NJSOM
New Jersey Society of Oncology Managers

Reimbursement E-News ISSUE: 52 March 2017

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:

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NJSOM
New Jersey Society of Oncology Managers

New Jersey Society of Oncology Managers
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E-mail: info@njsom.org

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

CMS awards approximately $100 million to help small practices succeed in the Quality Payment Program

New helpline launched to provide additional support

February 17, 2017, the Centers for Medicare & Medicaid Services (CMS) awarded approximately $20 million to 11 organizations for the first year of a five-year program to provide on-the-ground training and education about the Quality Payment Program for clinicians in individual or small group practices of 15 clinicians or fewer. CMS intends to invest up to an additional $80 million over the remaining four years. READ MORE

House Republicans Release American Health Care Act

On Monday, March 6, 2017, House Republicans released legislation to repeal and replace the Affordable Care Act.

Read the full American Health Care Act... CLICK HERE
Read the Section-by-Section Summary.... CLICK HERE
Read the New York Times Article.... CLICK HERE

IMPORTANT - See Novitas Pump code, G0498 denial update on page 3 of this newsletter!

Front Page News

COA Applauds New Oncology Payment Reform Bill by U.S. Senators Cornyn and Carper

The Community Oncology Alliance (COA) commends United States Senators John Cornyn (R-TX) and Tom Carper (D-DE) for introducing the *Cancer Care Payment Reform Act of 2017* (S.463) which establishes a national Oncology Medical Home (OMH) demonstration project to reform the way Medicare pays for cancer care. 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

OCM Evolving Best Practices: Lessons to Date

By Monique J. Marino, Senior Manager, Publications & Content, ACCC

Last June, the Centers for Medicare & Medicaid Services (CMS) announced that nearly 200 physician group practices and 17 health insurance companies had been selected to participate in the Oncology Care Model (OCM), the first oncology-specific alternative payment model (APM) pilot. (According to the latest information on the OCM website, participant numbers now stand at 190 practices and 16 payers.)

READ MORE

NJSOM Membership Renewal

NJSOM is pleased to announce the 2017 Membership Application Forms are now available online.

If your practice and/or company (corporate or individual) has not renewed their membership for 2017, please renew today!

Practice Members: CLICK HERE

Corporate Members: CLICK HERE

Novitas Solutions Inc.

Novitas Self-Service Tools

View all Self-Service Tools

VERY IMPORTANT

NOVITAS DENIALS FOR G0498

After inquiry by our Society, Novitas has let us know that the denials were an error due to an edit in their system. This edit has been removed and any claims wrongfully denied can be "resubmitted" for payment. YOU DO NOT HAVE TO SEND ANY ADDITIONAL DATA when billing the G0498 pump code.

Claim Reopening Decision Letters

Effective February 27, 2017, Novitas Solutions will consider a corrected claim reopening notification satisfied with a corrected Remittance Advice. READ MORE

Claims Issues Log

An update has been made to the duplicate appeal and general inquiry letter requests information.

READ MORE

Part B Top Inquiries Frequently Asked Questions (FAQs)

Our Part B Top Inquiries FAQs have been reviewed for January 2017 with new questions added to the Claim Denials category. Please take time to review these and other FAQs for answers to your questions.

READ MORE

Part B Top Claim Submission / Reason Code Errors

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

READ MORE

Novitas Solutions Inc.

CERT Identification Online Tool Updated

The CERT Identification Online Tool has been updated with the most recent claim sampling. You can find this tool on the CERT Center under "Interactive Tools". Simply enter the CID number and click the "search CID" button to obtain a status of your CERT sampled claims. The CID number assigned to the claim under review can be found on the letter from the CERT Documentation Contractor.

READ MORE

New Medicare Insights Podcast now available

In this Medicare Insights Podcast episode, we discuss modifier JW for discarded drugs. READ MORE

Provider Specialties/Services

We are pleased to announce the addition of Telehealth Services to the Part B Provider Specialties/Services page of our website.

Novitas Solutions e-News Electronic Billing Qtly Newsletter

Current Qtly Issue Available

CLICK HERE

Medicare Part B - HOT LINKS!

