The POHMS newsletter

We hope you enjoy this new version of
the POHMS Newsletter

Issue 50 MARCH '18

ACTIVE LEADERSHIP AND UNITY FOR ALL MEMBERS TO THRIVE IN THE EVOLVING HEMATOLOGY ONCOLOGY COMMUNITY

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POHMS Annual Spring Conference is scheduled for...

Thursday, May 17, 2018

FOR DETAILS AND REGISTRATION...

CLICK HERE

Editor: Michelle Weiss, Weiss Oncology Consulting - Michelle@WeissConsulting.org

This newsletter is intended for informational purposes only. Information is provided for reference only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions.

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NATIONAL NEWS

HOME

CMS Announces New Biosimilar Codes

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018. Read the MLN announcement CLICK HERE.

Congress passed and the President signed into law the Bipartisan Budget Act of 2018 on February 9-Part B Drug Payments are excluded from MIPS adjustments...and so much more!

Implications of the Budget Deal & the President's FY2019 Budget for Oncology

After another brief government shutdown, Congress passed the Bipartisan Budget Act of 2018 on Friday, February 9. Healthcare provisions embedded within this legislation will have an important impact on clinicians and patients. READ MORE

ASCO
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Important Oncology Related News Budget Deal Passed by Congress

Addresses Key Cancer Policy Issues

On February 9, Congress passed the "Bipartisan Budget Act of 2018," which funds the federal government through March 23, 2018 and raises the federal budget caps for the next two years. The budget deal includes several key policies of importance to the cancer community: READ MORE

Ten Things to Know and Do for Fast Approaching MIPS Deadlines

(ASCO in Action) Feb 14, 2018 - As deadlines draw near for submitting data for the 2017 Merit-based Incentives Payment System (MIPS) performance period, CMS has created a Top Ten List of things to know and do before the March deadline, along with important dates to remember.
READ ARTICLE

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

Quickly Correct Claims Online!

Make claim corrections in just minutes with Novitasphere, our free web-based portal. You can quickly locate your claim, make your corrections, and send it on its way, **it's that simple!** You'll even receive a written confirmation of the reopened claim in your MailBox!

Make these corrections **and more** with Novitasphere:

- Add, change or delete most modifiers
- Change the claim diagnosis codes
- Change the procedure code

Want to see what else you can fix? Review our Claims Correction Guide for a full list of the types of corrections you can make.

Expressions of interest for low volume appeals settlement (LVA) process

On February 5, 2018, CMS started accepting Expressions of Interest for its low volume appeals settlement (LVA) process. The LVA settlement option is for providers, physicians, and suppliers (appellants) with fewer than 500 appeals pending at the Office of Medicare Hearing and Appeals (OMHA) and the Medicare Appeals Council (Council) at the Departmental Appeals Board, combined, as of November 3, 2017, with a total billed amount of $9,000 or less per appeal. If you are interested in participating in LVA to address your pending appeals, visit CMS' website at go.cms.gov/LVA.

New Medicare Insights Podcast

In this Medicare Insights Podcast episode, we discuss the new Medicare card. READ MORE

Multiple PTAN Matches to Single NPI

Are you receiving claim rejections or development requests due to multiple Provider Identification Number (PIN) matches to a single National Provider Identifier (NPI)? Please read this article for guidance and helpful tips. READ MORE

Part B Top Inquiries / Frequently Asked Questions (FAQs)

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for January 2018. Please take time to review these FAQs for answers to your questions.
CLICK HERE

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

- Frequency of Laboratory Tests (L35099)
- Hydration Therapy (L34960)
- Intravenous Immune Globulin (IVIG) (L35093)

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for January 2018 for Delaware, Washington D.C., Maryland, New Jersey, and Pennsylvania are now available. Please take time to review these errors and avoid them on future claims.
READ MORE

Helpful Electronic Remittance Advice (ERA) Tips

If you are enrolled to receive your remittances via 835 Electronic Remittance Advice (ERA), please review these helpful tips for successfully managing your remittance files.

