

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: 45

August 2016

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

CMS Chief Andy Slavitt Again Floats Possible MACRA Delay

July 25, 2016

Author: Beth Jones Sanborn-Healthcare Finance News

In a continuing dialog with providers on MACRA, Andy Slavitt addressed the American Osteopathic Association at their annual meeting Friday, once again hinting at a possible delay in implementation so that providers, especially smaller practices, have time to prepare.

"Some of the things that are on the table include alternative start dates, looking at whether shorter periods could be used, and finding other ways for physicians to get experience with the program before the impact of it really begins," Slavitt said.

[READ MORE](#)

ASCO Submits Comments to Senate Finance Committee MACRA Hearing

July 26, 2016 - In a [statement](#) submitted to a Senate Finance Committee hearing, "Medicare Access and CHIP Reauthorization Act of 2015: Ensuring Successful Implementation of Physician Payment Reforms," ASCO reiterated its [comments](#) on a proposed rule for implementing the Medicare Access and CHIP Reauthorization ACT ([MACRA](#)).

[READ MORE](#)

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Physician Fee Schedule: Proposed CY 2017 Changes

On July 7, CMS proposed changes to the Physician Fee Schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the Diabetes Prevention Program within Medicare starting January 1, 2018. Proposed changes include: [READ MORE](#)

Hospital and ASC: Proposed OPPS Changes for CY 2017

On July 6, CMS proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community. Proposed changes include: [READ MORE](#)



Exclusive: MACRA author calls for delay in reporting requirements



Physicians won't have to start reporting quality under the legislation if U.S. Rep. Phil Roe, MD, has his way.

[» Read what you need to know here](#)



October 21, 2016
NJSOM Fall Conference
8:00 AM -4:00 PM
Hyatt Regency Princeton



102 Carnegie Center
Princeton, New Jersey, USA, 08540-6293
Tel: +1 609 987 1234

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Novitas Self-Service Tools

[View all Self-Service Tools](#)



Duplicate denials for resubmitted claims due to documentation not received

Effective with claims received on or after June 22, 2016, claim submissions that include lines previously denied by medical review, due to documentation not received, will deny as duplicate services. Please read the entire [article](#) for details.

Reporting Modifiers GV/GW on claims containing Quality Measurement Codes

We, at Novitas, have seen inconsistency in reporting modifiers GV and GW for hospice related services; specifically, when the claim contains Quality Measurement Codes. As a result, **effective September 26, 2016, we will begin denying/rejecting claims that do not report modifiers GV or GW with Quality Measurement Codes.** Please review the entire [article](#) for details.

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

- [Services That Are Not Reasonable and Necessary \(L35094\)](#)

The following JL Local Coverage Article has been added:

- [Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump \(A55134\)](#)

New Medicare Insights Podcast now available!

In today's Medicare Insights Podcast, we provide a reminder of the new self-service tool that allows you to correct an unlimited number of claims through the Interactive Voice Response unit. [READ MORE](#)

2016 Medicare Symposia

Registration is now available for all symposium locations:

August 17 – Pikesville, MD
September 21 – Glassboro, NJ
October 19 – Annapolis, MD
November 16 – Langhorne, PA



Details on the upcoming symposia can be found in the [Symposium Brochure](#) including the agenda, class descriptions, and helpful event day reminders.

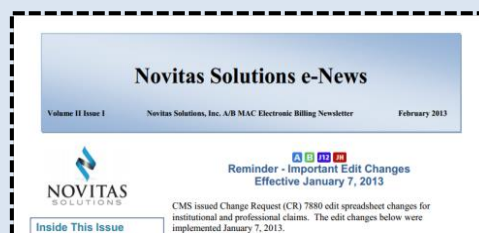
Registration for additional events is coming soon! We look forward to seeing you at one of our 2016 Medicare Symposia!

Novitas Solutions e-News Electronic Billing Qtly Newsletter

NEW!

And More...
AUGUST Qtly Issue Available

[CLICK HERE](#)



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 *](#)

Part B Top Claim Submission/Reason Code Errors

The [Top Claim Submission/Reason Code Errors](#) and resolutions for June 2016 are now available. Please take time to review these errors and avoid them on future claims.

