

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:**



**New Jersey Society
of Oncology Managers**

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Reimbursement E-News

ISSUE: 55

June 2017

The New Jersey Society of Oncology Managers (NJSOM) is a non-profit corporation of community based Oncology practice administrators and their staff, along with corporate entities involved with the treatment and care of cancer patients and their families.



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

NJSOM Annual Conference

Sink or Swim "How to keep your practice afloat"
June 21 - 23, 2017
Borgata Water Club Atlantic City, NJ



REGISTER TODAY!

For agenda and more information

[CLICK HERE](#)

NJSOM ANNUAL SUMMER SPECTACULAR

Water Club Atlantic City

Wednesday, June 21st - Friday, 23rd, 2017

NJSOM Active and Associate Member Business Meeting and Dinner

6:00 PM Old Homestead Steak House *sponsored by Flatiron Health*

6:00 pm - 6:30 pm Business Meeting

Dinner immediately following

Active & associate members must attend to receive complementary rooms

We have an exciting agenda and look forward to seeing you!

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At Hackensack Meridian Health, an Innovative Approach to CDS in Cancer Care

(Healthcare Informatics) May 29, 2017 - The Hackensack Meridian Health initiative is changing the delivery of oncology care in that integrated health system. [READ ARTICLE](#)

Top Senate Republican Says He Doesn't See "A Comprehensive Health Care Plan This Year"

(CBS News) June 2, 2017 - Sen. Richard Burr said Thursday he doesn't think the Senate will produce a "comprehensive" plan to repeal and replace Obamacare by the end of this year. [READ ARTICLE](#)



Oncology Care Model: Early Learnings

By Christina Bennett, MS - At the recent COA annual meeting, practice administrators from groups participating in the Oncology Care Model (OCM) shared their experiences and talked about the challenges and rewards presented in shifting to a value-based, alternative payment model.

[READ MORE](#)

Feds Wrongly Attempt to Take \$250k From Syracuse-Based Hematology-Oncology Associates Over Simple Clerical Error; Feds Forced to Reverse Negative & Unfair Decision

A Simple CMS Data-Entry Error Left Hematology-Oncology Associates of CNY On The Hook For A \$250K Loss For No Real Reason – Putting Health Of Practice At Risk.

[READ MORE](#)



Renewed Push To Tackle And Tame Out-Of-Network Medical Bills

Lilo H. Stainton / May 31, 2017 - Patient, business advocates call for 'two-pronged approach' that melds transparency and mechanism to resolve disputes over surprise charges [READ MORE](#)

SAVE THE DATE

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](#)

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Novitas Self-Service Tools

[View all Self-Service Tools](#)



Medical Policy

LCD L36711 Update - This is an update regarding bulletin [Provider Type Restriction for LCD L36711 – Intensity Modulated Radiation Therapy \(IMRT\)](#), posted on January 23, 2017. Discussions continue regarding provider type restrictions for IMRT. Please continue to watch our website for updates.

The following JL Local Coverage Determinations (LCDs) have been revised:

- [Biomarkers for Oncology \(L35396\)](#)
- [Biomarkers Overview \(L35062\)](#)
- [Thrombolytic Agents \(L35428\)](#)

The following JL Local Coverage Articles have been revised:

- [Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds \(A54117\)](#)
- [Biomarkers for Oncology \(A52986\)](#)
- [Prolonged Drug and Biological Infusions Started Incident To a Physician's Service Using an External Pump \(A55134\)](#)
 - Article revised and published on 05/11/2017 effective for dates of service on and after 04/01/2017 to add a note as clarification that HCPCS code G0498 should not be reported with CPT code 96416 per TN 3728, CR 10005

Claims

[Part B Top Claim Submission / Reason Code Errors](#)

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



CERT

[Comprehensive Error Rate Testing \(CERT\) Educational Posters are Online](#)

You've seen them at our educational events. You may have picked up a few for your facility or practice. Now, our Comprehensive Error Rate Testing (CERT) educational posters are online. Download and print as many posters as you need for your organization. The posters are in PDF format that can be shared. Jump start your CERT education today with these materials.