- ERA is generated 14 days from the date the file was submitted. That file is available to retrieve for 45 days.
- If you miss an ERA file within the 45 days, the EDI department can reset it for you. If you retrieve your ERA from a billing service or clearinghouse, please contact them to have it reset.
- When you retrieve your ERA, we encourage you to save it to location on your system where you can easily locate it in the future if necessary.
- ERA should be maintained in your system until all accounts are reconciled.
- Those saved ERA files can be translated by your claim software, or by one of our free software products: Medicare Remit Easy Print (MREP) for Part B, PC Print for Part A, or ABILITY | PC-ACE for Part A or Part B. These software products have the ability to print one or more patients as needed to send to a secondary insurance. Additionally, Novitasphere portal offers a translated copy of the remittance to its Part B customers.
- We suggest ERA customers get into the habit of retrieving ERAs each day so you don't miss any important information. ERA users should not request a paper copy unless they had a system issue when downloading the file.
- We offer training modules to help you successfully retrieve and read your ERA files.
    - Part B

Listed are Novitas training events an oncology practice should consider!

Novitas Self-Service Tools:

View all Self-Service Tools

Date	Starts	Ends	Event Details	CEUs	Media Type	
Tuesday, March 13, 2018	11:00 AM	12:00 PM	**Novitasphere Provider Portal Enrollment Overview** This course we will discuss the steps to enroll in Novitasphere, including the Enterprise Identity Management (EIDM) registration process.	1.0	Webinar	Register
Wednesday, March 14, 2018	2:00 PM	3:30 PM	**New and Small Provider Education - Part 2 Part B Claim Overview** This course is the second of a three part series focused on educating new and small Part B providers and staff on the Medicare program. Topics will focus on the timely filing, benefits of Electronic Data Interchange (EDI), steps to complete the claim form and a review of claim submission guidelines.	1.5	Webinar	Register
Friday, March 16, 2018	2:00 PM	3:00 PM	**Electronic Data Interchange (EDI) Enrollment** This course will improve your understanding of how to locate and complete the EDI Enrollment form to become an electronic submitter.	1.0	Webinar	Register
Tuesday, March 20, 2018	3:00 PM	4:00 PM	**Advantages of Electronic Billing** This course will explore the benefits of electronic billing. We will discuss the steps to become an electronic biller and the products and services offered by EDI. We will also discuss reports offered by EDI to assist you in tracking your electronic claims.	1.0	Webinar	Register

For many more opportunities and to register…

CLICK HERE

of the Part B Monthly Newsletter Now Available

Current Edition Now Available...[CLICK HERE]

Novitas Solutions e-News Electronic Billing Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE

Novitas Solutions e-News

Volume VI Issue II — Novitas Solutions, Inc. A/B MAC Electronic Billing Newsletter — May 2017

NOVITAS SOLUTIONS

Inside This Issue

A B Changes to EDI and Novitasphere Enrollment Forms Effective June 1, 2017

EDI forms are often updated to ensure the most relevant data is collected and to make the enrollment process more efficient. Customers who are making a

Medicare Part B – H O T L I N K S !

Medicare JL Part B Fee Schedule

Current Active Part B LCD Policies

Current Average Sales Price (ASP) Files

Quarterly Update to CCI Edits

2018 Final Rule

Physician Fee Schedule

Physician Fee Schedule Fact Sheet

HOPPS

HOPPS Fact Sheet

QPP

QPP Fact Sheet

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 *

HMS welcomes you to RAC-Info!
To visit the website CLICK HERE

HOME

Important Provider Updates

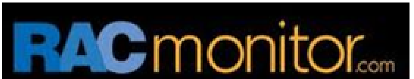
MOST RECENT RAC ISSUE BEING INVESTIGATED!

Excessive or Insufficient Drugs and Biologicals Units Billed

Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units. READ MORE

IMPORTANT PROVIDER UPDATE 2/6/2018: Refund Checks for RAC Identified Improper Payments

Refund checks for RAC Identified Improper Payments should not be sent to the RAC or the Medicare Administrative Contractor (MAC) upon receipt of the Informational Letters for an automated review, Review Results Letter for a complex review or the discussion period review outcome letter. Instead, Providers should wait to receive a demand letter, from the MAC, which identifies the improper payment amount and outlines repayment options. As a reminder, refund checks should never be sent to the RAC, but can be submitted to your MAC, after you receive a demand letter.



Are Peer-to-Peers Worth the Effort?