- 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

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

Novitas Solutions Inc.

NJSOM New Jersey Society of Oncology Managers

Listed are Novitas training events an oncology practice should consider!

DATE	TIME	EVENT	LOCATION
3/9/17	2:00p-3:00p	Part B Billing of Drugs and Biologicals	Via Webinar
3/14/17	9:00a-12:00p	Accuracy Matters – Lehigh Valley Hospital in Allentown, PA	In Person
3/14/17	11:00a-12:00p	Novitasphere Hot Topics and Frequently Asked Questions	Via Webinar
3/14/17	2:00p-3:00p	Part B Evaluation and Management Score Sheet: Part Three- Using the Score Sheet	Via Webinar
3/15/17	2:00p-3:00p	Novitasphere Claim Submission Overview	Via Webinar
3/16/17	8:30a-11:30a	Accuracy Matters – Hunderton Medical Center in Flemington, NJ	In Person
3/17/17	11:00a-12:00p	Novitasphere Claim Correction Overview	Via Webinar
3/27/17	2:00p-3:00p	Part B Evaluation and Management Score Sheet: Part Four-Scoring Medical Records Using the Score Sheet	Via Webinar
3/28/17	2:00p-3:00p	Evaluation and Management Modifiers	Via Webinar
3/29/17	8:30a-11:30a	Accuracy Matters – Lancaster General Hospital in Lancaster, PA	In Person
3/29/17	11:00a-12:00p	Subsequent Hospital Care Rules and Coding	Via Webinar
3/30/17	11:00a-12:00p	Novitasphere Claim Correction Overview	Via Webinar
3/31/17	8:00a-11:00a	Accuracy Matters – Uniontown Hospital in Uniontown, PA	In Person

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

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.

hdi

Home | Region D Information | Provider Information | New Issues | FAQ | Contact Us | Login

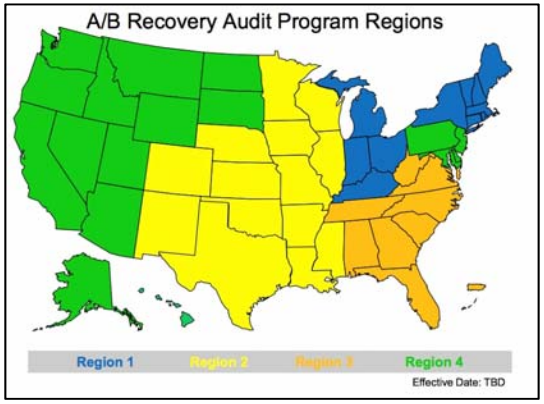
HealthDataInsights welcomes you to RAC-Info!

Important Provider Updates

02/20/2017: HMS RAC Region 4 Update

HMS Federal continues its transition from Region D to Region 4. We will furnish updates to the provider community as we progress toward performing claim reviews. Until the HMS Federal website is established, all updates will be posted to the Region D website at**https://racinfo.healthdatainsights.com/home**. In Addition, updates will be provided to the MACs and Associations within Region 4. Stay tuned for more information!

To visit the website CLICK HERE



RACmonitor.com

The Rules Don't Apply: Private Payers

Wednesday, 15 February 2017 | By David M. Glaser, Esq. - A client called me this week after receiving the results of an audit by a private insurer. While I have done Medicare audits for clients in nearly every state, audits by private insurers are rare. They happen, but they are atypical. If you are used to dealing with Medicare audits, it is important to understand that private pay audits, while similar, are not identical. The first major difference is that the private payor is not automatically entitled to use Medicare rules to recoup money, and similarly, you are not entitled to automatically rely on a Medicare-based defense. READ MORE

RAC Monitor continued on next page…

CMS Medicare

RACmonitor.com

CMS OPPS Final Rule and the 21st Century Cure Act – And Their Impact on Provider-Based Payments