Medicare Part B - HOT LINKS!

[2016 Medicare JL Part B Fee Schedule](#)
[Current Average Sales Price \(ASP\) Files](#)
[2016 Physician Fee Schedule Final Rule](#)

[Current Active Part B LCD Policies](#)
[Quarterly Update to CCI Edits](#)
[2016 CMS Physician Fee Schedule Final Rule Fact Sheet](#)

Part B Top Inquiries FAQs (Frequently Asked Questions)

The Part B Top Inquiries FAQs have been updated for June 2016. Please take time to review these FAQs for answers to your questions.

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WEBiNAR

Listed are Novitas training events
an oncology practice should consider!



DATE	TIME	EVENT	LOCATION
8/5/16	2:00p-3:00p	New Patient Guidelines and Coding	Via Webinar
8/9/16	2:00p-3:00p	Part B Telephone Claim Corrections Via the Interactive Voice Response Unit (IVR)	Via Webinar
8/11/16	2:00p-3:00p	Novitasphere Provider Portal Enrollment Overview	Via Webinar
8/16/16	10:00a-11:00a	Part B The Established Patient Billing and Coding Office Visits	Via Webinar
8/19/16	2:00p-3:00p	Novitasphere Claim Correction Overview	Via Webinar
8/23/16	11:00a-12:00p	Part B Telephone Claim Correction Via the Interactive Voice Response Unit (IVR)	Via Webinar
8/23/16	2:00p-3:30p	Part A/B New and Small Provider Education - Part 1 Medicare Basics	Via Webinar
8/24/16	2:00p-3:00p	Novitasphere Claim Submission Overview	Via Webinar
8/25/16	10:00a-1:00p	JL Part B Ask-the-Contractor Teleconference	Via Webinar
8/25/16	2:00p-3:00p	Part B Telephone Claim Correction Via the Interactive Voice Response Unit (IVR)	Via Webinar
8/31/16	11:00a-12:00p	Novitasphere Claim Correction Overview	Via Webinar
8/31/16	2:00p-3:30p	Part B How to Avoid Top Claim Errors - Third Quarter 2016	Via Webinar

[CLICK HERE](#)

to access the educational area of the Novitas website!

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RAC

Healthcare Services
Welcome to the Provider Portal
for the Medicare Region A RA

What's New!

06/02/2016 - Recovery Auditor Contracting Update:

CMS is in an active procurement process for the next round of Medicare Fee-for-Service Recovery Audit Program contracts. In anticipation of this contract transition, CMS must ensure that the current Recovery Auditors complete all outstanding claim reviews by the conclusion of the active recovery auditing phase of their current contracts. Providers should note the important dates below: [READ MORE](#)

To get to the
Performant
Recovery
website
[CLICK HERE](#)



CMS Proposed Rule to Implement Major Reforms to Medicare Appeals Process

Wednesday, 27 July 2016 - By Andrew B. Wachler, Esq. and Jessica C. Forster, Esq.

On July 5, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule heralding significant changes to the Medicare appeals process, particularly in light of the backlog of Medicare appeals currently pending. [READ MORE](#)

Avoid Hiring Black-and-White Thinking Compliance Professionals

Wednesday, 20 July 2016 - By David M. Glaser, Esq.

In a recent article, I quoted Dave Mason to illustrate the point that it can be reasonable to question authority. At times, however, people make unreasonable challenges. An irrational employee is not only a huge frustration; they also present a major compliance risk. Many *qui tam* lawsuits being with an employee who mistakenly believe you are breaking the law but won't listen to reason. [READ MORE](#)

RAC Monitor continued on next page...

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EXCLUSIVE: Medicare Appeals System is Broken – And it Might not be Fixable

Wednesday, 27 July 2016 By Edward M. Roche, PhD, JD

In 2010, there were 41,733 Medicare appeals filed with administrative law judges (ALJs). By 2015, the number had increased to 432,534, a jump of 936 percent. The number of ALJs handling this appeals load has remained more or less constant at 77 [READ MORE](#)

Provider-Based Rule: Questions and Interpretations

Tuesday, 05 July 2016 - By Duane Abbey, PhD, CFP

The Provider-Based Rule (PBR) is codified by the Centers for Medicare & Medicaid Services (CMS) at 42 CFR §413.65, along with the supervision regulations at 42 CFR §410.27. Guidance for the PBR has morphed since the rule was formally established through the April 7, 2000 Federal Register.

