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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

We hope you enjoy this new version of the POHMS Newsletter

Issue 49 FEDRUARY `18

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

TABLE OF CONTENTS

POHMS Annual Spring Conference is scheduled for…

Thursday, May 17, 2018

REGISTRATION OPEN

CLICK HERE

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

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Blood Test To Detect 8 Cancers Early Gives Promising Results

Jan 19, 2018 – Scientists are reporting progress on a blood test to detect many types of cancer at an early stage, including some of the most deadly ones that lack screening tools now. READ ARTICLE

CMS Releases First Annual Report from the Evaluation of the OCM

February 2, 2018 – This evaluation from the Centers for Medicare & Medicaid Services (CMS) seeks to examine the impact of the Oncology Care Model (OCM) on outcomes such as episode utilization and expenditures. This report examines characteristics of participating practices and their matched comparators prior to implementation of the model, and describes cancer care before any changes induced by OCM. It lays the foundation for evaluation results that will be presented in subsequent reports.

Read the full Report here.

Congress Urged to Fix Rule Distorting Quality Payment Program Adjustments

(ASCO in Action) Jan 24, 2018 – ASCO and 46 State and Regional Affiliates are among 109 healthcare groups urging Congress to address a rule that would penalize oncology and other medical specialties for their use of Medicare Part B drugs. READ ARTICLE

ACCC
Association of Community Cancer Centers

ACCC Patient Assistance & Reimbursement Guide Available

The 2018 Patient Assistance & Reimbursement Guide has the most up-to-date information on cancer drug assistance and reimbursement programs to help your patients alleviate the financial burden of their treatment. This publication contains:

- Pharmaceutical patient assistance and co-pay programs
- Non-for-profit and foundation patient assistance and co-pay programs
- Directions on how to apply and links to enrollment forms
- Patient assistance flow charts for specific patient populations
- Valuable advice on how to develop, implement, and improve co-pay, foundation and billing processes.

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Received an ADR letter?
Submit Your Documents with Novitasphere

If you have received an Additional Documentation Request (ADR) letter from Novitas, save your office time by submitting your documents via Novitasphere, our free, web-based portal.

Make sure you review the ADR letter carefully for the description of the type of documentation that is needed to make the coverage or coding determination, along with the date of service. Then log into Novitasphere to upload and submit your documents quickly and easily. You will receive an immediate confirmation that your request has been submitted, and you can review your submission via the Secure Message Submission History feature.

Start saving time today. To learn more or enroll now, visit our Novitasphere Center.

Part B Top Inquiries / Frequently Asked Questions

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for December 2017. New questions / answers have been added to all six categories. Check out our FAQs for answers to your questions.

READ MORE

Part B Claims Issues Log

We have updated the Part B Claims Issues Log regarding claim denials associated with National Coverage Determinations 220.4, Mammograms and 220.13, Percutaneous Image-Guided Breast Biopsy. A temporary correction has been implemented that will allow the new ICD-10 diagnosis codes to be submitted for these services until the permanent correction is implemented April 2, 2018. Please refer to the Part B Claims Issues Log for details.

READ MORE

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for December 2017 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

Medical Policy

The following JL Local Coverage Determinations (LCDs) have been revised to reflect the Annual CPT/HCPCS Code updates effective for dates of service on and after January 1, 2018:

- Biomarkers for Oncology (L35396)
- Biomarkers Overview (L35062)
- BRCA1 and BRCA2 Genetic Testing (L36715)
- Hemophilia Factor Products (L35111)
- Services That Are Not Reasonable and Necessary (L35094)

The following JL Local Coverage Articles have been revised to reflect the Annual CPT/HCPCS Code updates effective for dates of service on and after January 1, 2018:

- Biomarkers for Oncology (A52986)
- NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)

New Format for Novitas' Local Coverage Determinations (LCDs)

There are three new sections included in our LCDs that provide insight into the rationale for indications and limitations of coverage:

1. Summary of Evidence - Contains a summary of the pertinent literature and/or guidelines that were used to determine covered indications and limitations.
2. Analysis of Evidence (Rationale for Determination) - A high level overview and conclusion based on all of the literature and guidelines reviewed. This section provides the reasoning or basis for the indications and limitations of coverage.
3. Bibliography - A new subsection under the "Sources of Information" that includes all sources used to write the LCD.