Incident To Services

Have you ever wondered whether the office visit would qualify for "Incident to" services? Do new problems qualify? Does a complete plan of care need to be developed prior to the qualifying visit? Does the supervising physician need to be involved in the care? For answers to these questions and many more, don't forget to utilize the Novitas "Incident to Self-Service Tool" which will walk you step by step through the questions which determine qualification. [CLICK HERE](#) to visit this area of the Novitas website!

Frequently Asked Questions

[Part B Top Inquiries Frequently Asked Questions \(FAQs\)](#)

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

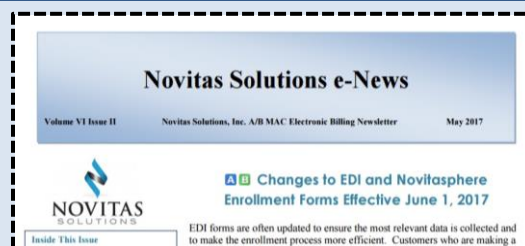
Education and Training

[New Medicare Insights Podcast](#)

In this Medicare Insights Podcast episode, we invite you to join us for one of our 2017 Medicare Symposiums.

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](#)

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WEBiNAR

Listed are Novitas training events
an oncology practice should consider!



DATE	TIME	EVENT	LOCATION
6/13/17	8:00a-4:30p	2017 Novitas Solutions Medicare Symposium - Pikesville, PA	In Person
6/14/17	11:00a-12:00p	Electronic Data Interchange (EDI) Enrollment	Webinar
6/15/17	8:00a-4:30p	2017 Novitas Solutions Medicare Symposium - Breinigsville, PA	In Person
6/15/17	2:00p-3:00p	Novitasphere Claim Submission Overview	In Person
6/16/17	10:00a-11:30a	Part A/B New and Small Provider Education - Part 1 Medicare Basics	Webinar
6/19/17	1:00p-2:30p	Meet HMS Federal Solutions Region 4 Recovery Audit Contractor	Webinar
6/23/17	11:00a-12:00p	Novitasphere Claim Correction Overview	Webinar
6/27/17	10:00a-11:30a	New and Small Provider Education - Part 2 Part B Claim Overview	Webinar
6/28/17	2:00p-3:00p	New Patient Guidelines and Coding	Webinar
6/29/17	10:00a-11:00a	The Established Patient: Billing and Coding Office Visits	Webinar
6/29/17	2:00p-3:00p	Novitasphere Claim Correction Overview	Webinar
6/30/17	10:00a-11:00a	New / Small Provider - Part 3 Self-Service	Webinar

[CLICK HERE](#)

to access the educational area of the Novitas website!

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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.



Home Region 4 Info Provider Info New Issues FAQ Contact Us Login

HMS welcomes you to RAC-Info!

Important Provider Updates

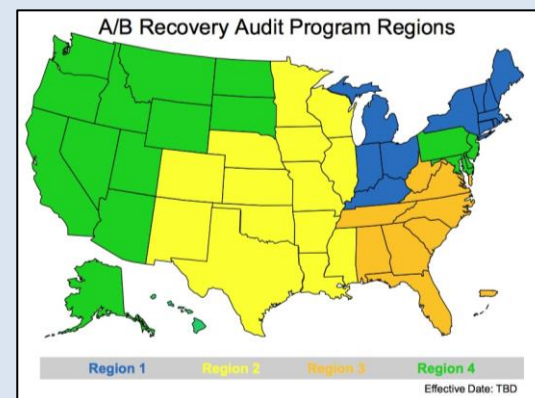
05/18/2017: RAC 4 Audits

HMS Region 4 RAC has received CMS approval to begin audits for the Noridian JE and JF MAC Part A and Part B Jurisdiction.

05/15/2017: RAC 4 Provider Outreach Presentations

The HMS Region 4 Part A and Part B Provider Outreach Presentations are now located under the "Links & Resources" on the Home page. Please continue to monitor the Provider Portal for updates on when HMS will initiate reviews in Region 4.