[READ MORE](#)

MACRA Could Be Delayed, CMS Tells Lawmakers

Wednesday, 13 July 2016 - By Chuck Buck

Testifying before the Senate Finance Committee yesterday, CMS Acting Administrator Andy Slavitt told committee members that the agency is considering the possibility of delaying the Medicare Access and CHIP Reauthorization Act (MACRA) until next January. The hearing was held to examine the CMS implementation of MACRA.

In testimony before the committee, Slavitt said MACRA, which replaced the Sustainable Growth Rate (SGR) formula, was “a more consistent way for paying physicians and other clinicians, provided new tools to modernize Medicare and simplify quality programs and payments for these professionals.”

[READ MORE](#)



Medicare Part B: CMS Should Take Additional Steps to Verify Accuracy of Data Used to Set Payment Rates for Drugs

GAO-16-594, July 1

- Report: <http://www.gao.gov/products/GAO-16-594>
- Highlights: <http://www.gao.gov/assets/680/678176.pdf>

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Overall Hospital Quality Star Ratings: Evaluation of National Distributions

CMS developed an Overall Hospital Quality Star Rating (Star Rating) that reflects comprehensive quality information about the care provided at our nation's hospitals. On July 21, CMS published data showing the national distribution of Overall Hospital Star Ratings based on hospital characteristics. For each hospital characteristic, CMS evaluated the distribution of hospitals across the five star categories.

- Analysis shows that all types of hospitals have both high performing and low performing hospitals
- Hospitals of varying bed size had similar average Star Ratings
- The average Star Rating for teaching hospitals was similar to but slightly lower than that for non-teaching hospitals
- Applying a previously accepted definition of hospital safety net status, CMS found that safety net hospitals had similar to but slightly lower average Star Rating than non-safety net hospitals
- CMS found a lower average Star Rating among Disproportionate Share Hospital (DSH) payment-eligible hospitals in comparison to non-DSH payment-eligible hospitals
- CMS found a higher average Star Rating among Critical Access Hospitals (CAHs) in comparison to the average Star Rating among non-CAHs

See the full text of this excerpted [CMS fact sheet](#) (issued July 21).

IMPORTANT!!!

You don't want to miss this one...

Comparative Billing Report on Modifier 25: Physician Assistant Webinar — August 24

Wednesday, August 24 from 3 to 4:30 pm ET

Join CMS for an informative discussion of the comparative billing report on Modifier 25: Physician Assistant (CBR201611), an educational tool for Medicare physician assistants who submit claims for established patient Evaluation and Management (E/M) services appended with modifier 25. During the webinar, suppliers will interact directly with content specialists and submit questions about the report. See the [announcement](#) for more information and find out how to participate.

How to Use the National Correct Coding Initiative Tools Booklet — Revised

A revised [How to Use the National Correct Coding Initiative \(NCCI\) Tools Booklet](#) is available. Learn about:

- Navigating the NCCI webpages
- Medicare code pair edits
- Medically unlikely edits
- Avoiding coding and billing errors



ASCO Unveils New Resources for MACRA Transformation

Are you ready for MACRA? Believe it or not, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed more than one year ago, and program changes begin in ***less than six months*** (January 1, 2017). MACRA will completely transform Medicare reimbursement and care delivery for oncology practices through the United States—and now is the time to understand and prepare for these changes. ASCO supports efforts to focus on quality of care, but appreciates this will require substantial and burdensome changes in our practices. If you're feeling overwhelmed or not ready for these big changes, ASCO is here to help. ASCO has prepared a MACRA [education series](#).