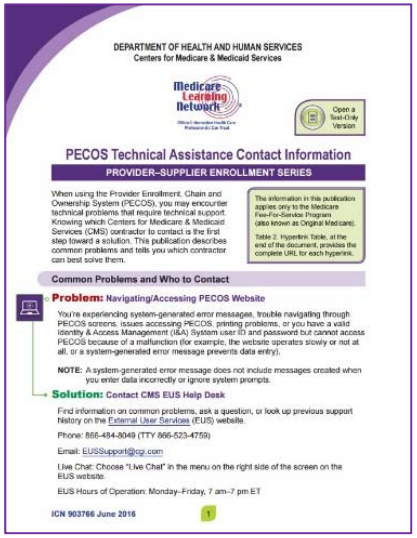
Wednesday, 01 March 2017 | By Stanley Sokolove, CPA, ALJ Emeritus - The Centers for Medicare & Medicaid Services (CMS) recently published its final Outpatient Prospective Payment System (OPPS) rule that addresses policies relating to off-campus provider-based entities (OCPBs). READ MORE

CMS Issues Final Rule for Emergency Preparedness

Wednesday, 22 February 2017 | By James M. Randolph - Natural and manmade disasters have ravaged the United States and the world extensively during the past decade, and they have put healthcare providers – especially hospitals' emergency teams' – preparedness to the test. READ MORE

Why You Should Use the New Request for Hearing Form

Wednesday, 15 February 2017 16:41 | By Bob Soltis - The advent of revised regulations for administrative law judge (ALJ) hearings of Medicare appeals includes a new request for ALJ hearing or review of dismissal form. READ MORE


DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

PECOS Technical Assistance Contact Information
PROVIDER–SUPPLIER ENROLLMENT SERIES

Common Problems and Who to Contact

Problem: Navigating/Accessing PECOS Website

Solution: Contact CMS EUS Help Desk

ICN 903766 June 2016

PECOS Technical Assistance Contact Information Fact Sheet

The PECOS Technical Assistance Contact Information Fact Sheet is available. Learn about:

- Common problems and who to contact
- Provider Enrollment, Chain and Ownership System (PECOS) resources

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules

HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet

The HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet is available. Learn about:

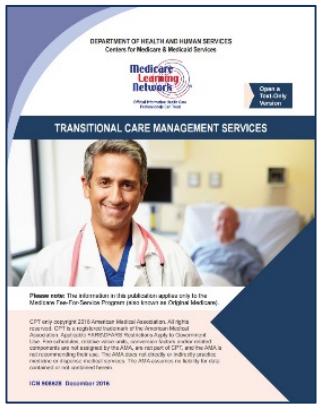
- Who must comply with Health Insurance Portability and Accountability Act (HIPAA) rules
- Covered entities

CMS CENTERS for MEDICARE & MEDICAID SERVICES

CMS Medicare

NJSOM New Jersey Society of Oncology Managers

Transitional Care Management Services Fact Sheet



A revised Transitional Care Management Services Fact Sheet is available. Learn about:

- Health care professionals furnishing these services and supervision
- Services settings, components, and billing
- Frequently asked questions on billing

CMS Extends Meaningful Use Attestation Deadline to March 17

The CMS has extended the date for eligible professionals (EPs) to register and attest to the Meaningful Use EHR Incentive Program requirements for 2016. **EPs have until Monday, March 17, 2017 at 11:59 PM PT to register and attest in order to avoid the 2018 penalty**. If you are participating in the Medicaid portion of the EHR Incentive Program, please refer to your state's deadline for attestation information.

EPs participating in both the Medicare and Medicaid EHR Incentive Programs must attest to meeting the criteria for one or the other to avoid the 2018 Medicare penalty. The Medicare Meaningful Use program for physicians will sunset after this reporting period. EHR use will continue to be measured under the Merit-Based Incentive Payment System (MIPS).

For more information, please visit the CMS 2016 registration and attestation webpage.