To visit the website [CLICK HERE](#)



Medicare Advantage Whistleblower Suit May be Just the Beginning



By Mark Spivey - The recently filed federal whistleblower lawsuit alleging that tens of billions of dollars in improper payments were made to insurers by Medicare Advantage over the course of several years could be just the tip of the iceberg, according to the attorneys for the plaintiff in the case. [Read the full story »](#)

RAC Monitor continued on next page...

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Obstruction of Justice Important, Timely Counsel

By David M. Glaser, Esq. - All of the talk in the news about obstruction of justice should serve as a reminder of the importance of knowing what you can and can't do when a government investigation begins. [Read the full story »](#)

OIG: Releases Medicaid Fraud Control Unit (MFCU) Review: Increased Recoveries and Prosecutions Abound

By Michael Rosen, Esq. - Each year the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) releases its annual Medicaid Fraud Compliance Performance Report. There is much to learn from this compendium of information provided by 50 Medicaid Fraud Control Units (MFCUs), and this article will highlight some of... [READ MORE](#)

Former UnitedHealth Finance Director Files Bombshell Whistleblower Lawsuit as HCC Issue Looms

By Chuck Buck and Mark Spivey - A former high-ranking official with a health insurance industry titan has filed a whistleblower lawsuit alleging that Medicare Advantage annually made tens of billions of dollars in improper payments to insurers over the course of years, the New York Times reported last week. [READ MORE](#)

CMS NEWS – FOR IMMEDIATE RELEASE, May 30, 2017

Contact: CMS Media Relations (202) 690-6145 | [CMS Media Inquiries](#)

- **New Medicare cards offer greater protection to more than 57.7 million Americans**
- **New cards will no longer contain Social Security numbers, to combat fraud and illegal use**

[READ MORE](#)

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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.



Centers for Medicare and Medicaid Services Offers New Health Coverage Enrollment Option for Small Business

Today, the Centers for Medicare & Medicaid Services (CMS) announced a plan to change the way that small businesses enroll in insurance coverage through the Federal exchanges, offering employers the help they need to find affordable insurance for their employees. [READ MORE](#)

Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised

A revised [Dual Eligible Beneficiaries under Medicare and Medicaid](#) Booklet is available. Learn about:

- Medicare and Medicaid Programs
- Dual eligible beneficiaries
- Prohibited billing of Qualified Medicare Beneficiaries and Medicare assignment

Emergency Preparedness Call: Audio Recording and Transcript — New

An [audio recording](#) and [transcript](#) are available for the [April 27](#) call on Emergency Preparedness Requirements Final Rule Training. During this call, learn about implementation of the final rule, including an overview of the regulation and training and testing requirements.

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Requesting Appeal Redeterminations

You now have the option to submit requests for appeal redeterminations with electronic, digital, and/or digitized signatures by mail or fax. You may also continue to submit via a CMS-approved secure Internet portal/application.

Office of Inspector General Report: Stem Cell Transplantation

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the February 2016 OIG report and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services. [READ MORE](#)



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](#)

SNF Billing Reference Booklet — Revised

A revised [SNF Billing Reference](#) Booklet is available. Learn about:

- Medicare-covered Skilled Nursing Facility (SNF) stays
- SNF payment and billing requirements

Medicare Basics: Parts A and B Claims Overview Video — Reminder

The [Medicare Basics: Parts A and B Claims Overview](#) video is available. Learn about Medicare claims, what you need to know before filing a claim, and how to submit a claim.

Quality Payment Program: Technical Assistance Resource Guide Available

The [Technical Assistance Resource Guide](#) concisely highlights all of the support that is available to clinicians participating in the Quality Payment Program. It contains brief summaries on each branch of technical assistance, contact information, and maps to illustrate coverage areas. Visit the [Quality Payment Program](#) website for more information.

