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: 53 April 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

CMS News - FOR IMMEDIATE RELEASE

April 3, 2017 - **CMS finalizes 2018 payment and policy updates for Medicare Health and Drug Plans, and releases a Request for Information**

Rate Announcement supports benefit flexibility, efficiency, and innovation in Medicare Advantage and Part D

For a fact sheet on the 2018 Rate Announcement and Call Letter, please visit: CLICK HERE.

The 2018 Rate Announcement and Call Letter, and the Request for Information may viewed through: CLICK HERE and selecting "2018 Announcement."

ASCO

U.S. Cancer Care System Poised for Transformation, but Challenges Loom Large

In "State of Cancer Care in America: 2017," ASCO Lays Out Vision for Cancer Care Delivery System to Address Growing Patient Population, and Access, Affordability Challenges

Read entire article CLICK HERE.

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

Front Page News

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

Seema Verma Confirmed as CMS Administrator

The Senate has confirmed President Trump's nominee to run CMS, Indiana health care consultant Seema Verma. Verma is a protégé of Vice President Mike Pence, after designing a Medicaid expansion along conservative lines for Indiana when he was governor. Her consulting business has about a dozen staffers, and if confirmed, she would run an agency with nearly 6,500 employees.

Novitas Solutions Inc.

Novitas Self-Service Tools

View all Self-Service Tools

Evaluate Our Services Beginning April 5, 2017

The MAC Satisfaction Indicator (MSI) is coming April 5, 2017. You will have the opportunity to take this 10 minute survey administered by the Centers for Medicare & Medicaid Services (CMS). The MSI is the best way to share your opinions directly with CMS about your experience with Novitas. These survey results will help us find ways to better serve you. Watch for the survey on our website to participate. We look forward to hearing your experiences about the services we provide.

Fully Favorable Redetermination Decision Letters

Effective March 20, 2017, Novitas will no longer issue fully favorable redetermination decision letters. Please review the "Fully Favorable Redetermination Decision Letters" article on our website for further details.

READ MORE

Part B Top Claim Submission / Reason Code Errors

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

READ MORE

Evaluation & Management: 4x4 Method

We are pleased to announce the addition of our article, Evaluation & Management: 4x4 Method, available on the Evaluation & Management page of our website.

READ MORE

Part B Top Inquiries Frequently Asked Questions (FAQs)

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

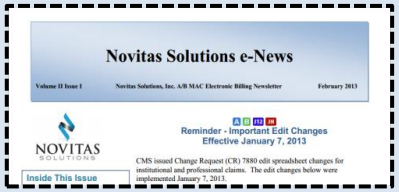
READ MORE

Novitas Solutions Inc.

Let Us Help You Locate and Use Proper Modifiers (4/6) 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
4/12/17	2:00p-3:00p	Novitasphere Claim Submission Overview	Via Webinar
4/13/17	2:00p-3:00p	Novitasphere Claim Correction Overview	Via Webinar
4/18/17	11:00a-12:00p	Part B Incident To and Shared Split Billing	Via Webinar
4/19/17	2:00p-3:30p	Medicare Part B Updates - 2017 Second Quarter	Via Webinar
4/21/17	8:00a-11:00a	Accuracy Matters – Ocean Medical Center in Brick, NJ	In Person
4/25/17	11:00a-12:00p	ABILITY | PC-ACE Overview	Via Webinar
4/27/17	2:00p-3:00p	Novitasphere Claim Correction Overview	Via Webinar
5/2/17	8:00a-11:00a	Accuracy Matters – Southern Ocean Medical Center in Manahawkin, NJ	In Person
5/5/17	8:00a-11:00a	Accuracy Matters – J.C. Blair Memorial Hospital in Huntingdon, PA	In Person