MLN Matters® — Information for Medicare Fee-For-Service Health Care Professionals

Recent LearnResource & MedLearn Matters Articles

- ICD-10 Coding Revisions to National Coverage Determination (NCDs) (MM 9861)
- ICD-10 Coding Revisions to National Coverage Determinations (NCDs) (MM 9982)
- Implementation of New Influenza Virus Vaccine Code
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April CY 2017 Update
- Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims
- Episode Payment Model Operations
- Healthcare Provider Taxonomy Codes (HPTCs) April 2017 Code Set Update
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Updates to the "Medicare Claims Processing Manual," Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits
- Medicare Outpatient Observation Notice (MOON) Instructions
- Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.1, Effective April 1, 2017

Horizon Payer Updates

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

Medicare Supplemental Claims Adjustment

Horizon Blue Cross Blue Shield of New Jersey determined that certain claims for our members with Medicare Supplemental coverage were processed incorrectly, resulting in overpayments to some professional physicians.

READ MORE

Medicare Outpatient Observation Notice (MOON)

Horizon Blue Cross Blue Shield of New Jersey reminds you that beginning **March 8, 2017**, hospitals and critical access hospitals are required to provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries who are receiving observation services as an outpatient for more than 24 hours.

READ MORE

Quarterly Update to Injectable Medication Fee Schedule: Q2 2017

Horizon Blue Cross Blue Shield of New Jersey will update our fee schedule for injectable medications on **May 1, 2017**. READ MORE

Medical Policy Updates

*****We have only listed the updates that may affect your oncology practice***

- NEW Olaratumab (Lartruvo)
- NEW Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- 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)
- REVISED Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- REVISED Radiation Treatment of Bone Metastases

Update to Add-on Code Implementation

On **March 26, 2017**, Horizon Blue Cross Blue Shield of New Jersey will implement a claim editing change to align our approach with the nationally recognized guidelines of the Centers for Medicare & Medicaid Services (CMS) for claims that include "add-on" CPT® and HCPCS codes. Please note that this claim editing change was previously scheduled to be effective for services provided on and after February 1, 2017.

READ MORE

Other Payer Updates

AmeriHealth

AmeriHealth drug program formulary updates

Effective April 1, 2017, changes will be made to the AmeriHealth Select Drug Program® Formulary. The Select Drug Program is a formulary-based prescription drug benefit program available to commercial members.

READ MORE

AmeriHealth.

Important information about the Medicare Outpatient Observation Notice

Effective March 8, 2017, the Centers for Medicare & Medicaid Services (CMS) requires that all hospitals and critical access hospitals (CAH) provide the Medicare Outpatient Observation Notice (MOON) to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as an outpatient for more than 24 hours.

READ MORE

AmeriHealth.

Professional Injectable and Vaccine Fee Schedule updates effective April 1, 2017

Effective April 1, 2017, we will implement a quarterly update to our Professional Injectable and Vaccine Fee Schedule for all contracted providers. These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables and modifications to the percentage premium for the following:

Drug	Code	Narrative
Actemra®	J3262	Injection, tocilizumab, 1 mg
Entyvio®	J3380	Injection, vedolizumab, 1 mg
Inflectra™	Q5102	Injection, infliximab, biosimilar, 10 mg
Orencia®	J0129	Injection, abatacept, 10 mg
Remicade®	J1745	Injection, infliximab, 10 mg
Simponi® Aria™	J1602	Injection, golimumab, 1 mg, for intravenous use
Stelara®	J3357	Injection, ustekinumab, 1 mg

AmeriHealth.

Providing notice to Medicare Advantage members for covered and non-covered services

Under the AmeriHealth Provider Agreement (Agreement), when treating Medicare Advantage members of one of our affiliates, providers must give members **written** notice that non-covered/excluded services are not covered and that the member will be responsible for payment before services are provided. READ MORE

Other Payer Updates

UnitedHealthcare Commercial Reimbursement Policies

Required Modifiers for Biosimilar Drugs - UnitedHealthcare will begin requiring biosimilar biological products to include a modifier that identifies the manufacturer of the specific product for dates of service on or after June 1, 2017. This coding edit is consistent with the Centers for Medicare & Medicaid Services (CMS) and will be addressed in UnitedHealthcare's Procedure to Modifier Policy. The corresponding modifier requirement will be applicable as additional biosimilar procedure codes and/or modifiers are created. Biosimilar drug codes reported without the modifier will be denied. Claims that are denied can be resubmitted with the appropriate modifier.