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New Quality Payment Program Resources Available

CMS recently revamped the look of the [Quality Payment Program](#) website and posted new resources to help clinicians successfully participate in the first year of the Quality Payment Program:

- [MIPS Quick Start Guide](#): Outlines the steps Merit-based Incentive Payment System (MIPS) clinicians need to take between now and March 2018 to prepare for and participate in MIPS
- [2017 CAHPS for MIPS Conditionally-Approved Survey Vendor List](#): Includes contact information for the list of conditionally-approved survey vendors to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey in 2017
- [Medicare Shared Savings Program and Quality Payment Program Fact Sheet](#): Explains how the Shared Savings Program and the Quality Payment Program align reporting requirements for participating Accountable Care Organizations (ACOs) and MIPS clinicians and how certain tracks in Shared Savings Program ACOs meet Advanced Alternative Payment Model (APM) criteria under the Quality Payment Program
- [MIPS APM Fact Sheet](#): Provides an overview of this specific type of APM and the special APM scoring standard

For More Information:

- Visit the [Quality Payment Program](#) website
- Contact Quality Payment Program Service Center at 866-288-8292 (TTY 877-715- 6222) or QPP@cms.hhs.gov



Implementing MACRA in Your Practice

The ASCO Connection recently published a blog by Harvey Bichkoff of Marin Cancer Care on practical steps for implementing MACRA that we hope will be of value to you and your practice.

Mr. Bichkoff has managed medical groups and hospitals for over 30 years, is a member of ASCO's Clinical Practice Committee (CPC) and Chair of the CPC's Oncology Administrators Workgroup. [Read the blog at ASCO Connection.](#)

Updated CY 2018 eCQM Specifications Available

CMS posted the annual update for Electronic Clinical Quality Measures (eCQMs) for CY 2018:

- [Eligible Hospitals and Critical Access Hospitals](#) – for reporting
- [Eligible Professionals and Eligible Clinicians](#) – for performance

These updated eCQMs are fully specified and may be used to electronically report 2018 clinical quality measure data for CMS quality reporting programs. Measures will not be eligible for 2018 reporting unless they are proposed and finalized through notice-and-comment rulemaking for each applicable program. To learn more, visit the [Electronic Clinical Quality Improvement Resource Center](#).



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, 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.

EHR Incentive Programs: Review 2017 Program Requirements

CMS encourages eligible hospitals, critical access hospitals, and dual-eligible hospitals to review [2017 program requirements](#) for the Electronic Health Record (EHR) Incentive Programs, including:

- Modified [Stage 2](#) and [Stage 3](#) Attestation Worksheets
- [Overview of the OPPI/ASC Final Rule Changes](#)
- [EHR Incentive Programs](#) website

Lookup Tool to Help Determine MIPS Participation Status

Unsure of your participation status in the Merit-based Incentive Payment System (MIPS)? Clinicians can now use an interactive tool on the [Quality Payment Program](#) website to determine if they should participate in 2017. To determine your status, enter your National Provider Identifier into the entry field on the tool and find out whether or not you should participate in MIPS this year and where to find resources.

To get the latest information, visit the [Quality Payment Program](#) website. Contact the Quality Payment Program Service Center at 866-288-8292 (TTY 877-715- 6222) or QPP@cms.hhs.gov.



ASCO Underscores Importance of Fairly, Accurately Measuring Cost of Care in MIPS Episodes

ASCO's letter recommends three principles for establishing a fair and accurate assessment of cancer costs under MIPS:

1. Data on the cancer type, stage, genetic mutation(s), and patient comorbidities must be used to create adequate risk-adjustment methodologies;
2. CMS should not include unadjusted Part B and Part D drug costs when analyzing the costs of cancer care; and
3. CMS should directly take into account the added costs and vulnerabilities associated with disparities in the health care system that are associated with low-income and underserved populations.