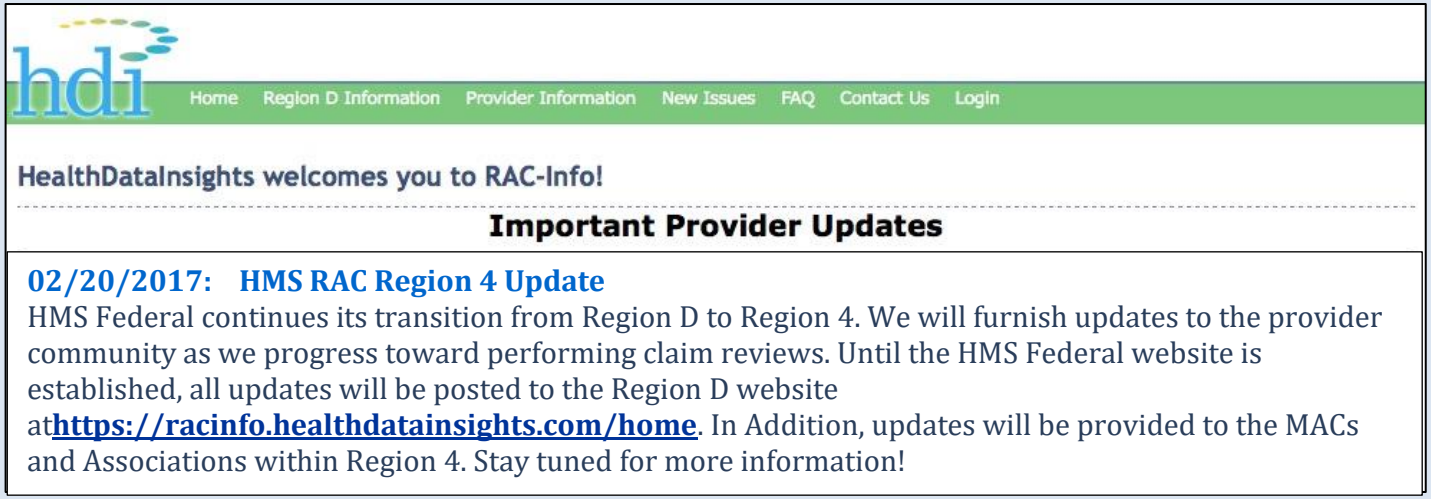
CLICK HERE

to access the educational area of the Novitas website!

CMS Medicare

REGION 4 RAC – HMS Federal Solutions

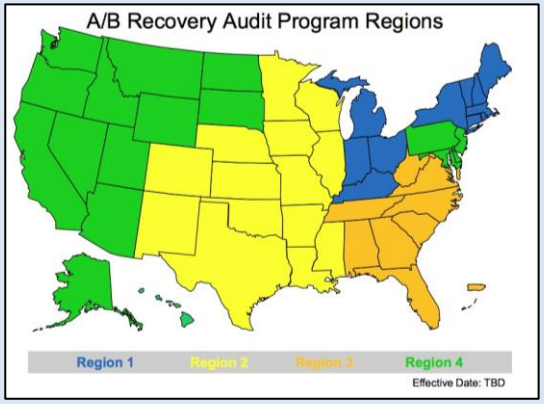
Temporarily all information found on HDI website



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.



Making the Case for a Single-Payer System

By Howard Stein, DO, MHA, CHCQM-PHYSADV

EDITOR'S NOTE: As congressional Republicans and the Trump administration grapple with challenges associated with their efforts to repeal and replace the Patient Protection and Affordable Care Act, talk continues to swirl about the possibility of a single-payer healthcare system. In this exclusive story, Howard Stein offers his personal opinion in… READ MORE

RAC Monitor continued on next page…

CMS Medicare

Who Filed That Compliant Against Me?

By David Glaser, Esq.
Who complained? That might seem like a totally reasonable question. But it's something that compliance officers might want to discourage from being asked. Read the full story »

RAC Integration for Medicare Advantage Audits

By Duane Abbey, PhD, CFP
Section 6411(b) of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires the expansion of the Recovery Audit Contractor (RAC) program to Medicare Part C. While we may refer to either MA as Medicare Advantage (or a more accurate acronym, MAO, for Medicare Advantage Organizations), the simple fact… READ MORE

New Reporting Rules for State Medicaid Fraud Control Units

By Michael Rosen, Esq.
There is no doubt that state Medicaid Fraud Control Units (MFCUs) have their hands full and are charged with a difficult task. They are responsible for investigating Medicaid fraud. Read the full story »

Self-Auditing: Don't Fight Yourself

By David M. Glaser, Esq.
When you get a request from a MAC, RAC, ZPIC, BISC or other entity in the alphabet soup of government contractors seeking records for an audit, what should you do? READ MORE

CMS Medicare

MACRA Implementation Has Begun: Will You Avoid a 4 Percent Reimbursement Penalty?