Biosimilar HCPCS Code	Product Brand Names	Corresponding Required Modifier
Q5101 – Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Zarxio	ZA – Novartis/Sandoz
Q5102 – Injection, infliximab, biosimilar 10 mg	Inflectra	ZB – Pfizer/Hospira

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

How Does Medicaid Work and What's at Stake Under a Block Grant or Per Capita Cap?: A Video Slideshow

A new video slideshow from the Kaiser Family Foundation explains how Medicaid works now and what is at stake as policymakers in Washington consider converting program financing to a block grant or per capita cap.

The 3-minute video describes how Medicaid is financed under current law, whom it covers and how spending is distributed across various groups of enrollees, including children, adults, seniors, and people with disabilities. It shows, for instance, that although seniors and people with disabilities comprise about a quarter of Medicaid enrollees, they account for nearly two-thirds of Medicaid spending because they have more complex health needs and therefore higher per person costs.

Watch the Video

Other Payer Updates

NEW!

UnitedHealthcare
NetworkBulletin
An important message to health care professionals and facilities

A Few Articles You Won't Want to Miss:

- **Front & Center**
  - Demographic Data Attestation Requirement
  - Pharmacy Update – Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and Oxford
- **UnitedHealthcare Commercial**
  - UnitedHealthcare Medical Policy, Drug Policy and Coverage Determination Guideline Updates
- **UnitedHealthcare Commercial Reimbursement Policies**
  - Required Modifiers for Biosimilar Drugs
- **UnitedHealthcare Community Plan**
  - UnitedHealthcare Community Plan Medical Policy & Coverage Determination Guideline Updates
- **UnitedHealthcare Medicare Solutions**
  - UnitedHealthcare Medicare Advantage Coverage Summary Updates
- **UnitedHealthcare Affiliates**
  - Oxford Medical and Administrative Policy Updates

And Much More…
MARCH Monthly Issue Available HERE

NEW!

UnitedHealthcare
Medical Policy Update
Bulletin

Oncology Related Articles You Won't Want to Miss:

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

Medical Benefit Drug Policy Updates
- Revised:
  - Exondys 51™ (Eteplirsen) - Effective Apr. 1, 2017
  - Infliximab (Remicade® and Inflectra™) - Effective Apr. 1, 2017

Utilization Review Guideline Updates
- New:
  - Office Based Program - Effective Apr. 1, 2017
- Updated:
  - Immune Globulin Site of Care Review Guidelines for Medical Necessity of Hospital Outpatient Facility Infusion - Effective Apr. 1, 2017
- Revised:
  - Chemotherapy Observation or Inpatient Hospitalization - Effective Apr. 1, 2017
  - Specialty Medication Administration – Site of Care Review Guidelines - Effective Apr. 1, 2017

MARCH Monthly Issue Available HERE

NEW!

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 Northeast 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 approved Xermelo for Xermelo (telotristat ethyl) tablets in combination with somatostatin analog (SSA) therapy for the treatment of adults with carcinoid syndrome diarrhea that SSA therapy alone has inadequately controlled. More Information. February 28, 2017
- FDA granted approved lenalidomide (Revlimid, Celgene Corp.) as maintenance therapy for patients with multiple myeloma following autologous stem cell transplant. More Information. February 22, 2017

Phase II Study Supports Potential for Genentech's Tecentriq® (Atezolizumab) Plus Avastin® (Bevacizumab) for People with Locally Advanced or Metastatic Renal Cell Carcinoma

(Genentech) Feb 17, 2017 - Genentech, a member of the Roche Group, today announced encouraging results from the Phase II IMmotion150 study that compared TECENTRIQ® (atezolizumab) plus Avastin® (bevacizumab) and TECENTRIQ monotherapy to sunitinib alone in people with previously untreated, locally advanced or metastatic renal cell carcinoma (mRCC).

Read Corporate Press Release

In-House Specialty Pharmacy at Cancer Center Improves Quality of Care, Reduces Medical Errors

(2017 Quality Care Symposium) Feb 27, 2017 - An influx of new oral cancer drugs provides patients with a more convenient and less invasive way to take medication, but such treatments are often associated with adherence challenges and medical errors.