By Juliet B. Ugarte Hopkins, MD, CHCQM-PHYADV

An analysis of your peer-to-peer process might lead to your abandoning the program. The peer-to-peer (P2P) process is a particularly abhorrent chore for physicians. READ MORE

RAC Monitor continued on next page…

News Backgrounder: Anthem & the 25 Modifier

Anthem Blue Cross Blue Shield (BCBS) were set to implement a new processing edit with regard to the use of Modifier 25, effective March 1, 2018, but things didn't go as planned. Anthem instead submitted a letter to the American Medical Association (AMA) on Feb. 23, 2018 announcing that it was rescinding the new policy … for now. READ MORE

Lawsuit Against Epic Systems Dismissed as Other EHR Providers Face Legal Woes

By Mary Inman, Esq.

The court ruled that the whistleblower's complaint lacked credible allegations that any false claims were submitted to Medicare. Last week, a federal Judge in the Middle District of Florida dismissed a lawsuit against electronic health record (EHR) giant Epic Systems. An EHR is a digital version, or database, of a…READ MORE

CMS Paid $390 Billion in Claims; $36 Billion Paid in Error—2017 CERT Report

With nearly a million physicians in this country, how do auditing organizations determine who to audit? READ MORE

Who Pays for Outpatient Services to Beneficiaries Who Are Inpatients of Other Facilities?

In a recent report, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced it has determined that Medicare inappropriately paid acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities. READ MORE

New Medicare Card: Video for Your Waiting Room

In April, CMS will begin mailing new Medicare cards with new numbers. Help inform Medicare patients by playing the New Medicare Cards are coming! video in your waiting room. The video tells patients when and how they will receive the new card. This one minute video is available on YouTube and in opened caption and 1080p formats. Visit the Provider webpage for the latest information on the new Medicare card.

Provider Compliance Tips for Laboratory Blood Counts Fact Sheet — New

In 2017, the Medicare Fee-For-Service improper payment rate for blood counts was 19.2 percent with projected inaccurate payments of $56.6 million. Improper payments resulted from:

- Insufficient documentation - 89 percent
- Incorrect coding - 8.3 percent
- No documentation - 2.7 percent

Prevent denials by reviewing the Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet, which details coverage and documentation requirements.

Patients over Paperwork

CMS is conducting the 2018 Burdens Associated with Reporting Quality Measures study, as outlined in the Quality Payment Program Year 2 final rule to:

- Examine clinical workflows and data collection methods using different submission systems
- Understand the challenges clinicians face when collecting and reporting quality data
- Make future recommendations for changes that will attempt to eliminate clinician burden, improve quality data collection and reporting, and enhance clinical care

Clinicians and groups who are eligible for the Merit-based Incentive Payment System (MIPS) that participate successfully in the study will receive full credit for the 2018 MIPS Improvement Activities performance category. Applications for this study will be accepted through March 23. Applicants will be notified by email of their status in spring of 2018.

For More Information:

- Application
- Feedback webpage
- Email MIPS_Study@abtassoc.com

Patients over Paperwork Newsletter

The February Patients over Paperwork newsletter discusses the new Meaningful Measures Initiative, field visits for feedback from providers, as well as the latest documentation review improvements:

- Supplier use of bar codes to track Certificates of Medical Necessity
- Teaching physician verification of student medical record documentation
- Physician delegation of documentation requirements
- Skilled nursing facility: Streamlined process for Advanced Beneficiary Notice

Learn more about Patients over Paperwork, and view past editions of this newsletter. Visit the Simplifying Documentation Requirements webpage for previous updates, and find out how to submit an idea.

MIPS Claims Based Quality Measures Projections and Results Video

This video demonstrates a new Quality Payment Program website feature for the Merit-Based Incentive Program (MIPS). This feature allows users from groups who submit Quality Measures using the claims based submission method to log in and view monthly calculations.

MIPS 2018 QCDR Measure Specifications

CMS posted the Qualified Clinical Data Registries (QCDRs) Measure Specifications on the 2018 Resources webpage:

- QCDR measures for the 2018 Merit Based Incentive Payments System (MIPS) performance period
- Step-by-step instructions for searching the measures

For More Information:

- QCDR Qualified Posting - contact information for the 2018 approved vendors
- Quality Payment Program Resource Library webpage
- Contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know

Deadlines are fast approaching if you plan to submit data for the 2017 Merit-based Incentive Payment System (MIPS)performance period. The two key dates are:

- March 16 at 8 pm ET for group reporting via the CMS web interface
- March 31 for all other MIPS reporting, including via the Quality Payment Program website

Read the article for 10 things you need to do and know if you are an eligible clinician.