By now, most oncology professionals know that the Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act (MACRA), began on Jan.1, 2017, but did you know that 2017 is a transition year, meaning you can

"Pick Your Pace" when implementing QPP in your practice? "Pick Your Pace" refers to the options that practices in the Merit-Based Incentive Payment System can chose from to report 2017 quality data. The options for 2017 are:

1. Testing the program by submitting a minimum amount of data (one measure for one chart)
2. Reporting some data for at least 90 days
3. Reporting full data for at least 90 days

Practices that do not report any 2017 data will receive a four percent Medicare reimbursement penalty in 2019.

As your partner in practice transformation, ASCO has prepared a "Top Ten List for MACRA Implementation in 2017." The list offers step-by-step guidance for picking a pace and successfully navigating the transition year.

QPP is completely changing the way physicians are reimbursed for services provided under Medicare Part B. ASCO urges all oncology practices to understand and to prepare for these changes ahead of time. While 2017 is a transition year, in 2018 practices will be required to do full reporting-including reporting on 60 percent of eligible charts for at least six quality measures-to avoid a penalty in 2020.

In addition to the top 10 list, ASCO has developed a range of tools and educational materials to help the oncology community prepare for the changes ahead, including webinar recordings and slides from the MACRA education series.

ASCO will continue to update its online QPP toolkit throughout the MACRA implementation process. Stay tuned to ASCO in Action and bookmark asco.org/MACRA for the latest news and updates.

ABN, Form CMS-R-131 Renewal

The Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. While there are no changes to the form itself, providers should take note of the newly incorporated expiration date. The effective date for use of this ABN form is 60 days from this announcement. More information on the ABN and the ABN form instructions can be found at: FFS ABN - Centers for Medicare & Medicaid Services

CMS Medicare

Quality Payment Program: New Materials

CMS recently posted new resources on the Educational Resources webpage to help clinicians successfully participate in the first year of the Quality Payment Program, including:

- Alternative Payment Models (APMs) in the Quality Payment Program - Includes a comprehensive list of all APMs operated by CMS, including Advanced APMs and MIPS APMs for the Quality Payment Program
- Support for Small Practices - Contains contact information for the local, experienced organizations that will help clinicians in small and rural practices participate in the Quality Payment Program

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is intended to make it easier for providers, suppliers, and the general public to understand the changes CMS is proposing or making.

CMS publishes this update to inform the public about the following:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or cancelled.
- New/Revised manual instructions

The Quarterly Provider Update can be accessed on the CMS website.

MIPS Annual Call for Measures and Activities through June 30

The Annual Call for Measures and Activities for the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP) will be open through June 30. CMS encourages clinicians, measure stewards, organizations, and other stakeholders to identify and submit measures and activities to be considered for three performance categories of MIPS in future years. Submission details:

- Quality: Submit measures through JIRA with the JIRA Measures Under Consideration template and other associated documents
- Advancing Care Information: Submit measures using the Advancing Care Information Submission Form to CMSCallforMeasuresACI@ketchum.com
- Improvement Activities: Submit activities using the Improvement Activities Submission Form to CMSCallforActivitiesIA@ketchum.com

For more information see the Annual Call for Measures and Activities fact sheet. Direct any questions to the Quality Payment Program Service Center at QPP@cms.hhs.gov.

CMS Medicare

Items and Services Not Covered under Medicare Booklet — Revised

A revised Items and Services Not Covered under Medicare Booklet is available. Learn about:

- Four categories of items and services not covered under Medicare and applicable exceptions
- Advance Beneficiary Notices

SNF Consolidated Billing Web-Based Training Course — Revised

With Continuing Education Credit

A revised Skilled Nursing Facility (SNF) Consolidated Billing (CB) Web-Based Training (WBT) course is available through the Learning Management System. Learn about:

- SNF coverage and payment guidelines
- Bundled prospective payments
- Services that are excluded from SNF CB

Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6

Thursday, April 6 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects Event Registration.

Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19

Wednesday, April 19 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects Event Registration.

Open Payments: Prepare to Review Reported Data Call — April 13

Thursday, April 13 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects Event Registration.

CMS Medicare

IMPORTANT

Social Security Number Removal Initiative: New Details

Updated Social Security Number Removal Initiative Home and Provider webpages will help you prepare to transition to Medicare Beneficiary Identifiers next year. Find new information including

- How to identify railroad retirement board beneficiaries
- Coordination of benefits with other payers
- Where to direct your patients to correct their addresses so they receive new Medicare cards

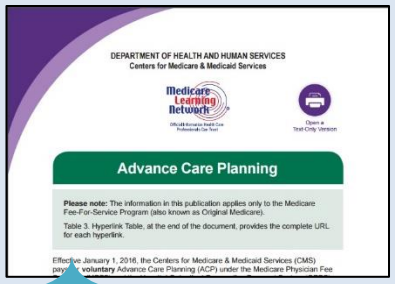
Chronic Care Management Services Call: Audio Recording and Transcript

An audio recording, transcript, and post-call clarification are available for the February 21 call on Understanding and Promoting the Value of Chronic Care Management (CCM) Services. During this call, CMS experts discuss the benefits of providing CCM services and changes for CCM in the Physician Fee Schedule final rule.

Advance Care Planning Fact Sheet — Reminder

The Advance Care Planning Fact Sheet is available. Learn about:

- Beneficiary eligibility
- Provider and location eligibility
- Diagnosis requirements



NPI: What You Need to Know Booklet — New

CLICK HERE

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

Recent LearnResource & MedLearn Matters Articles

- SE1605 – Provider Enrollment Revalidation – Cycle 2
- SE0801 – Clarification of Patient Discharge Status Codes and Hospital Transfer Policies
- Billing for Advance Care Planning (ACP) Claims
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2017
- FISS Implementation of the Restructured Clinical Lab Fee Schedule
- Clarification of Admission Order and Medical Review Requirements
- Provider Enrollment Revalidation - Cycle 2

Horizon Payer Updates

NJSOM New Jersey Society of Oncology Managers

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

Administrative Policy Revision: Provider Directory Management

Effective **May 1, 2017**, Horizon Blue Cross Blue Shield of New Jersey will change the way we address situations in which we are unable to validate whether information included within our provider files is current and accurate.

READ MORE

Medical Policy Updates

- 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
- REVISED - Computed Tomography (CT) Perfusion Imaging of the Brain

Additional Medications to be Added to Our Medical Injectables Program

Effective **May 1, 2017**, additional injectable medications will be included as part of our Medical Injectables Program (MIP) administered by Magellan Rx Management.

See the list and read more (Includes many oncology products)

Quarterly Claim Editing Update: 2nd Quarter 2017

Horizon Blue Cross Blue Shield of New Jersey will implement a quarterly update to our claim editing rules and processes. Please review our Quarterly Claim Editing Update Report that identifies the changes that will be implemented as noted below….

READ MORE

Other Payer Updates

Corrected claim resubmission requirements

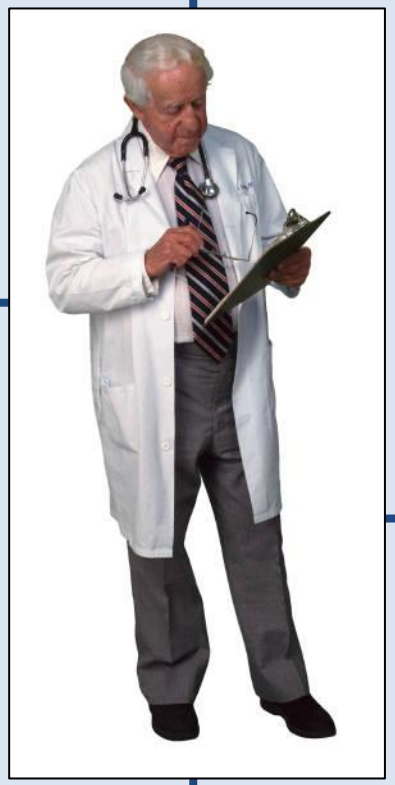
Posted March 9, 2017
Recently, we have seen a large volume of corrected claims that are incomplete due to missing information in the appropriate fields on the CMS-1500 (professional) and UB-04 (facility) claim forms, such as the original reference/claim number.