READ PRESS RELEASE

Other News

EXPRESS SCRIPTS CAUGHT UP IN PHARMACY FEUD

Increased litigation by independent pharmacies against one of the country's leading pharmacy benefit managers spotlights the high stakes faced by independent pharmacies kicked out of a PBM network: It's nearly impossible for the independents to compete for customers outside the network system.

READ MORE

Updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) and the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for WM/LPL

NCCN has published updates to the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) and the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL). These NCCN Guidelines® are currently available as Version 1.2017.

- Workup (WM/LPL-1)
  - Added "CXCR4 gene testing for patients being considered for ibrutinib" with a new footnote.

- New footnote, "Studies have shown that mutations in this gene are found in up to 40% of patients with WM/LPL and can impact ibrutinib response."
- Relapse (WM/LPL-2)
  - For relapsed disease, to choose between alternate therapy or therapy used previously, the time taken into consideration was changed from 12 to 24 months.

For the complete updated versions of the NCCN Guidelines, NCCN Guidelines with NCCN Evidence Blocks™, the NCCN Compendium®, the NCCN Biomarkers Compendium®, the NCCN Chemotherapy Order Templates (NCCN Templates®), and the NCCN Imaging Appropriate Use Criteria (NCCN Imaging AUC™), please visit CLICK HERE.

To view the NCCN Guidelines for Patients®, please CLICK HERE.

Other News

PAN Foundation

Cost Sharing and Access to Prescription Medications

Overview - Access to medically necessary healthcare is critical for successful patient outcomes, yet access is often impeded or blocked entirely by cost sharing. Despite its value as a tool to limit discretionary healthcare spending, cost sharing can also create insurmountable barriers between patients and diagnostic tests, office visits, surgery and other needed services. READ MORE

Medical Economics
SMARTER BUSINESS. BETTER PATIENT CARE.

How to eliminate EHR-based medical errors

February 23, 2017 by Todd Shryock - Electronic health record (EHR) systems are part of most physicians' lives, but unfortunately, so is the risk of medical errors caused by software glitches or poor programming.

READ MORE

Medical Economics
SMARTER BUSINESS. BETTER PATIENT CARE.

The Challenges of Switching EHRs

That's the attitude of many physicians when they think about replacing their electronic health record (EHR) system, and it may explain a seeming contradiction in the results of *Medical Economics'* 2016 EHR Report Card:

READ MORE

ASCO in Action

ASCO Criteria for High-Quality Clinical Pathways in Oncology Featured as Special Article in JOP

ASCO's "Criteria for High-Quality Clinical Pathways in Oncology," is featured as a special article in the *Journal of Oncology Practice*. ASCO developed the 15 inter-related criteria to provide an overarching framework for assessing pathways programs in the United States and to guide stakeholders in assessing the quality, utility and integrity of clinical pathways in oncology. READ MORE in ASCO in Action.

Other News

QOPI® Spring Round of Reporting Opens March 14 — Register Now

(ASCO in Action) Mar 1, 2017 - On March 14, the Spring Round for ASCO's Quality Oncology Practice Initiative (QOPI®) will open for reporting.

READ ARTICLE

ASCO Tracking Action on Capitol Hill; Advocating for Cancer Policy Priorities Amid Unknowns

(ASCO in Action) Feb 7, 2017 - With the new Congress and Administration in place, ASCO has been on Capitol Hill monitoring the issues that affect the cancer care community, and educating lawmakers on how best to serve Americans with cancer.

READ ARTICLE

New Survey of Advanced Practice Providers in Oncology Launched

To better understand the contributions of advanced practice providers (APPs) working in oncology, ASCO is partnering with four other healthcare provider organizations to conduct a survey that will examine the specific roles and responsibilities of APPs within the cancer care delivery team. READ MORE

If you are contacted to participate, you will receive the survey via postal mail or an email from ASCO.Survey@jacksonsurveys.com. **ASCO urges members to complete the survey and return it as instructed by March 29**. The survey should take 20 minutes or less to complete.