Read ASCO's complete article, [full comment letter](#), and keep an eye on [ASCO in Action](#) for all the latest on implementing MACRA and QPP. [CLICK HERE](#)

MIPS: Submit Measures for the Advancing Care Information Performance Category by June 30

CMS encourages providers to identify and submit measures for the Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS):

- The CMS Annual Call for Measures and Activities ends June 30
- To submit, send the [Advancing Care Information Submission Form](#) to CMSCallforMeasuresACI@ketchum.com
- To learn more about the process, visit the [Call for Measures](#) webpage, and review the [Call for Measures and Activities](#) fact sheet

Recent LearnResource & MedLearn Matters Articles

- [New Common Working File \(CWF\) Medicare Secondary Payer \(MSP\) Type for Liability Medicare Set-Aside Arrangements \(LMSAs\) and No-Fault Medicare Set Aside Arrangements \(NFMSAs\)](#)
- [Office of Inspector General Report: Stem Cell Transplantation](#)
- [Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System](#)
- [The Process of Prior Authorization](#)
- [Update FISS Editing to Include All Three Patient Reason for Visit Code Fields](#)
- [Update FISS Editing to Include the Admitting Diagnosis Code Field](#)
- [Claim Status Category and Claim Status Codes Update](#)
- [Implement Operating Rules - Phase III Electronic Remittance Advice Electronic Funds Transfer: CORE 360 Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes and Claim Adjustment Group Code Rule - Update from Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange](#)
- [July 2017 Update of the Hospital Outpatient Prospective Payment System \(OPPS\)](#)
- [Quarterly Healthcare Common Procedure Coding System \(HCPCS\) Drug/Biological Code Changes July 2017 Update](#)
- [Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements \(formerly referred to as Locum Tenens Arrangements\)](#)
- [MCS Implementation of the Restructured Clinical Lab Fee Schedule](#)
- [Quarterly Update to the Medicare Physician Fee Schedule Database \(MPFSDB\) - July CY 2017 Update](#)



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

Medicare Advantage Claim Editing Updates to be Implemented: NCDs and LCDs

Effective **June 26, 2017**, Horizon Blue Cross Blue Shield of New Jersey will implement updates to our claim editing rules and processes to help ensure that claims for members enrolled in our Medicare Advantage (MA) plans are processed according to standard Centers for Medicare & Medicaid Services (CMS) guidelines. See list and [READ MORE](#)

Overview: P.L. 2017, Chapter 28, the New Jersey Substance Use Disorder Law

Places certain restrictions on prescribed opioids, such as a five-day supply limit on initial prescriptions issued by a New Jersey prescriber for acute pain, which was effective **March 1, 2017** pursuant to emergency rules. [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 \(Xolair\)](#)

Appealing Claims Denied for Post Service Medical Necessity

Members and physicians and other health care professionals on behalf of the member, and with the member's written consent, generally have the right to pursue an appeal of any adverse benefit determination involving a post service medical necessity decision made by Horizon BCBSNJ. [READ MORE](#)

Molecular and Genomic Testing Orientation Sessions

Horizon Blue Cross Blue Shield of New Jersey is expanding our collaboration with eviCore healthcare1 (eviCore) to administer a Medical Necessity Determination (MND) program for Molecular and Genomic Testing services. This program will be implemented on July 3, 2017, for services rendered July 3, 2017 and after. [READ MORE](#)

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AmeriHealth.

Seven drugs to be added to *Most Cost-Effective Setting Program*

Read about this update and the REST THAT WILL be included by September 1, 2017! [CLICK HERE](#)



AmeriHealth.

Update: New NaviNet® Authorizations transaction

As we have previously communicated, during the third quarter of 2017, Independence will transition to a new medical management system for processing requests for authorization. As a result, the Authorizations transaction on the NaviNet web portal will be



AmeriHealth.

Required lead time when updating your provider information

At least 30 days! [CLICK HERE](#) to read this important article!



AmeriHealth.

Update to our Radiation Treatment of Breast Carcinoma guideline

To review this update [CLICK HERE](#)



AmeriHealth.

AmeriHealth drug program formulary updates

Effective July 1, 2017, changes will be made to the AmeriHealth Select Drug Program® Formulary. [READ MORE](#)



AmeriHealth.