Free, Hands-On MACRA Workshop at ASCO Headquarters on Sept. 23

(*ASCO in Action*) **July 26, 2016** - On Friday, Sept. 23, ASCO will present a free, hands-on workshop, "Are you ready for MACRA? Tools and resources to help you prepare," at ASCO Headquarters in Alexandria, Va. [READ ARTICLE »](#)

Enhanced Administrative Simplification Website

Visit the newly enhanced [Administrative Simplification](#) website. To reduce paperwork and streamline business processes across the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Patient Protection and Affordable Care Act (ACA) set national standards for:

- [Electronic transactions](#)
- [Code sets](#)
- [Unique identifiers](#)

PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10

Wednesday, August 10 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

IMPACT Act Call: Audio Recording and Transcript

An [audio recording](#) and [transcript](#) are available for the July 7 call on [Quality Measures and the IMPACT Act](#). CMS experts discuss key quality measures related to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and how they will affect you.

Clinical Labs Call: Audio Recording and Transcript

An [audio recording](#), [transcript](#), and [post-call clarification](#) are available for the July 6 call on the [Clinical Diagnostic Laboratory Test Payment System Final Rule](#). CMS experts provide a high level overview of the final policies.

Quality Payment Program: What's Available Online

If you have not explored the [Quality Payment Program](#) website, take a look at the information that is available, including:

- [Overview](#) video
- [Support and Flexibility for Small Practices](#) fact sheet
- Overview presentation: [long version](#) and [short version](#)
- [Advancing Care Information](#) presentation
- [Merit-Based Incentive Payment System \(MIPS\)](#) presentation
- [Quality Performance Category under MIPS](#) presentation
- [Resource Use Performance Category under MIPS](#) presentation
- [Clinical Practice Improvement Activities Performance Category under MIPS](#) presentation
- [All-Payer Overview](#) presentation

Video Slideshow for QRUR Webcast — New

The [video slideshow](#) for the May 19 MLN Connects webcast on [2015 Mid-Year QRURs](#) is available. This event gives an overview of the 2015 Mid-Year Quality and Resource Use Reports (QRURs) and explains how to interpret and use the information.

July Quarterly Provider Update Available

The July [Quarterly Provider Update](#) is available. Find out about:

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

HHS Announces Major Initiative to Help Small Practices Prepare for the Quality Payment Program

Over the last few weeks, HHS made several important announcements related to the Quality Payment Program, which is proposed to implement the new, bipartisan law changing how Medicare pays clinicians, known as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). On June 20, HHS announced \$20 million to fund on-the-ground training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer. These funds will help provide hands-on training tailored to small practices, especially those that practice in historically underresourced areas including rural areas, health professional shortage areas, and medically underserved areas.

As required by MACRA, HHS will continue to award \$20 million each year over the next five years, providing \$100 million in total to help small practices successfully participate in the Quality Payment Program. In order to receive funding, organizations must demonstrate their ability to strategically provide customized training to clinicians. And, most importantly, these organizations will provide education and consultation about the Quality Payment Program at no cost to the clinician or their practice. Awardees will be announced by November 2016.

For More Information:

- Solicitation on [FedBizOpps.gov](#)
- [Quality Payment Program](#) webpage

See the full text of this excerpted [HHS press release](#) (issued June 20).

Suite of Products & Resources for Compliance Officers Educational Tool

The [Medicare Learning Network Suite of Products & Resources for Compliance Officers](#) Educational Tool is available. Learn about:

- General compliance guidelines
- The claims submission process
- Initiatives and incentives

Suite of Products & Resources for Billers & Coders Educational Tool

The [Medicare Learning Network Suite of Products & Resources for Billers & Coders](#) Educational Tool is available. Learn about:

- Claims submission
- Federal initiatives and incentive programs

Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet

The [Medicare Enrollment Guidelines for Ordering/Referring Providers](#) Fact Sheet is available. Learn about:

- Three basic requirements for ordering and referring
- How to enroll in Medicare as an ordering/referring provider

Complying with Medicare Signature Requirements Fact Sheet

A revised [Complying With Medicare Signature Requirements](#) Fact Sheet is available. Learn about:

- Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements
- Documentation needed to support a Medicare claim