COA State of Community Oncology and 2017 Priorities

(COA) Feb 8, 2017 - Today, the Community Oncology Alliance (COA) hosted a "State of the Union" briefing on the state of community oncology at the National Press Club in Washington, DC.

READ PRESS RELEASE

Patient Assistance

Patient Assistance NOW

- Home
- Patient Assistance Program Finder
- Program Information & Other Support
- Understanding US Healthcare Reform
- Manage Your Diseases & Conditions
- Caregiver Resources
- Novartis Medicines
- Novartis Clinical Trials
- Helping You When It Matters Most

- Oncology Resource Center
- Eye Care Patient Assistance Programs

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Learn more

Manage Your Disease

Learn all you can about your medical condition and take an active role in managing your health.

Look up my condition

NOVARTIS ONCOLOGY

VISIT THIS WEBSITE….CLICK HERE

NJSOM Featured Corporate Sponsor Assistance Program

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

Frequently Asked Questions

Reimbursement Questions & Answers

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

Question: Sometimes we receive denials that we are over the number of units for our administration codes. For example, we billed 6-96367 infusions for this unique protocol and we received a denial. Can you tell me how many units are allowed to be billed for this code and for the push code and where to go to find this information?

Answer: CPT Code 96367 has an MUE of 4. CPT Code 96375 has a MUE of 6.

An MUE is a "Medically Unlikely Edit" and this list is found on the CMS website: To find the table: CLICK HERE

Once at this site, go to the bottom and download Practitioner Services MUE Table - Effective 1/1/17. Once downloaded you will be able to search through the spreadsheet for the various codes.

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Question: I keep hearing about PWK, what is that? Does this mean we can upload documentation for our Medicare claims?

Answer: PWK is actually an ELECTRONIC STAPLE that connects paper documentation to an electronic claim. Utilizing this process you will still need to fax or mail the information to the Medicare contractor. This process is often used when a provider knows that their Medicare contractor will require specific documentation. Rather than wait for the contractor to send the ADR (additional documentation request), providers can expedite the claim processing by indicating in the PWK segment on their claim (to alert the contractor) and then utilizing the Medicare contractor's designated cover sheet (located on their website) and fax over the information immediately.

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There are more specifics about the use of the PWK segment within the manual. Link is provided below. Many oncology providers find this process very useful.

For more information and specifics, please refer to Medicare Claims Processing Manual, Chapter 24, Section 50.10 – CLICK HERE

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Question: I am still confused on many of our claims determining if we need to add the JW modifier or not. My pharmacist says that every time there is waste, we must bill a line with the JW. I'm not comfortable because the HCPCS code is already covering the whole amount. If I do another claim line with the waste, we would be billing for more than the vial size. Say we use 50 mg of a 100 mg vial with a 100 mg code. Can we bill a .5 unit for the 50 mg the patient received and then .5 unit for the 50 mg that we wasted from the single dose vial with the JW modifier?

Answer: No, you can't bill for partial (.5) unit.

Within the Medicare Claims Processing Manual Chapter 17 – Drugs and Biologicals, Section 40, Medicare provides a good example of how you can bill one line when the HCPCS (j-code) allows for both the amount the patient received and the waste. Here is their example:

"The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. For example, one billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted."

As a reference, CLICK HERE to review this information within the Medicare Manual, section 40.

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Question: I am kind of new to oncology billing and, for the first time, we are billing for intrathecal administration. Can you tell me where to find the code for this? Our doctor is the one that did the procedure, not our nurse.

Answer: I would recommend reviewing CPT code 96450 – Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture.

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Thank You

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Question: If a patient comes in the office and we remove their pump, then start all over to change the batteries, redo the line, refill the pump and start the patient again, can we bill the initiation (96416) code since it is the same thing we do on the first day?

Answer: No, if a patient presents with a pump on and you refill, including all the items you described, this would be billed as a "refill and maintenance of a portable pump", 96521. While it does reimburse less than the 96416, and it feels like you are providing the same service as the initiation, within the 96416 extra "teaching" time that is spent with the patient reviewing how to use the pump and what will happen, when to contact the office in an emergency, etc. is included. So, long story short, if a patient presents and leaves with the pump, you bill 96521.

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