E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21

Wednesday, March 21 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

CMS is looking for physicians and non-physician practitioners to provide feedback on Evaluation and Management (E/M) services. CMS seeks comments from stakeholders on potential updates to the E/M guidelines to reduce burden and better align coding and documentation with the current practice of medicine. This listening session follows CY 2018 Medicare Physician Fee Schedule rulemaking and is part of an ongoing effort to seek input from stakeholders on these topics.

Target Audience: Individual physicians and non-physician practitioners who perform and bill E/M services; state and national associations that represent healthcare providers; and other interested stakeholders.

Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet — Revised

A revised Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet is available. Learn about:

- Quick Start Guide for physicians, Non-Physician Practitioners (NPPs), and supplier organizations
- Determining if you are eligible to enroll
- How to enroll

Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet — New

A new Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet is available. Learn about:

- Reasons for denial
- How to prevent claim denials
- Documentation requirements
- Coverage criteria

Open Payments: The Program and Your Role Call — March 14

Wednesday, March 14 from 2 to 3 pm ET
Register for Medicare Learning Network events.

CMS Provider Minute Video: Utilizing Your MAC to Prepare for CERT Review — New

Discover how your Medicare Administrative Contractor (MAC) can help you with a Comprehensive Error Rate Testing (CERT) review. Learn the review process and how to be prepared. The CMS Provider Minute: Utilizing Your MAC video gives you the tools necessary to be successful in navigating CERT review. Learn about:

- Your MAC's role
- CERT process
- Your role

PECOS for Physicians and NPPs Booklet — Revised

A revised The PECOS for Physicians and Non-Physician Practitioners (NPPs) Booklet is available. Learn about:

- Registering in the Provider Enrollment, Chain, and Ownership System (PECOS) system
- Obtaining a National Provider Identifier
- Entering information
- Responding to Medicare Administrative Contractor requests

PECOS FAQs Booklet — Revised

A revised PECOS FAQs Booklet is available. Learn about:

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

Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet — New

A new Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet is available. Learn about:

- Requirements for Infusion pumps
- How to prevent claim denials
- Documentation needed to submit a claim

Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder

The Beneficiaries in Custody under a Penal Authority Fact Sheet is available. Learn about:

- Medicare policy, claims processing, and appeals
- Determining whether a Medicare beneficiary is in custody under a penal statute or rule
- Social Security Administration policy

PECOS Technical Assistance Contact Information Fact Sheet — Revised

A revised 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

Medicare Secondary Payer Booklet – Reminder

The Medicare Secondary Payer Booklet is available. Learn about:

- When Medicare may pay first or second
- Conditional payments
- Coordination of benefits rules
- The Benefits Coordination & Recovery Center's role

Recent LearnResource & MedLearn Matters Articles

- Healthcare Provider Taxonomy Codes (HPTCs) April 2018 Code Set Update (MM 10402)
- ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) (MM 10473)
- Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System (MM 10397)
- Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2018 Update (MM 10488)
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update (MM 10489)

Drugs included in the *Most Cost-Effective Setting Program*

The following is a complete list of drugs that will require precertification approval for medical necessity and setting **as of June 1, 2018:***

- Actemra® (tocilizumab)
- Aralast NP® (alpha-1 proteinase inhibitor [human])
- Benlysta® (belimumab) – **NEW FOR JUNE 1, 2018**
- Cerezyme® (imiglucerase)
- Elelyso™ (taliglucerase alfa)
- Entyvio® (vedolizumab)
- Exondys-51™ (eteplirsen)
- Fabrazyme® (agalsidase beta)
- Glassia® (alpha-1 proteinase inhibitor [human])
- Inflectra® (infliximab-dyyb)
- Intravenous/subcutaneous immunoglobulin (IVIG/SCIG)
- Ixifi™ (infliximab-qbtx)
- Lumizyme® (alglucosidase alfa)
- Neulasta® (pegfilgrastim)
- Neulasta® (pegfilgrastim) Onpro®
- Nucala® (mepolizumab)
- Ocrevus™ (ocrelizumab)
- Orencia® (abatacept)
- Prolastin® (alpha-1 proteinase inhibitor [human])
- Prolia® (denosumab)
- Radicava™ (edaravone)
- Remicade® (infliximab)
- Renflexis® (infliximab-abda)
- Sandostatin® LAR Depot (octreotide acetate)
- Simponi Aria® (golimumab)
- Soliris® (eculizumab)
- Somatuline® Depot (lanreotide)
- Stelara® (ustekinumab)
- Vimizim® (elosulfase alfa)
- VPRIV® (velaglucerase alfa)
- Xolair® (omalizumab)
- Zemaira® (alpha-1 proteinase inhibitor [human])