Medicare Quarterly Provider Compliance Newsletter Educational Tool

A new [Medicare Quarterly Provider Compliance Newsletter \[Volume 6, Issue 4\]](#) is available. Learn about:

- How to avoid common billing errors and other erroneous activities when dealing with the Medicare Program
- How to address and avoid the top issues of the particular Quarter



Rough Start for Oncology Care Model

Tony Hagen @oncobiz / July 12, 2016

Many oncology practices were motivated to join the Oncology Care Model (OCM) in order to keep up with the evolution of value-based care. But when the Center for Medicare & Medicaid Innovation (CMMI) started telling practices that their applications had been accepted, it was panic time for some, says Robert “Bo” Gamble, director of strategic practice initiatives for the Community Oncology Alliance (COA). [READ MORE](#)

Many Well-Known Hospitals Fail to Score 5 Stars in Medicare’s New Ratings

By Jordan Rau - Of the 102 hospitals that received a five-star rating, few are among the elite generally praised for great care. [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

CMS Proposed Rule Implements Limitations on Medicare Payments for Off-Campus Outpatient Hospital Departments

7/11/16/McDermott, Will & Emery

On July 6, 2016, the Centers for Medicare & Medicaid Services released the CY 2017 Outpatient Prospective Payment System (OPPS) Proposed Rule, which includes proposed regulations to implement Section 603 of the Bipartisan Budget Act of 2015. Effective January 1, 2017, Section 603 bars Medicare payments under the OPPS for items or services (other than services furnished by a dedicated emergency department) furnished at an off-campus provider-based department, unless the location was billing as an outpatient department of a hospital prior to November 2, 2015. [READ MORE](#)

Some NJ Hospitals Unhappy with How They Score in New Ranking System

Lilo H. Stainton / July 28, 2016

Critics say system penalizes facilities that treat poor patients with complex conditions. [READ MORE](#)



Recent LearnResource & MedLearn Matters Articles

- [Outpatient Prospective Payment System \(OPPS\) Pricer Code](#)
- [Correction of Remark Code Information](#)
- [Remittance Advice Remark Code, Claims Adjustment Reason Code, Medicare Remit Easy Print and PC Print Update](#)
- [New Waived Tests](#)
- [Shared Savings Program \(SSP\) Accountable Care Organization \(ACO\) Qualifying Stay Edits](#)





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

Fee Information Available Online

Posted by on Posted on Monday August 01 2016

Did you know that you can access Horizon Blue Cross Blue Shield of New Jersey's fee schedule information, including Injectable Medication Fee Schedule information, online?

[READ MORE](#)

Oncology Specific Medical Policy Updates

- **New!** [Radiation Treatment of Urethral Cancer and Upper Genitourinary Tract Tumors](#)
- **New!** [Radiation Treatment of Testicular Cancer](#)
- **New!** [Radiation Treatment of Kidney and Adrenal Cancer](#)
- **New!** [Radiation Treatment of Hepatobiliary Cancer](#)
- **New!** [Radiation Treatment of Bladder Cancer](#)
- **New!** [Proteogenomic Testing for Patients with Cancer \(GPS Cancer™ Test\)](#)
- **New!** [Drug Therapy for Transgender Policy](#)
- **New!** [BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia](#)
- **Revised!** [Immune Globulin Subcutaneous \(Vivaglobin, Hizentra, Gammagard Liquid, Gamunex-C/Gammaked, and HyQvia for Subcutaneous Administration\)](#)
- **Revised!** [Intravenous Immunoglobulin \(IVIG\) Therapy](#)

Quarterly Update to Injectable Medication Fee Schedule: Q4 2016 Posted on Monday August 01 2016

Horizon Blue Cross Blue Shield of New Jersey will update our fee schedule for injectable medications on **November 1, 2016**. We update our injectable medication fee schedule each quarter, usually reflecting industry-wide changes to the Average Sales Price (ASP) or the Average Wholesale Price (AWP) of an injectable medication.

The table below identifies decreases in injectable medication fee amounts effective **November 1, 2016**. These listed rates do not reflect industry-wide changes in the ASP/AWP of the medications in question.

