AVYXASSIST®

CLAIMS PROCESSING CHECKLIST

FOR COMMUNITY ONCOLOGY AND UROLOGY PRACTICES

PROACTIVE

- ☑ Confirm active insurance coverage and coordination of benefits, if applicant is covered by multiple health plans.
- ☑ Complete benefit investigation.
- ☑ Determine if prior authorization or referral is required by the payor before administration and submission.
- ☑ Confirm with the payer if PA can be submitted at the organization level.
- ☑ Include the NDC, NDC qualifier, NDC number of units, and the NDC units of measure (when billing NOC code, report 1 unit on the CMS-1500. Include the actual number of units administered in box 19).
- ☑ Include correct cancer diagnosis codes, specialized chemotherapy encounter diagnosis Z-codes, and antiemetics diagnosis codes, unless payer guidelines dictate otherwise.
- ☑ When billing KYXATA®, include the KX modifier as directed by CMS to indicate that the gender-specific drug is being used under a valid clinical exception.
- ☑ Include the JW (wastage) and JZ (no wastage) modifiers when filing Medicare claims.
- ☑ Include a screenshot from Redbook, Medi-Span, or FDB listing the WAC pricing of the NDC used. Some may require a copy of the provider invoice.

REACTIVE

- ☑ Following verification of the ICD-10-CM, HCPCS Level II, and CPT codes submitted, the provider is required to furnish documentation in support of medical necessity.
- ☑ Acceptable documentation includes the NCCN Clinical Practice Guidelines in Oncology, the product prescribing information, or the applicable Compendia, as appropriate.
- ☑ Claims denied under Claim Adjustment Reason Code (CARC) 50, indicating lack of medical necessity, are subject to appeal.

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CONTACT US

For assistance, please call an AVYXASSIST® Patient Access Specialist at **866-939-8927**, or email **reimbursement@avyxa.com**