For details, please review this article in its entirety.

NOVITAS SOLUTIONS

WEBINAR

Listed are Novitas training events an oncology practice should consider!

HOME

Novitas Self-Service Tools:

View all Self-Service Tools

Date	Starts	Ends	Event Details	CEUs	Media Type
Thursday, February 15, 2018	10:00 AM	11:00 AM	**JL Part B Ask The Contractor Webinar** The Ask The Contractor webinar gives providers the opportunity to ask representatives from our operational departments general questions on a variety of topics. We will review topics of provider interest on: CERT errors, Electronic Data Interchange (EDI), enrollment reminders, Medicare quarterly updates, website improvements, and upcoming education.	1.0	Webinar
Thursday, February 15, 2018	2:00 PM	3:00 PM	**Novitasphere Claim Submission Overview** This course will focus on how to submit claims through the Novitasphere portal. We will show you how to submit an 837 ANSI batch claim file, how to enter single claims into the Direct Data Entry feature, and how to download your electronic claim reports.	1.0	Webinar
Wednesday, February 21, 2018	11:00 AM	12:00 PM	**Novitasphere Claim Correction Overview** This course will examine how to determine when a claim correction can be performed in Novitasphere and how to complete a clerical reopening. We will also provide examples of claims that can and cannot be updated through the Novitasphere Claim Correction feature.	1.0	Webinar
Friday, February 23, 2018	11:00 AM	12:00 PM	**Novitasphere Hot Topics and Frequently Asked Questions** This course will discuss Novitasphere hot topics and provide answers to the most frequently asked questions. We will also provide tips and resources to assist you when using Novitasphere.	1.0	Webinar

For many more opportunities and to register…

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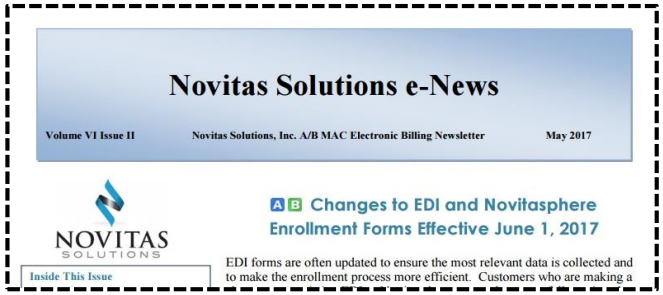
Novitas Solutions e-News Electronic Billing Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



Medicare Part B – H O T L I N K S !

Medicare JL Part B Fee Schedule

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

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

Four Tough Questions About HEDIS Review in 2018

By Greg Ford

Best practices are described for eliminating redundancies and easing workloads during the HEDIS season now underway.

Healthcare Effectiveness Data and Information Set (HEDIS) reviews are conducted by health plans and government payers every year from January to mid-May. With the official 2018 HEDIS review season now in full swing, this article seeks to answer four tough questions about these reviews and suggests best practices to follow as hospitals prepare their teams. READ MORE

340B Drug Program: An Update

By Timothy Powell, CPA

The 340B drug discount program continues to be in a state of flux

The American Hospital Association (AHA) recently filed suit to stop reductions to the 340B drug program. On Dec. 29, 2017, the lawsuit was dismissed by the judge, who ruled: "In conclusion, plaintiffs' failure to present any concrete claim…" READ MORE

2018
Value Modifier Results and Payment Adjustment Factor

CMS announced the results of the 2018 Value Modifier and the adjustment factor that will be applied to clinicians receiving an upward payment adjustment. In 2018, over 20,000 clinicians will receive an increase of 6.6% to 19.9% on their Medicare physician fee schedule payments as a result of their high performance on quality and cost measures in 2016. The 2018 Value Modifier results and the payment adjustment factor are available on the 2016 QRUR and 2018 Value Modifierwebpage.
The Value Modifier payment adjustment ends in 2018. The Merit-based Incentive Payment System under the new Quality Payment Program is replacing the Value Modifier.