[READ MORE](#)

Code	Dose	Final Rate	Prior Rate
J1447	1 mcg	\$0.85	\$4.31
J1561	500 mg	\$41.82	\$43.63
J2405	1 mg	\$1.37	\$1.39
J2430	30 mg	\$66.09	\$72.30
J2778	0.1 mg	\$390.95	\$395.71
J7503*	0.25 mg	\$1.17	\$1.22
J9171	1 mg	\$2.45	\$2.93
J9267	1 mg	\$0.31	\$0.35
Q5101	1 mcg	\$0.98	\$1.01

*Injectable medication moving from AWP to ASP pricing.

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Two more hospitals drop challenge to Horizon tiered health plan in N.J.

By Erica Teichert / July 13, 2016

Capital Health System and JFK Medical Center have both exited a lawsuit in New Jersey state court alleging state regulators shouldn't have allowed Horizon Blue Cross and Blue Shield to place them in a lower-tier provider network.

JFK Medical Center confirmed on Wednesday that it had dismissed its claims against the state's top health insurer without prejudice. Capital Health made a similar move on July 8, according to court filings. [READ MORE](#)

UnitedHealthcare Community Plan

Outpatient Injectable Chemotherapy Prior Authorization Program for UnitedHealthcare Community Plan in Ohio, Michigan, Mississippi and Wisconsin



Effective Oct. 1, 2016, UnitedHealthcare Community Plan members in Ohio, Mississippi, Michigan and Wisconsin will require prior authorization for injectable outpatient chemotherapy drugs given for a cancer diagnosis. Read more on page 17 of the UHC Bulletin. [CLICK HERE](#)

Specialty Pharmacy Program Expansion – Level of Care Review FAQs

Summary – For Anthem members who require infusion or injection therapy services, the places of infusion or injection service, out-of-pocket expenses, safety, time and convenience are contributing factors that can impact health care value and member satisfaction. Many members prefer to receive their infusion or injection therapy in the physician's office, ambulatory infusion suite (AIS) or at home by a licensed home infusion therapy (HIT) provider. [CLICK HERE](#) to read the entire FAQ.



Other Payer Updates



A Few Articles You Won't Want to Miss:

- ✓ Front & Center
 - Reminder: Please Complete CMS-required Model of Care Training
 - New Link Applications Launching; Some UnitedHealthcareOnline.com Functions Retiring
 - New Clinical Laboratory Improvement Amendments (CLIA) Identification Requirements Policy
- ✓ UnitedHealthcare Community Plan
 - Outpatient Injectable Chemotherapy Prior Authorization Program for UnitedHealthcare Community Plan in Kansas, Ohio, Michigan, Mississippi and Wisconsin
- ✓ UnitedHealthcare Affiliates
 - Oxford® Medical and Administrative Policy Updates

And Much More...

AUGUST Monthly Issue Available [HERE](#)



Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

Updated

- ✓ Chemosensitivity and Chemoresistance Assays in Cancer - Effective Aug. 1, 2016

Coverage Determination Guideline Updates

Updated

- ✓ Breast Reconstruction Post Mastectomy - Effective Sep. 1, 2016

AUGUST Monthly Issue Available [HERE](#)



A Few Articles You Won't Want to Miss:

- Updates to our National Precertification List
- Digital ID cards and eligibility and benefits inquiry
- Reminder: inpatient timely notification requirement
- Our Office Manual keeps you informed
- Learning Opportunities
- Medicare compliance news: action required in 2016
- Medicare-Enroll by August 1 to prescribe Medicare Part D drugs
- Use electronic prior authorization services for Aetna Specialty drugs
- Where to find our Medicare and Commercial formularies

And Much More....JUNE Northeast Region

Qtly Issue Available [HERE](#)



AmeriHealth.