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

[READ MORE](#)

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



On-Line Chemotherapy Prior Authorization System to Display Outcome Findings

UnitedHealthcare is adding a new feature to our on-line chemotherapy prior authorization tool. Starting in the third quarter of 2017, the following outcome data will be provided to practices that request prior authorization for cancer treatment regimens:

- Median duration of treatment
- Relapse rate for adjuvant therapy
- Hospitalization rate
- Average monthly cost of care (while on treatment)
- Selection frequency for treatment regimen (by cancer and line of therapy)

This information on outcomes of cancer treatment regimens in our members is intended to supplement data obtained from clinical trials, which include selected patients and may not reflect the patients in your practice. We hope you find the additional information useful as you select the best treatment options for your patients and that you share this data and its impact on your decision making process with your patients. If you have any questions, send an email to unitedoncology@uhc.com.



New Policy – Advanced Practice Health Care Professional Evaluation and Management Procedures Policy

Effective for claims with dates of service on or after Sept. 1, 2017, UnitedHealthcare will require physicians reporting evaluation and management (E/M) services on behalf of their employed Advanced Practice Health Care Professionals to report the services with a modifier to denote the services were provided in collaboration with a physician. UnitedHealthcare will accept the modifier SA on claims for these services when provided by nurse practitioners, physician assistants and clinical nurse specialists.

In addition, the rendering care provider's National Provider Identifier (NPI) must also be documented in field 24J on the CMS-1500 claim form or its electronic equivalent. Use of the modifier SA and documentation of the rendering care provider will assist UnitedHealthcare in maintaining accurate data with regard to the types of practitioners providing services to our members.



A Few Articles You Won't Want to Miss:

- **Front & Center**
 - UnitedHealth Premium® Designation Program – July 2017 Assessment Letters
 - Colony-Stimulating Factors Require Prior Authorization
 - Levoleucovorin Will Require Prior Authorization
- **UnitedHealthcare Commercial**
 - UnitedHealthcare Genetic and Molecular Testing Prior Authorization Requirement
 - UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates
- **UnitedHealthcare Commercial Reimbursement Policies**
 - Revision to the Consultation Services Reimbursement Policy
- **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...
JUNE Monthly Issue Available [HERE](#)



Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

- Revised:
 - Gene Expression Tests - Effective Jul. 1, 2017
 - Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) - Effective Jul. 1, 2017

Medical Benefit Drug Policy Updates

New:

- White Blood Cell Colony Stimulating Factors - Effective Sep. 1, 2017

Revised:

- Benlysta® (Belimumab) – Eff. Jul. 1, 2017
- Clotting Factors and Coagulant Blood Products - Effective Jul. 1, 2017
- Entyvio® (Vedolizumab) – Eff. Jul. 1, 2017
- Mifeprex® (Mifepristone) – Eff. Jul. 1, 2017
- Rituxan® (Rituximab) - Effective Jul. 1, 2017

Coverage Determination Guideline Updates

Updated:

- Clinical Trials - Effective Jun. 1, 2017

Utilization Review Guideline Updates

Revised:

- Site of Service Guidelines for Certain Outpatient Surgical Procedures – Eff. Jul. 1, 2017
- Specialty Medication Administration – Site of Care Review Guidelines – Eff. Jul. 1, 2017

JUNE Monthly Issue
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A Few Articles You Won't Want to Miss:

- Updates to our national participating provider precertification list
 - Additional site of care precertification requirements
- Learn about our NaviNet® webinars
- Aetna Open Access® HMO plans don't need PCP or referrals
- Changes to commercial drug lists begin on October 1, 2017