For More Information:

- Value-Based Payment Modifier webpage
- Quality Payment Program website

For questions about the 2018 Value Modifier, contact the Physician Value Help Desk at 888-734-6433 (select option 3) or pvhelpdesk@cms.hhs.gov

CMS NEWS - FOR IMMEDIATE RELEASE
February 1, 2018
CMS proposes Medicare Advantage and Part D payment and policy updates to provide new benefits for enrollees, new protections to combat opioid crisis

Today, the Centers for Medicare & Medicaid Services (CMS) released proposed changes for the Medicare health and drug programs in 2019 that increase flexibility in Medicare Advantage that will allow more options and new benefits to Medicare beneficiaries, meeting their unique health needs and improving their quality of life. Furthermore, the proposal includes important new steps to ensure new patient-doctor-plan communication in combatting the opioid crisis.

As a part of these changes, CMS is redefining health-related supplemental benefits to include services that increase health and improve quality of life, including coverage of non-skilled in-home supports, portable wheelchair ramps and other assistive devices and modifications when patients need them.

"Our priority is to ensure that our seniors have more choices and lower premiums in their Medicare health and drug plans," said CMS Administrator Seema Verma. "We are focused on addressing the specific needs of beneficiaries and providing new flexibilities for Medicare Advantage plans to offer new health-related benefits. This is a big win for patients."
READ MORE

Targeted Probe and Educate: New Resources

Find out how the Targeted Probe and Educate (TPE) program helps providers and suppliers reduce claim denials and appeals through one-on-one education. The updated TPE webpage has new resources, including:

- Common claim errors
- TPE process graphic
- One-pager about the program to download and share
- Q&As

Next Generation Accountable Care Organization - Implementation MLN Matters® Article — Revised

A revised MLN Matters Special Edition Article on Next Generation Accountable Care Organization - Implementation is available. Learn about the model's waiver initiatives and supplemental claims processing direction.

CMS Updates Open Payments Data

On January 17, CMS updated the Open Payments dataset to reflect changes to the data that took place since the last publication on June 30, 2017. CMS updates the Open Payments data at least once annually to include updates from disputes and other data corrections made since the initial publication of the data.

The refreshed Open Payments Data Set includes:

- Record Updates: Changes to non-disputed records that were made on or before November 15, 2017, are published.
- Disputed Records: Dispute resolutions completed on or before December 31, 2017, are displayed with the updated information. Records with active disputes that remained unresolved as of December 31, 2017, are displayed as disputed.
- Record Deletions: Records deleted before December 31, 2017, were removed from the Open Payments database. Records deleted after December 31, 2017, remained in the database but will be removed during the next data publication in June 2018.

For More Information:

- Open Payments website
- If you have questions, contact the Help Desk at openpayments@cms.hhs.gov or 855-326-8366

New Medicare Card: Web Updates for Providers

To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices.

Beginning in October 2018, through the transition period, when providers submit a claim using a patient's valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

- Medicare Remit Easy Print (Medicare Part B providers and suppliers)
- PC Print for Institutions
- Standard Paper Remits: FISS (Medicare Part A/Institutions), MCS (Medicare Part B/Professionals), VMS (Durable Medicare Equipment)

Find more new information on the New Medicare Card provider webpage.

New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the Mailing Strategy. Also starting April 2018, your patients will be able to check the status of card mailings in their area on Medicare.gov.