A Few Articles You Won't Want to Miss:

- ✓ Required lead time when updating your provider information
- ✓ Carenet outreach program continues
- ✓ New transactions on NaviNet® and user guides available
- ✓ Reminder: Utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests now in effect
- ✓ View up-to-date policy activity on our Medical Policy Portal

And Much More...AUGUST Monthly....[CLICK HERE](#)

To visit their Provider pages....[CLICK 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

NONE AT THIS TIME



Bristol-Myers Squibb Announces Regulatory Updates for Opdivo (nivolumab) in Previously Treated Recurrent or Metastatic Squamous Cell Carcinoma of the Head and Neck

(BMS) July 18, 2016 - Bristol-Myers Squibb Company announced today U.S. and European marketing applications to expand the use of Opdivo for patients with previously treated recurrent or metastatic squamous cell carcinoma of the head and neck (SCCHN) were accepted for filing by the U.S. Food and Drug Administration (FDA) and validated by the European Medicines Agency (EMA). [READ CORPORATE PRESS RELEASE »](#)

What Is Immunotherapy? The Basics on These Cancer Treatments

(New York Times) July 30, 2016 - Here are answers to some basic questions about this complex and rapidly evolving field. [READ ARTICLE »](#)



EHR-enabled fraud remains a concern

Imagine, in an effort to bill a higher fee, a colleague cuts and pastes a complete history and physical examination you wrote in the EHR of your patient, but forgets to make adjustments based on his/her findings. [» Read the disturbing data](#)



Practice Administrators – ASCO Has a New Member Category Dedicated to You!

As the world's leading professional society representing medical professionals who treat people with cancer, ASCO endeavors to represent all members of the patient care team. To better support and serve you and the role you play in oncology, we have created a member category for Practice Administrators. Originally part of the Affiliated Health Professionals member category, this new category allows ASCO to remain flexible in providing the most relevant and useful member services. Benefits include access to participate in the Quality Oncology Practice Initiative (QOPI®) and PracticeNET, tools such as ASCO's Coding and Reimbursement Service and ASCO Guidelines, clinical trial resources, templates for documenting treatment plans and summaries, and much more. In addition to the Practice Administrators category we also have dedicated member categories for Advanced Practice Providers and Patient Advocates. Current Affiliated Health Professional members who qualify for the new categories will automatically be transitioned over. To learn more about the new categories please visit asco.org/membership/member-benefits.



[CLICK HERE](#) to find out
more information about
the group purchasing
program.



Community Oncology Alliance Launches Advanced Practice Provider Network

(COA) *July 28, 2016* - The Community Oncology Alliance (COA) has launched a new initiative to support advanced practice providers in oncology. Called the Advanced Practice Provider Network or CAPP Network, the initiative will support oncology nurse practitioners, physician assistants, and other advanced practice providers who play a larger part in care for patients with cancer.

[READ PRESS RELEASE »](#)

Community Oncology Alliance Announces Major Support Initiative for CMS Oncology Care Model

COA Fully Committed to Success of OCM, Oncology Payment and Delivery Reform, Providing Expert Support to OCM Practices, Launches Peer-to-Peer Learning Network, and Gathering Stakeholder Guidance for Future Support. Read Announcement

[CLICK HERE](#)

find financial assistance | **explore** tools and resources | **learn** about your Specialist

Celgene Patient Support® is a free and personal service that provides you and your patients support with accessing Celgene medications.

No matter what type of insurance your patients have, your Celgene Patient Support® Specialist is here to help your patients access the Celgene medication you have prescribed. You and your patients will speak to the same Specialist every time you call. Your Specialist can provide you with a full range of services when one of our medications is prescribed. We can help:



Reduce

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

To access their website and get complete details

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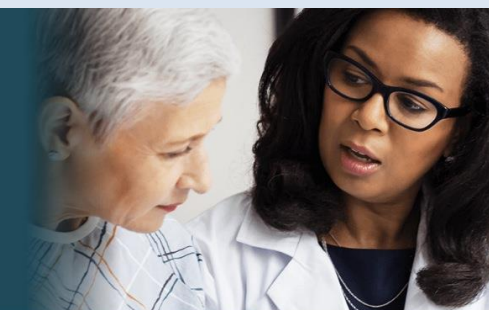


Are you looking for support to address your patient's out of pocket expenses? Do you think Foundations take too long and are too complicated to even apply? Did you know that the PAN foundation patient applications take only a few minutes to apply, online and grants are awarded within minutes of the application? **READ MORE** about PAN.....