And Much More....
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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 ceritinib (ZYKADIA, Novartis Pharmaceuticals Corp.) for patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. [More Information](#). May 26, 2017
- FDA granted accelerated approval to pembrolizumab (KEYTRUDA, Merck & Co.) for adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options or with MSI-H or dMMR colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. [More Information](#). May 23, 2017
- FDA granted regular approval to pembrolizumab (KEYTRUDA, Merck and Co., Inc.) for patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. [More Information](#). May 18, 2017
- FDA granted accelerated approval to pembrolizumab (KEYTRUDA, Merck and Co., Inc.) in combination with pemetrexed and carboplatin for the treatment of patients with previously untreated metastatic non-squamous non-small cell lung cancer (NSCLC). [More Information](#). May 10, 2017
- FDA granted accelerated approval to avelumab (BAVENCIO, EMD Serono, Inc.) for patients with locally advanced or metastatic urothelial carcinoma whose disease progressed during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy. [More Information](#). May 9, 2017
- FDA has approved the Kisqali ®Femara ® Co-Pack (ribociclib tablets; letrozole tablets) for the treatment of hormone receptor-positive, human epidermal growth factor receptor-2 negative (HR+/HER2-) advanced or metastatic breast cancer in postmenopausal women. [More Information](#). May 8, 2017

NEW Vial Size for Herceptin

Recently, the FDA approved a revised USPI for Herceptin that lists a new 150mg single-dose configuration, along with additional label changes to meet updated FDA guidance. The new 150mg single-dose vial configuration for Herceptin will be introduced on May 30, 2017. Important information for you to know:

- All customers will be asked to transition to the 150mg single-dose vial, once available.
 - After July 7, 2017, Genentech will only ship 150mg vials to distributors and will discontinue shipping the 440mg multiple-dose vial to distributors.
- The NDC for the Herceptin 150mg vial is: 50242-132-01.
- The Herceptin WAC per milligram and J-code will not change.

While not listed in the revised USPI, the current 440mg multi-use vial configuration [NDC 50242-134-68] will continue to be available and can be utilized until product expiration. Please refer to the USPI supplied with the 440mg vial for more information on the 440mg vial (approved and dated 3/2016).

• Genetech is requesting all providers to add the NDC for Herceptin 150mg single-dose vials, and confirm that the current NDC for the 440mg multi-use vial remains active, within all systems (Billing, Payment, EMR, Ordering, etc.) in order to ensure this medicine remains available. The current ASP does not change for the 440mg vial.

Congress Sends Letter to HRSA Requesting Information on 340B

The Energy & Commerce Committee sent a letter yesterday to the Health Services and Resources Administration (HRSA) requesting audit information on the explosive growth of the 340B drug discount program in hospitals. Read the letter [HERE](#).



Free eLearning Program from the ACCC Financial Advocacy Network (FAN)



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More New Cancer Drugs Mean Higher Costs but Also Longer Lives

Spending on cancer treatments has spiked past the \$100 billion mark globally over the past five years, with almost half that amount in the United States alone, according to a report released Thursday. [Read the full article on NBC News here.](#)

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NCCN Pfizer Inc. Clinical Pathways in Breast Cancer Program Grant Opportunity – Submit Letter of Intent (LOI) by Monday, June 26, 2017

National Comprehensive Cancer Network® (NCCN®) is pleased to announce it is collaborating with Pfizer's Independent Grants for Learning & Change (IGLC) team to offer a new grant opportunity seeking proposals that use clinical pathways to address a quality improvement (QI) initiative along the continuum of care for breast cancer patients. The Request for Proposals (RFP) clearly outlines the scope and process that will be followed for the submission of Letters of Intent (LOIs). [READ MORE](#)

'We Can't Have It Both Ways': Len Saltz on Hype vs Hope, Drug Costs, and ASCO 2017

(Medscape Medical News) May 31, 2017 - What a difference a year makes. The last time oncologists from around the world gathered in Chicago for the American Society of Clinical Oncology (ASCO) meeting, the national conversation around healthcare, and cancer specifically, was markedly different. [READ ARTICLE](#)
([free registration required](#))

Hypothetical OCM. 2.0 Addresses Obstacles and Opportunities

By Megan Garlapow, PhD

At COA, a presentation by Executive Director Ted Okon and Dr. Kavita Patel of Johns Hopkins described desired changes to improve upon the current OCM, dubbing the changes "OCM 2.0." Things like patient-centered and universal payment came up in the discussion. Learn what else would make OCM better in this one. [READ MORE](#)