For More Information:

- Mailing Strategy
- Questions from Patients? Guidelines
- New Medicare Card overview and provider webpages

CMS NEWS-FOR IMMEDIATE RELEASE-January 2, 2018
CMS Launches Data Submission System for Clinicians in the Quality Payment Program

Website makes it easier for clinicians to submit data by offering one user-friendly site for all submissions

Today, the Centers for Medicare & Medicaid Services (CMS) announced that doctors and other eligible clinicians participating in the Quality Payment Program can begin submitting their 2017 performance data using a new system on the Quality Payment Program website (qpp.cms.gov). The data submission system is an improvement from the former systems under the CMS legacy programs, which required clinicians to submit data on multiple websites. Now, eligible clinicians will use the new system to submit their 2017 performance data for the Quality Payment Program during the 2017 submission period which runs from January 2, 2018 to March 31, 2018, except for groups using the CMS Web Interface whose submission period is January 22, 2018 to March 16, 2018.

"The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement the Quality Payment Program, and we are committed to doing so in the least burdensome way possible," said Seema Verma, Administrator of CMS. "The new data submission system makes it easier for clinicians to meet MACRA's reporting requirements and spend more time treating patients instead of filing paperwork." READ MORE

Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

A 2017 Office of the Inspector General (OIG) report noted that, in some cases, pharmacies incorrectly billed Medicare Part B for claims using the KX modifier for immunosuppressive drugs. It is estimated that Medicare paid $4.6 million for these claims that did not comply with Medicare requirements.

In response to this report, CMS clarified manual instructions on the use of the KX modifier to help pharmacies document the medical necessity of organ transplant and eligibility for Medicare coverage. Resources for pharmacies:

- Pharmacy Billing of Immunosuppressive Drugs MLN Matters® Article
- Clarification of the Billing of Immunosuppressive Drugs MLN Matters Article
- Change Request 10235
- OIG Report on the proper use of the KX modifier for Part B immunosuppressive drug claims

Physician Compare:
2016 Performance Information Available

CMS recently added PY 2016 performance information to Physician Compare. For the first time, CMS publicly reported a small subset of 2016 Physician Quality Reporting System (PQRS) group-level measures on Physician Compare profile pages as star ratings.

The updated 2016 measures CMS released on the Physician Compare public-facing profile pages include:

- Fifteen 2016 PQRS measures for groups as star ratings
- 2016 Consumer Assessment of Healthcare Providers and Systems for PQRS patient experience measures for groups as top-box scores
- 2016 non-PQRS Qualified Clinical Data Registry measures with performance rates expressed as percentages for clinicians and groups
- 2016 Accountable Care Organization measures

Data are also available via the Physician Compare Downloadable Database on data.medicare.gov. The 2016 performance information is anticipated to be made publicly available for download in late spring/early summer 2018. While the profile pages are intended for patients and caregivers, the Downloadable Database is a resource for clinicians and group representatives as well as third-party data users.

For More Information:

- Fact Sheet
- Physician Compare Initiative website

2018 Medicare EHR Incentive Program Payment Adjustment for Eligible Clinicians

The payment adjustment amount for the Electronic Health Record (EHR) Incentive Program is established by statute for specific calendar years and continues through the end of CY 2018. A new fact sheet for eligible clinicians includes: Payment adjustments, Exceptions process, Applicable hardship exceptions categories

For more information, visit the EHR Incentive Programs website.

QRUR Video Presentation — New

A video presentation is available for the October 19 webcast on the 2016 Annual Quality and Resource Use Reports (QRURs). This event provides an overview of the report and explains how to interpret and use the information.

Quality Payment Program Resources

CMS posted new Merit-based Incentive Payment System (MIPS) resources on Quality Payment Program Resource Library webpage:

- CMS Web Interface: Excel template for uploading sample beneficiary data with corresponding user guide and instructional video
- Extreme and Uncontrollable Circumstances Fact Sheet: Overview of the policy established in the interim final rule with comment period to support clinicians affected by the California wildfires and Hurricanes Harvey, Irma, and Maria
- MIPS 101 Guide: Overview of MIPS, including who is eligible to participate, three ways to participate in 2017, and reporting requirements for the four performance categories
- MIPS Optometry Specialty Guide: Sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to optometry in 2017
- MIPS Participation Infographic: Three ways eligible clinicians can participate in MIPS in 2017
- Quality Payment Program FAQs: Answers to nearly 40 questions about the Quality Payment Program in 2017