This list of drugs is subject to change.

Note: All biosimilars to the originator products in this program are subject to precertification review for most cost-effective setting.

NaviNet® Provider File Management transaction now available

Posted March 7, 2018

We are pleased to announce that the Provider File Management transaction on the NaviNet web portal is now available to accept submissions. This transaction allows professional providers to view and submit specific updates to their Independence provider record.

- Add/Delete a participating practitioner to/from an existing practice
- Add/Delete an address (i.e., doing business as [DBA], check, mailing, main, or practice)
- Add/Delete contact name, title, or communication device type/number
- Add/Delete office hours
- Update "Walk-in" acceptance status
- Update Patient and Appointment Options (i.e., accepting new patients)
- Update General Practice Availability (i.e., Urgent, Routine Visits, etc.)
- Update Member Access number (i.e., the telephone number that appears on the member's identification card – which must be the location-specific telephone number for a patient to make an appointment)
- Update Electronic Medical Records (EMR) status
- Update the availability of other clinical staff (i.e., mid-wife, nurse practitioner, etc.)
- Update office accessibility and services (i.e., handicapped, parking, and communication and language services)

READ MORE

Reminder: Updates to the list of specialty drugs that require precertification

As of March 1, 2018, new precertification requirements are in effect for Independence commercial and Medicare Advantage HMO and PPO members for the following specialty drugs that are eligible for coverage under the medical benefit: Includes…. Ixifi™ (infliximab-qbtx), Pemfexy™ (pemetrexed) READ MORE

Medical codes for services that require precertification

A list of services that require preapproval/precertification from Independence prior to being performed for our members is available for providers on our Medical Policy Portal. This list, *Services that require precertification*, includes the CPT® and HCPCS codes, where applicable, that correlate with the services and injectable drugs that are included on our Preapproval/Precertification List.

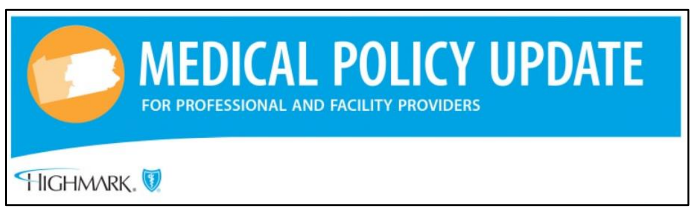
To access *Services that require precertification*, visit our Medical Policy Portal and select *Accept and Go to Medical Policy Online*. Choose the *Commercial* or *Medicare Advantage* tab from the top of the page, then select *Services Requiring Precertification* from the left-hand menu.

ICD-10 in Action

This Independence series, *ICD-10 in Action*, features articles to recap some of the ICD-10 diagnosis code changes, introduce new coding scenarios, and communicate updates to ICD-10 coding conventions.

The ICD-10-CM Manual contains official guidelines for coding and reporting. There are coding conventions, general coding guidelines, and chapter-specific guidelines, as described below, which must be followed to classify and assign the most appropriate ICD-10 code when submitting a claim. Understanding these guidelines and conventions is key to reaching the most appropriate code assignment.

Read more and view scenario examples CLICK HERE



Be sure not to miss the
HIGHMARK MEDICAL POLICY UPDATE
Published Monthly

CLICK HERE

Provider Resource Center Updated!

We have updated the Provider Resource Center! Includes advanced search functionality and so much more! Please view our video tutorial to help you understand the new site.