READ MORE

Transition to a new medical management system

Posted March 23, 2017
During the third quarter of 2017, AmeriHealth will transition to a new medical management system for processing requests for Authorization. Please read this communication in its entirety as it includes a request for action. This transition will require changes to several administrative procedures, as noted below.

READ MORE



Required lead time when updating your provider information

Posted March 28, 2017
AmeriHealth would like to remind you about the importance of submitting changes to your provider information in a timely manner. Keeping your provider information current and up-to-date helps to ensure prompt payment of claims, delivery of critical communications, seamless recredentialing, and accurate listings in our provider directories.

SEE TIMES AND READ MORE….

Billing for professional services during an inpatient stay

Posted March 21, 2017
During claims processing, we have been experiencing problems when trying to correlate professional services rendered to members during inpatient stays. As a reminder, you *must* populate the hospitalization date on the CMS-1500 (professional) claim form.

READ MORE

Other Payer Updates

Notification/Prior Authorization Requirements for Spinraza™

You may have heard about the new specialty medication Spinraza, which recently was approved by the U.S. Food and Drug Administration for the treatment of spinal muscular atrophy. We've been evaluating this medication and have developed our coverage policy for it.

We're requiring coverage reviews for this medication because it's important to us to provide our members access to care that's medically appropriate, as we work toward the Triple Aim of improving health care services, health outcomes and overall cost of care. We want to make you aware of notification/prior authorization requirements for Spinraza that will apply to UnitedHealthcare Commercial and UnitedHealthcare Community Plan members.

Clinical Coverage Reviews for Spinraza
Clinical coverage reviews for Spinraza will be conducted as part of our prior authorization process. The reviews will evaluate whether the drug is appropriate for the individual member, taking into account:

- Our drug coverage policy
- Applicable state Medicaid guidelines (for UnitedHealthcare Community plans only)
- Confirmation of the gene mutation or deletion of genes in chromosome 5q resulting in a condition amenable to treatment with Spinraza (nusinersen)
- The member's respiratory status
- Dosage recommendation from the U.S. Food and Drug Administration approved labeling

Additional criteria also may be considered. We encourage you to submit any information you would like us to review as part of your prior authorization request.

UnitedHealthcare Commercial Plan Requirements for Spinraza
Our coverage policy for Spinraza for UnitedHealthcare Commercial plan members is effective April 1, 2017. The notification/ prior authorization requirement for Spinraza will apply to all UnitedHealthcare Commercial plans including affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare Oxford, Neighborhood Health Partnership and UnitedHealthcare of the River Valley. A clinical coverage review will be conducted as part of our prior authorization process, if the member's benefit plan requires that services be medically necessary to be covered.

UnitedHealthcare Community Plan Requirements for Spinraza
Coverage of Spinraza for UnitedHealthcare Community Plan members will vary based on state Medicaid program decisions. Some states may decide to cover Spinraza through the Medicaid fee-for-service program, and not through managed care organizations such as UnitedHealthcare. We encourage you to verify benefits before submitting the prior authorization request or administering the medication.

Please read the April 2017 Issue of the Network Bulletin for additional information.

UnitedHealthcare®

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

BUILDING A SECURE DATABASE FOR PATIENTS' END-OF-LIFE PLANS

Lilo H. Stainton | April 3, 2017

New Jersey could soon join a handful of states that use electronic registries to help ensure healthcare providers treat patients according to their wishes when it comes to end-of-life care — instead of automatically using all available medical technology to keep them alive.