Other Resources:

- MIPS Scoring 101 Guide
- Specialty guides for radiologists and podiatrists
- Virtual Groups Toolkit

For More Information:

- Visit the Quality Payment Program website to check your participation status, explore measures, and review guidance
- Quality Payment Program Resource Library webpage
- For questions, contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Quality Payment Program: Patient-facing Encounters Resources

CMS posted these resources on the 2018 Resources webpage:

- Patient-facing Encounter Codes Fact Sheet: Defines patient-facing encounters and details the categories included in the patient-facing encounter codes list
- Patient-facing Encounter Codes List: Code and description for each patient-facing encounter
- Operational List of Care Episode and Patient Condition Codes Background: Context for the information presented in the Operational List of Care Episode and Patient Condition Codes document
- Operational List of Care Episode and Patient Condition Codes: Operational list of eight episode-based cost measures and their corresponding episode group trigger codes

For More Information:

Quality Payment Program website

Resource Library webpage

Contact the QPP Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

ASCO in Action

Missed our Webinar on the Quality Payment Program? Slides and Recording Coming Soon

(ASCO in Action) Dec 12, 2017- On December 12, ASCO held a webinar, Quality Payment Program: Preparing for 2018, Surviving in 2017, on data reporting under the Merit-Based Incentive Payment System (MIPS) in 2017 and 2018. Anyone who missed this event should bookmark ASCO's MACRA resources page, where a recording and slides from the webinar will be posted. READ ARTICLE

MLN Matters

Recent LearnResource & MedLearn Matters Articles

- Next Generation Accountable Care Organization - Implementation (Revised SE 1613)
- Next Generation Accountable Care Organization (NGACO) Year Three Benefit Enhancements (Revised MM 10044)
- ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) (Revised MM 10318)
- Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures (Revised SE 1422)

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Independence | PROVIDER News Center

Changes to our policy on facility appeals for lack of medical necessity

Posted January 17, 2018 - When all or part of an admission or outpatient service at an eligible facility is denied for failure to meet medical necessity criteria, the Independence member is held harmless and cannot be billed for the denied day(s) or service(s). The facility may appeal the denial for lack of medical necessity through the process detailed below. This process is the exclusive means of resolving such disputes. Please note that facility appeals for lack of medical necessity and payment reviews for lack of preapproval may *not* be pursued through the member grievance or member appeal processes.

Effective February 15, 2018, the response time to communicate our decision to the facility to uphold or overturn all, or a portion, of the adverse determination will increase from 60 to 90 calendar days from receipt of the written appeal request **and** the complete medical record from the appealing facility. The updated process is outlined below.

READ MORE

View up-to-date policy activity on our Medical Policy Portal

Posted January 16, 2018 - Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefit Programs occur in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal to stay up to date with changes to our policies.

READ MORE

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Independence | PROVIDER News Center

Reminder of changes to our Medicare Advantage plans for 2018

As previously communicated, Independence is offering five Medicare Advantage plans in 2018: Keystone 65 Focus HMO, Keystone 65 Preferred HMO, Keystone 65 Select HMO, Personal Choice 65SM PPO, and the new Keystone 65 Basic HMO.

Below are a few of the plans' features.

Referrals are no longer needed to see a specialist!

As of January 1, 2018, members in our Medicare Advantage HMO plans will no longer need referrals to see a specialist. We encourage our members to continue to see their primary care physician for coordination of care.

READ MORE

Updated NaviNet® Authorizations transaction resources now available

Posted January 25, 2018 – The Authorizations transaction on the NaviNet web portal has been modified. As part of the update, there are changes to some of the screen displays within the Create New Authorization portion of the transaction.