Four Codes To Be Added to Highmark's List of Procedures Requiring Authorization 3/1/18

Effective with dates of service of March 1, 2018, and beyond, we will revise our list of outpatient procedures/services requiring authorization to add four procedures codes. READ MORE

PROVIDER NEWS

Most Recent Issue …

CLICK HERE

***Attention POHMS Members –
list includes J9032-Beleodaq and J9039-Blincyto*

NEW!

NEW!

NEW!

aetna

A Few Articles You Won't Want to Miss:

- Changes to our National Precertification List (NPL)
- Request precerts electronically — it's fast, secure and simple
- Ordering genetic tests in the correct sequence will result in fewer denials
- Changes to commercial drug lists begin on July 1, 2018

And Much More….

MARCH
Northeast Region
Qtly Issue Available HERE

A Few Articles You Won't Want to Miss:

Front & Center

- Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members
- Denosumab (HCPCS code J0897) Will Require Prior Authorization

UnitedHealthcare Community Play

- UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

UnitedHealthcare Medicare Advantage

- UnitedHealthcare Medicare Advantage Coverage Summary Updates

And Much More…MARCH Monthly Issue Available HERE

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

Updated:

- Platelet Derived Growth Factors for Treatment of Wounds - Effective Mar. 1, 2018
- Proton Beam Radiation Therapy - Effective Mar. 1, 2018

Revised:

- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions - Effective Apr. 1, 2018

Medical Drug Benefit Policy Updates

New:

- Denosumab (Prolia® & Xgeva®) - Effective Mar. 1, 2018

Updated:

- Orencia® (Abatacept) Injection for Intravenous Infusion - Effective Mar. 1, 2018

Utilization Review Guideline (URG) Updates

Updated:

- Immune Globulin Site of Care Review Guidelines for Medical Necessity of Hospital Outpatient Facility Infusion - Effective Apr. 1, 2018

Revised:

- Chemotherapy Observation or Inpatient Hospitalization - Effective Apr. 1, 2018
- Office Based Program - Effective Apr. 1, 2018
- Hospital Readmissions - Effective Apr. 1, 2018

MARCH Monthly 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 abemaciclib (VERZENIO, Eli Lilly and Company) in combination with an aromatase inhibitor as initial endocrine-based therapy for postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. More Information. February 26, 2018

- FDA approved durvalumab (Imfinzi, AstraZeneca Inc.) for patients with unresectable stage III non-small cell lung cancer (NSCLC) whose disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy. More Information. February 16, 2018

- FDA approves apalutamide for non-metastatic castration-resistant prostate cancer. More Information. February 14, 2018

- FDA approved abiraterone acetate (Zytiga, Janssen Biotech Inc.) tablets in combination with prednisone for metastatic high-risk castration-sensitive prostate cancer (CSPC). More Information. February 7, 2018

- FDA approved Feraheme for the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance to oral iron or have had unsatisfactory response to oral iron. Feraheme is also indicated for the treatment of iron deficiency anemia in adult patients with chronic kidney disease (CKD). More Information. February 2, 2018

- FDA approved a new formulation of IMBRUVICA. One pill, once daily IMBRUVICA® is approved in 560 mg, 420 mg, 280 mg, 140 mg, and 70 mg dosages. More Information.

FDA launches a new set of REMS webpages
Drug Information Update

January 29, 2018, the U.S. Food and Drug Administration (FDA) is launching a new set of webpages that aims to provide a one-stop source for general information about Risk Evaluation and Mitigation Strategy (REMS) programs. These webpages organize general REMS information according to audience (i.e., patients, health care professionals and industry) and most pages are presented in a short question and answer format.

In 2007, the Food, Drug Administration Amendments Act gave FDA the authority to require a REMS when FDA determines it is necessary to ensure the benefits of the drug outweigh the risks. Over the past decade, REMS have enabled FDA to approve drugs that otherwise might not have been approvable. However, REMS can also place a burden on the healthcare delivery system.

One piece of valuable feedback FDA has received regarding REMS is that information on drug-specific REMS, and on REMS more generally, can be difficult to locate on the web. REMS information will now be easier to find, relevant and ultimately more useful because organization of the new web content is based on the role a person might have in a REMS program. Also, other newly created pages guide visitors to current information about REMS programs, FDA guidances, public meetings, and educational resources.

Our goal is to enable easier compliance with these programs so that patient access to drugs with REMS can be maintained, while still preserving their safe use.