Cancer Care Costs Pose a Huge Financial Burden on Patients

By John McCleery

Real world data on out of pocket costs to patients with cancer have been recently published in a Milliman white paper. As you might have guessed, financial distress can be considered a major issue associated with cancer treatment, even if you have health insurance. [READ MORE](#)



New "NDC Express" Mobile Application

FDA launched a mobile application (app) to offer access to National Drug Code (NDC) data from phones or tablets. The new app, NDC Express, presents the NDC database in a mobile-friendly format, using display and navigation features available in both Android and iOS devices. Download NDC Express for free at [iTunes](#) (for Apple devices) or [Google Play](#) store (for Android devices).

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Reimbursement Questions & Answers

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



Question: I know I saw somewhere that United Healthcare was going to be requiring the modifier for Zarxio effective August 1, 2017. Is this correct and where can I find that information? What about Medicare?

Answer: Beginning January 1, 2016, Medicare requires the modifier for biosimilar products including Zarxio and Inflectra. Here is a link to that announcement: [CLICK HERE](#)

According to the May issue of the UHC Bulletin, page 26, beginning August 1, 2017, UHC will require the modifier for their Medicare Advantage Plans. [CLICK HERE](#)

Then, in April 2017, posted on the UHC website for Commercial Reimbursement Policies the stated that for services on or after June 1, 2017 they will also require the modifier for all commercial claims. This was published in our April E-bulletin as a separate article.

Question: I see changes to the Medicare ASP files and sometimes there is a retroactive higher reimbursement on drugs. Does Medicare automatically send the additional money or do we have to manually appeal?

Answer: Medicare publishes updates to the ASP files quarterly. Each quarter they release the new updates and often have updates to prior quarters due to late/new information from the manufacturers. Medicare does not automatically make changes to claims already paid. This includes changes that are

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in our favor and not in our favor. In order to receive additional payment, you would need to appeal the claim.

Question: I have a patient that is going to receive a drug supplied though pharmaceutical sponsor and made available to the patient in the form of compassionate use. A separate expanded access protocol was created for this patient in order to measure her safety while receiving this medication. The sponsor in no way will receive a research benefit regarding her participation in voluntarily receiving this medication. She will NOT be enrolled in the original protocol for this investigational product.

My question to you is we are billing Medicare for all service except for the investigational drug, but since she is not in the actual study are we required to use the clinical trial modifier?

Answer: CMS states that the Q0 and Q1 modifiers can only be utilized if the patient is enrolled in a clinical research study that is an approved clinical research study. Here is a link for informational reference:

<http://www.medicalbillingcptmodifiers.com/2016/07/cpt-modifier-q0-and-q1-definition-and.html>

Question: We recently became a outpatient facility and report our drugs on a CMS 1450 claim form (UB04). We were wondering if the JW modifier applies to us or just the private practice physicians?

Answer: Yes, the outpatient hospital providers also have to comply with the mandate that drug waste from a single dose vial be reported on a separate line with the JW modifier because the payment for the drugs for an outpatient facility also comes from Medicare Part B. Here is a link to the JW modifier FAQ information which includes additional resources:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf>

Question: We sometimes have to throw away drug that is expired from a multiuse vial. Can we bill for that waste as well using the JW modifier? Sometimes the multiuse vial is a single use because we don't use the remainder in enough time.

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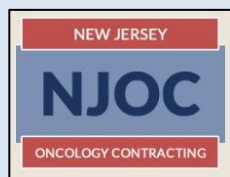
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to find out more information about
the group purchasing program.

Answer: No, CMS has been VERY clear that you are only allowed to bill for waste from a SINGLE use vial. Multi-use vials are not subject to payment for discarded amounts of drug or biological. Their definition of a single-dose vial is below:

What is a single-dose or single-use vial?

A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative.



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