READ MORE

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MEDICAL POLICY UPDATE
FOR PROFESSIONAL AND FACILITY PROVIDERS

HIGHMARK BLUE SHIELD

HIGHMARK

January 2018

Be sure not to miss the Highmark Medical Policy Update – Published Monthly

CLICK HERE *to read the January issue which includes the articles below and more…*

Coverage Criteria Revised for Chimeric Antigen Receptor T-Cell Therapy

Highmark Blue Shield has revised coverage criteria for tisagenlecleucel (Kymriah™) from patients 3 to 26 years of age to patients 25 years of age or younger. This Medical Policy will apply to both professional provider and facility claims. The effective date was January 29, 2018

Coverage Criteria Revised for Denosumab (Prolia, Xgeva)

Highmark's Medicare Advantage products have revised the coverage criteria for denosumab (Prolia®, Xgeva®) based on the National Comprehensive Cancer Network and Food and Drug Administration approved indications.

This Medical Policy will apply to both professional provider and facility claims. The effective date was December 18, 2018.

Please refer to Medical Policy I-20, Denosumab (Prolia, Xgeva) for additional information

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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

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

Most Recent Issue …

CLICK HERE

OTHER PAYER UPDATES

NEW!

NEW!

A Few Articles You Won't Want to Miss:

- New precertification requirement effective March 1, 2018
- Clinical payment, coding and policy changes

And Much More….

DECEMBER
Northeast Region
Qtly Issue Available HERE

A Few Articles You Won't Want to Miss:

Front & Center
- New to Therapy Short-Acting Opioid Supply and Daily Dose Limits for UnitedHealthcare Community Plan and UnitedHealthcare Commercial Plans – Effective March 1, 2018
- Billing for Intravenous and Subcutaneous Immune Globulin and Remicade®
- Pharmacy Update: Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and Oxford

UnitedHealthcare Medicare Advantage
- New Professional and Technical Component Policy

And Much More…FEBRUARY
Monthly Issue Available HERE

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

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

Utilization Review Guideline (URG) Updates

Revised:
- Office Based Program - Effective Apr. 1, 2018

FEBRUARY Monthly Issue
Available HERE

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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 approved lutetium Lu 177 dotatate (LUTATHERA, Advanced Accelerator Applications USA, Inc.) a radiolabeled somatostatin analog, for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults. More Information. January 26, 2018

- FDA granted approval to afatinib (Gilotrif, Boehringer Ingelheim Pharmaceutical, Inc.) for a broadened indication in first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test. More Information. January 12, 2018

- FDA granted regular approval to olaparib tablets (Lynparza, AstraZeneca Pharmaceuticals LP), a poly (ADP-ribose) polymerase (PARP) inhibitor, for the treatment of patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), HER2-negative metastatic breast cancer who have been treated with chemotherapy either in the neoadjuvant, adjuvant, or metastatic setting. More Information. January 12, 2018

- FDA updated the U.S. Prescribing Information for XGEVA® (denosumab) to include patients with multiple myeloma*. The new indication states: XGEVA® is a RANK ligand (RANKL) inhibitor indicated for prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors. More Information. January 5, 2018

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.

Statement by FDA Commissioner Scott Gottlieb, M.D., updating on some ongoing shortages related to IV fluids

Earlier this month, we updated on the FDA's efforts to mitigate ongoing IV saline shortages that resulted from, or were worsened by, the devastating impact of Hurricane Maria in Puerto Rico. We also provided some additional updates related to our continued efforts to help the island fully recover from this disaster. As we continue to hear concerns about shortages in our discussions with hospitals and health care providers, as well as in media reports, I wanted to provide more information on this evolving challenge. Continue reading…

MedWatch – The FDA Safety Information and Adverse Event Reporting Program

Varubi (rolapitant) Injectable Emulsion: Health Care Provider Letter - Anaphylaxis and Other Serious Hypersensitivity Reactions

AUDIENCE: Pharmacy, Oncology, Nursing

ISSUE: Anaphylaxis, anaphylactic shock and other serious hypersensitivity reactions have been reported in the postmarketing setting, some requiring hospitalization. These reactions have occurred during or soon after the infusion of Varubi (rolapitant) injectable emulsion. Most reactions have occurred within the first few minutes of administration. Symptoms of anaphylaxis can include wheezing or difficulty breathing; swelling of the face or throat; hives or flushing; itching; abdominal cramping, abdominal pain or vomiting; back pain or chest pain; hypotension or shock. See the Health Care Provider Letter for important prescribing information to reflect the new safety information.