As always, FDA welcomes feedback. Please use the Contact REMS Form to send us any comments you have on the newly created REMS webpages. For more information, please visit: New REMS Webpages.

The Solution to Drug Pricing? Don't Fix the Blame, Fix the Problem

The debate over drug pricing has devolved into the repetition of the same old shibboleths. Perhaps the best response is (in the words of Aldous Huxley): “Facts do not cease to exist because they are ignored.”
READ MORE

Grassley Introduces Bill to Bring Transparency to the 340B Prescription Drug Program

U.S. Sen. Chuck Grassley introduced legislation that would inject needed transparency in a targeted way into the 340B program. The 340B program was created by Congress in the Veterans Health Care Act of 1992 and allows hospitals and other health care entities to receive discounted prices on prescription drugs and biologics from drug manufacturers. By law, these drug manufacturers must offer 340B discounts to covered entities in order to participate in the Medicaid program.

Read the full article on Grassley.Senate here.

Reports Find Risk Of Non-ACA-Compliant Plans To Be Higher Than Federal Estimates

Three new reports—by the Urban Institute, Avalere, and Oliver Wyman—provide additional data on the impact of two recent proposed rules to expand access to short-term, limited-duration insurance and association health plans (AHPs). These rules were issued in response to an executive order from President Trump to expand access to these and other alternatives to coverage under the Affordable Care Act (ACA).

Read the full article on Health Affairs here.

NCCN Conference to Address Value-Based Healthcare Models, Payer Perspectives, New NCCN Guidelines, and Other Updates in Cancer Care

(NCCN) Mar 5, 2018 - The National Comprehensive Cancer Network (NCCN®) is hosting the 23rd NCCN Annual Conference to address some of the biggest emerging issues in oncology today, including receiving cancer care in value-based healthcare models, managed care and CMS reimbursement.

READ PRESS RELEASE

Is Spending for Infused Chemotherapy By Commercial Insurers Lower at Physician Offices?

(The JAMA Network) Feb 22, 2018 - Bottom Line: Delivering infused chemotherapy in a physician office was associated with lower spending by commercial health insurers compared with chemotherapy administered in a hospital outpatient department. READ PRESS RELEASE

Two paths ahead for MACRA and QPP

More providers than ever before are getting a full pass on pay-for-performance in 2018, and even those that are required to participate have a path that is only marginally more difficult than this year. Is all that too good to be true? Download now

FDA clarifies information about payment and reimbursement to research subjects

January 29, 2018, the Food and Drug Administration (FDA) published updates to the Payment for Research Subjects: Information Sheet to clarify that reimbursement for travel expenses to and from the clinical trial site and associated costs such as airfare, parking, and lodging are acceptable under current practices. These updates were made in response to inquiries FDA received from stakeholders about appropriate reimbursement practices. The title of this information sheet has been revised to reflect these changes. The new title is Payment and Reimbursement to Research Subjects.

How to succeed under the new CMS payment model

The Merit-Based Incentive Payment System (MIPS) is intended to measure - and adjust payments based on - the value of care provided across four categories, with bonuses for meeting exceptional performance thresholds. Read this MIPS Scoring Guide to understand how MIPS scoring works and how you can optimize your MIPS score. Download now

COA 2017 Year in Review

(COA) Jan 23, 2018 - It was a busy year for COA and community oncology. From the OCM to PBMs to 340B and more, we had our hands full. Read the COA 2017 Year in Review for highlights of what we accomplished together and the challenges ahead.

READ ARTICLE

Reimbursement Questions & Answers

If you have reimbursement questions you need answers to, please submit them to the Editor at Michelle@WeissConsulting.org

Question: In the CPT book it states, Hydration is described as an IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCl/liter….)

We purchase normal saline bags and add potassium. It is cost effective for our practice. Is this still considered pre-packaged fluids? Should we switch to billing therapeutic infusion codes since it was not shipped to our practice in the pre-packaged situation? Also, what if we add magnesium? Would that be hydration or therapeutic? Does it depend on the amount?

Answer: If you were treating your patient for dehydration and using pre-packaged fluid or the equivalent of pre-packaged fluid, you would bill hydration (as long as it is not concurrent with other medications and longer than 30 minutes).