READ MORE

Other Payer Updates

NJSOM
New Jersey Society of Oncology Managers

NEW!

UnitedHealthcare
NetworkBulletin
An important message to health care professionals and facilities

A Few Articles You Won't Want to Miss:

- **Front & Center**
  - Enhanced claimsLink App Replacing Other Online Options
  - New Prior Authorization Requirement for Levoleucovorin
- **UnitedHealthcare Commercial**
  - UnitedHealthcare Medical Policy, Drug Policy and Coverage Determination Guideline Updates
- **UnitedHealthcare Community Plan**
  - UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates
- **UnitedHealthcare Affiliates**
  - Oxford Medical and Administrative Policy Updates

And Much More…
APRIL 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:

Utilization Review Guideline Updates

- Revised:
  - Specialty Medication Administration – Site of Care Review Guidelines - Effective May 1, 2017

APRIL 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 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 granted regular approval to palbociclib (IBRANCE, Pfizer Inc.) for the treatment of hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine based therapy in postmenopausal women. More Information. March 31, 2017

- FDA granted regular approval to osimertinib (TAGRISSO, AstraZeneca Pharmaceuticals, LP) for the treatment of patients with metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC), as detected by an FDA-approved test, whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy. More Information. March 30, 2017

- FDA approved niraparib (ZEJULA, Tesaro, Inc.), a poly ADP-ribose polymerase (PARP) inhibitor, for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy. More Information. March 27, 2017

- FDA granted accelerated approval to avelumab (BAVENCIO, EMD Serono, Inc.) for the treatment of patients 12 years and older with metastatic Merkel cell carcinoma (MCC). Avelumab is a programmed death-ligand 1 (PD-L1) blocking human IgG1 lambda monoclonal antibody. This is the first FDA-approved product to treat this type of cancer. More Information. March 23, 2017

- FDA granted accelerated approval to pembrolizumab (KEYTRUDA), Merck and Co., Inc.) for the treatment of adult and pediatric patients with refractory classical Hodgkin lymphoma (cHL), or those who have relapsed after three or more prior lines of therapy. More Information. March 15, 2017

- FDA approved ribociclib (KISQALI, Novartis Pharmaceuticals Corp.), a cyclin-dependent kinase 4/6 inhibitor, in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. More Information. March 13, 2017

Other News

Can the payer/physician relationship be salvaged?

We break down our exclusive data from *Medical Economics'* 2017 Payer Scorecard to find the answer. READ MORE

Top 15 tips to improve payer/physician relationship

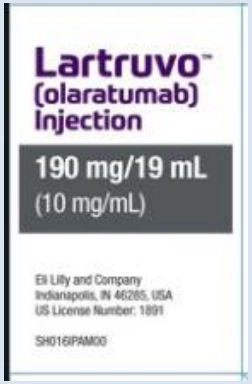
We polled our doctors to get to the heart of the disconnect. READ MORE

Feedback needed for an Oncology Practice Platform

ASCO is trying to develop a platform geared to practice administrators, but we need you help in order to do so. We are conducting an online exercise that will help to organize resources for practices. The activity is easy and should only take 15 to 20 minutes to complete.

Please note that the activity needs to be performed in a single session. Participate online by **April 14th by 11:50 PM EST**. Feel free to email the researchers with any questions or comments.

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 http://www.LARTRUVO.com/HCP/Resources for more information.

U.S. Department of Health & Human Services
Office of Inspector General
U.S. Department of Health & Human Services

HHS OIG Hotline Telephone Number Used in Scam

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently confirmed that the **HHS OIG Hotline telephone number is being used as part of a telephone spoofing scam targeting individuals throughout the country**. READ MORE...

Patient Assistance

Partnering with your practice: We've got your patients covered

Xtandi (enzalutamide) 40 mg capsules

SUPPORT SOLUTIONS℠

XtandiSupportSolutions.com
1-855-8XTANDI
(1-855-898-2634)
Monday – Friday, 8 AM - 8 PM ET

CLICK HERE to visit the Xtandi Patient Support Program Website

Financial assistance

Tarceva Access Solutions

Tarceva® erlotinib tablets

Tarceva erlotinib | ACCESS SOLUTIONS

Tarceva Access Solutions can connect you to the medicine you need. If you are concerned about paying for Tarceva, we are here to help.