BACKGROUND: Varubi (rolapitant) injectable emulsion is approved to prevent delayed phase chemotherapy-induced nausea and vomiting (emesis). Varubi is approved in adults in combination with other drugs (antiemetic agents) that prevent nausea and vomiting associated with initial and repeat courses of vomit-inducing (emetogenic and highly emetogenic) cancer chemotherapy.

RECOMMENDATION: READ MORE

What We Mean When We Say Evidence-Based Medicine

People understand different things by this term, and the arguments don't divide along predictable partisan lines, either.

In medicine, the term "evidence-based" causes more arguments than you might expect. READ MORE

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.

Obtain Data to Improve Your Practice; Take ASCO's 2018 Survey of Oncology Practice Operations by Feb. 23

(ASCO in Action) Jan 30, 2018 - ASCO is inviting all oncology practices to participate in the annual Survey of Oncology Practice Operations, which looks at the current state of business and operational issues in oncology. READ ARTICLE

ASCO in Action

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

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

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

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Reimbursement Questions & Answers

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



Question: A doc in my practice just went from 60,000 units of procrit to 80,000 units of procrit. I always thought the limit was 60,000 units. Where can I find this type of information?

Answer: The Medically Unlikely Edit for Procrit is 60,000. If your patient dosing is above the CMS MUE, you will likely be rejected and will need to show medical necessity with your appeal. You can do this by referencing the drug package insert or the compendia in most cases.

CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An **MUE** for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an **MUE**, but you will find MUEs for administration codes and most drugs on the CMS site.

Keep in mind, just because there is a MUE, it doesn't mean that CMS will only reimburse up to that amount. For example, because some drugs are dosed by weight, we occasionally have doses that are above the MUE, especially with heavy patients. In those situations be prepared to receive a rejection because of the MUE, and appeal the claim based on medical necessity, showing the FDA approved weight based dosing.

You can download the MUE table from the CMS site:
Practitioner Services MUE Table - Effective 1/1/18 - Opens in a new window
Outpatient Services - MUE Table - Effective 1/1/18 - Opens in a new window

Continued on next page...

Question: How should we report (to Medicare) commercially available drugs that are mixed together to be administered simultaneously?

Answer: If commercially available drugs are being mixed together to facilitate their concurrent administration, you should report the quantity of each drug (reported by HCPCS code) used in the care of the patient. (For more on this, see the Medicare Claims Processing Manual, chapter 17, section 90.2). As far as administration coding, this would be considered ONE administration since the drugs are mixed in the same bag and therefore, only one administration code should be reported.

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Question: Do you know whether the rates for Part B covered drugs have decreased or increased for 2018?

Answer: On its website, CMS states that it compared the first quarter 2018 payment amounts with the prior quarter and that, on average, there was no change in payment amounts for the top 50 Part B drugs. For half of the higher volume drugs (25 out of the top 50), the prices changed 2 percent or less. Overall, the prices for 19 of the top 50 drugs decreased, while three remained the same. The ASP files are updated quarterly.

You can find this information and download the ASP files at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html

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Question: What is the difference between a health plan and a payer?

Answer: A health plan (as defined in 45 CFR 160.103) is an individual plan or group health plan that provides or pays the cost of medical care. The term "payer" is an industry term and may include a health plan, but may also designate other entities that do not meet the definition of a health plan, such as a third party administrator (TPA).

CORPORATE ALLIES

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AMGEN

Bayer HealthCare Pharmaceuticals

Bristol-Myers Squibb

Celgene

CHOC Community Hematology Oncology Consortium

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Lilly

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Programs Committee
CHAIR: Azlynn Swartz

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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