If you are treating the patient for a condition or to prevent a condition such as nephrotoxicity, and you are administering 1 gram of potassium or magnesium for example, then this would be billed as a therapeutic infusion during the time it runs alone. This higher dose of electrolytes cannot be purchased as pre-packaged fluid.

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Question:
Drug: Ativan J2060 - IV infusion over 16 minutes, but it is given over 15 minutes and it is billed as 96367. The time tells me it is not an IV infusion, it is a IV push. But I don't have an order noting that it must be given IV push. The order says IV Infusion. Technically, should it be billed as an IV push? Please advise.

Continued on next page…

Answer: The nurse must follow the physician order. If the order says to administer over 15 minutes IV - and the nurse gave it over 15 minutes IV, you will bill for a 15 minute IV infusion. The extra minute the nurse documented would not be "medically necessary" if the physician order stated to give over 15 minutes. With that said, in order to BILL a 15 minute IV infusion - YOU, the biller, must use the push code on your claim per the AMA CPT requirements. Technically you are still billing an IV infusion.

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Question: If we come across an order that is not signed in the EMR can we sign the order when found? If not is there any way to correct this after the fact?

Answer: Essentially, if the nurse administers a drug without having a signed order, they are in violation of the state law and therefore, adding a late signature will not correct the situation. Medicare policy states; "If the signature is missing from an order, ACs, MACs, PSCs, ZPICs, and CERT will disregard the order during the review of the claim. If the signature is missing from any other documentation, ACs, MACs, PSCs, ZPICs, and CERT will accept a signature attestation from the author of the medical record entry." The only variable I can think of is the situation where the order was documented as a verbal order- a late signature in that situation may be acceptable as long as the signature is dated and "authenticates" the verbal order.

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Question: With verbal orders is there a time limit for those to be signed off by the physician?

Answer: I have not seen requirements within the CMS online manual related to the time frame of the signature specific to verbal orders. In fact, in 2011, CMS attempted to pass policy that required verbal order signatures within 48 hours. That rule was rescinded on July 16, 2012; it was stated in the Federal Register, "Verbal Orders: We have eliminated the requirement for authentication of verbal orders within 48 hours and have deferred to applicable State law to establish authentication time frames."

Continued on next page…

However, WPS Medicare has documentation requirements within their website that states: "Physician offices should have a protocol in place to have physicians sign their records within a reasonable time, generally 48 to 72 hours after the encounter, but certainly prior to submitting the claim to Medicare."

Another Medicare MAC, Novitas states on their website: "If the order is verbal, follow it within 14 days by a signature to be timely."

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Question:
Would you mind clarifying the proper use of 96368 for billing in chemotherapy. So many of our payers are not paying for this code and some denials are for "incidental to" denials. Can we bill for the 96368 if they are a therapeutic drug and a chemotherapy drug going to the same access site? Can we only bill the 96368 when they are concurrent and going to different access sites? I have gotten so many different answers and feel that you could answer this question once and for all.

Answer: I used to call it "Concurrent Confusion" because it is challenging to understand. If you have a therapeutic agent, in a SEPARATE BAG, hanging at the same time as another - (concurrently) - then you can use the code. Some payers look for a 59 modifier on the 96368.

The AMA defines a concurrent infusion as one in which two drugs are simultaneously infused or multiple infusions are provided through the same intravenous line. Note: Multiple substances mixed in one bag are considered to be one infusion, not a concurrent infusion.

There is no concurrent code for hydration. The concurrent CPT/Charge is limited to unit of one regardless of the duration of the concurrent infusion.

CORPORATE ALLIES

DIAMOND LEVEL

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Our Mission

POHMS provides education and operational best practices to Hematology Oncology members through professional development and networking. The organization empowers members by creating an environment of support, collaboration and continuous learning.

Vision Statement

Active leadership and unity for all POHMS members to thrive in the evolving Hematology Oncology community.

Values Statement

At POHMS, we are committed to the highest standards of ethics and integrity and strongly believe that we are responsible to our members, stakeholders, and to the communities we serve. As a part of our responsibility, we strive to create an environment of continuous learning and improvement in the oncology hematology industry.

We are passionate about the success of our members. Our driving innovation and commitment to personal and professional development makes an invaluable resource. Educational programs and professional meetings help foster a network of growth, support, and collaboration. The sharing of ideas and trends enable POHMS to continue to build upon our tradition of innovation.

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