM) Publication 100-04, Chapter 26, which is available on the CMS website.

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Question: Our patient's primary insurance recently changed. Whom does the beneficiary call to update the information?

Answer: The Benefits Coordination and Recovery Center (BCRC) is responsible for updating a Medicare beneficiary's Coordination of Benefits (COB) file. Providers and beneficiaries can contact the BCRC at 1-855-798-2627 to report changes to a beneficiary's primary payer information. For more information about the BCRC and Medicare's COB rules, see the CMS website.

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Continued on next page…

Frequently Asked Questions

Question: We are now considered an outpatient hospital facility and bill for the doctor's services on the CMS1500 but the hospital bills for the chemotherapy. If a doctor sees a patient on the same day they get their chemotherapy do we need to include Modifier 25?

Answer: No, because the physician bills the office visit on the CMS1500 and the hospital bills the chemotherapy on the CMS1450, the modifier 25 to identify a separately identifiable service would not be necessary.

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Question: We get confused when billing by NDC (for Blue Cross) and use the JW modifier. Can you provide an example of how this would be done for Anthem?

Answer: I cannot find an example on Anthem's website - except that they require the NDC and they require the JW. Here is an example of how we have been told to code this:

NDC Billing
580 MG of Avastin/Bevacizumab

Avastin 400mg/16ml Vial	N450242006101 16ML	
Avastin 100mg/4ml Vial	N450242006001 3.2ML	
Avastin 100mg/4ml Vial	N450242006001 .8ML	JW

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Question: Our physicians are considering setting up an Oncology Medical Home. Can you point me in the right direction to find information on this?

Answer: In my opinion the VERY BEST resource for information related to an Oncology Medical Home is from COA. They had a team working on this for a long time and have launched it's own website with tons of information. I have provided the link to the site for you below:
http://www.medicalhomeoncology.org/coa/what-is-an-oncology-medical-home.htm

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Continued on next page…

Thank You

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NEW JERSEY NJOC ONCOLOGY CONTRACTING

CLICK HERE
to find out more information about the group purchasing program.

Question: It appears that CMS has a Medically Unlikely Edit on J9035, Avastin for 180 units (1800 mgs) but our patient needed 2200 mgs. Our doctors did dose according the FDA package insert but we are getting denials. What should we do and where do we find this information so we know ahead next time?

Answer: Yes, reviewing the MUE table for Practitioner Services, which can be downloaded from the CMS website, CLICK HERE, I do see that the MUE is **180**. If the weight based dosing is higher than the MUE, you will need to appeal and provide documentation that shows you followed the FDA dosing however, the patient was heavier and therefore needed more medication than the Medically Unlikely Edit allows. Be sure to include the patient's BSA.

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