Whether you have healthcare coverage or not, we can help you by:

- Finding out if your healthcare plan pays for your medicine
- Guiding you through the process of getting your medicine
- Connecting you with our patient assistance programs

If you don't have a healthcare plan, you may be eligible to get your medicine for free. To learn more about how we can help, contact us. Call (888) 249-4918 to speak live with one of our Specialists. You can also visit **www.Genentech-Access.com/Tarceva/patients**.

The Access Solutions logo is a registered trademark of Genentech, Inc.

CLICK HERE to visit the Tarceva Patient Financial Assistance Website

NJSOM Featured Corporate Sponsor Assistance Program

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

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Frequently Asked Questions

Reimbursement Questions & Answers

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

Question: I received payment on a brand new drug (it didn't have a NOC code yet) but only received payment for the invoice amount. I thought we were supposed to be reimbursed WAC +6% when the ASP isn't established!

Answer: According to the CMS Claims Processing Manual, Chapter 17, Drugs and Biologics: *"The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP."*

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Question: Our nurses gave a chemo injection – Lupron and billing with the administration code 96402. Additionally the patient was nauseous and we gave an antiemetic using 96367. We were rejected for the 96367 code, why?

Answer: CPT 96367 is an add-on code and must be combined with an initial code. Since 96402 is not an initial code, this combination would deny. Most recommend billing the therapeutic infusion as the initial code along with the injection.

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Question: What is the difference between a co-pay and co-insurance?

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Frequently Asked Questions

Answer: A copayment (or copay) is a fixed-dollar amount that you pay each time for certain services. Most commonly, each time you have a doctor's visit and for each prescription medication you fill. For example, you may pay a $15 copayment for each primary care physician visit, $25 copayment for a specialist visit, and $20 for each brand-name prescription.

Coinsurance is a percent of the cost of your care. You are responsible for paying the co-insurance amount. For example, if a doctor's visit is $100 and you have a 20% coinsurance, you will pay the doctor $20 and your health plan will pay the doctor $80.

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Question: NEW PATIENT, SHARED/SPLIT SERVICE - When we have a new patient in the office, the non-physician practitioner (NPP) sees the patient and performs the history and exam. The NPP then discusses the case with the physician and the physician sees the patient and performs the medical decision-making. Can we bill this under the physician provider number as an incident to service?

Answer: No, in the situation you describe, you must bill the service under the NPP number. A new patient service does not meet the incident to guidelines as described in the Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Chapter 15, Section 60.1. One of the requirements is that the services are part of the physician's professional service in the course of diagnosis or treatment of an injury or illness. Section 60.2 states "There must have been a direct, personal professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part."

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Question: What is the difference between modifier 25 and 59, to me they are the same thing!

Answer: They both are similar and used for identifying a separately identifiable service. Modifier 25 is used with E & M visits while the 59 modifier is used with services, like our administration codes;

25 = Definition:
• *Significant, separately identifiable evaluation and management (E/M) service by the same physician* on the day of a procedure*

59 = Definition:
• *Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances.*

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Question: If we do a push of Adriamycin and it takes the nurse 25 minutes to do the push, can we bill for an infusion because the push took longer than 15 minutes?

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Thank You

NEW JERSEY NJOC ONCOLOGY CONTRACTING

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to find out more information about the group purchasing program.

Answer: A push is a push no matter how long it takes. The AMA CPT book does not have a code for a long push and therefore you must utilize a push code regardless of the time it takes.

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Question: Our physician, in his dictated note said, "Begin the patient on Neulasta". Can this be considered the order?

Answer: This does not meet the requirements of an order as the dose and route of administration are not included. Under audit, payers have been taking back Neulasta payments and the reimbursement for the injection because the order is not complete. Make sure your order meets all the requirements!

Elements of an order (besides the patient name)
• Medication •Dose •Route •Frequency •Length of treatment •Date
•Physician signature

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