[CLICK HERE](#)

Providers

Healthcare providers are committed to bettering the health of their patients. They also are concerned about how the cost of patients' prescribed treatments will impact their ability to best manage their disease. We are here to help.



Are high co-pays preventing your patients from accessing their critical treatments?

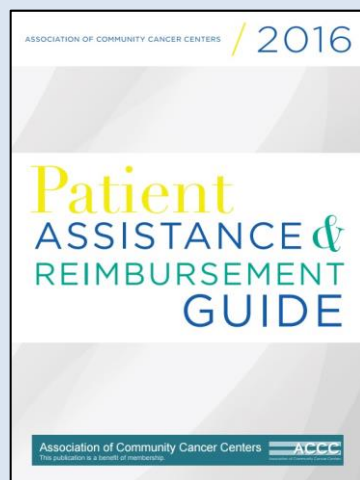
High deductibles and co-pays should never prevent people with life-threatening, chronic, or rare diseases from getting the treatment they need. Because we believe this so passionately, PAN is focused on helping people with serious illnesses pay for the out-of-pocket costs of their treatment.

Apply on behalf of your patients today, using our secure online portals

[Provider Portal](#)

[Pharmacy Portal](#)

Or call 1-866-316-7263



Member Favorite ACCC 2016 Patient Assistance Guide

NEW REVISED PDF WITH IMPROVED FUNCTIONALITY & NAVIGATION....[CLICK HERE](#)

Access a PDF of the ACCC 2016 Patient Assistance & Reimbursement Guide!

New in this year's guide:

- Tips for optimizing co-pay assistance programs
- New financial advocate skills for the new healthcare environment.

Plus, a list of pharmaceutical and non-pharmaceutical patient assistance programs with enrollment information and direct links to forms, a patient assistance flow chart for specific patient populations, and more. A print copy of the guide mailed with your January/February *Oncology Issues*.

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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 was recently on a COA webinar and heard that there may be a delay in MACRA? Have you heard this? Is it true? Does that include MIPS?

Answer: This is the lead article in our August newsletter, front page news. CMS MIGHT delay but there is no guarantee at this point. IF they do, yes, this would include MIPS as that is a portion of the MACRA program.

Question: We are confused about the documentation requirements for observation. We often admit to short stay. We write the orders, take phone calls from the hospital nurses and oversee the care of the patient. Where to I find the regulations about Observation and specifically what needs to be documented?

Answer: Directly from the Medicare Claims Processing Manual:

C. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;*
- Documentation identifying the billing physician was present and personally performed the services; and*
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician. In the rare*

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circumstance when a patient receives observation services for more than 2 calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.



Here is the link to the manual - be sure to review the entire section 30.6.8

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

Question: We are now an outpatient hospital (our practice was purchased by the hospital) and we were wondering if the new rules regarding the pump billing pertains to us since we bill Medicare Part A?

Answer: As an outpatient hospital facility, you actually are Medicare Part B. There is often confusion because the Medicare MACs differentiate the policies between outpatient hospital and private practice so they put the outpatient hospital policies under Part A.

Here is something that might help understand what is paid under A vs B. As you will see, Part A is ONLY FOR INPATIENT HOSPITAL and is paid under the DRG system.

<http://www.medicareinteractive.org/get-answers/introduction-to-medicare/explaining-medicare/what-does-medicare-cover-parts-a-b-c-and-d>

As far as the billing of Pumps and the SE1609, yes, this clarification went into effect on July 1 and according to the policy we are to bill our MAC for the services provided in the private practice and outpatient hospital settings. Reviewing SE1609, you will see in the first paragraph they reference both the private practice and the outpatient hospital. Even as an outpatient hospital provider, you or a supplier can no longer bill the pump to the DME when it is applied in the Part B setting. Under this clarification from CMS, you must bill both the pump and the initiation (and removal) under the NOC code to the MAC. To review the SE1609 MedLearn Matters clarification, [CLICK HERE](#).

Question: Are there any physicians who are exempt from participation in the new physician payment system MIPS?

Answer: The following groups of physicians and practitioners will NOT be subject to the proposed Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Medicare Physician Fee Schedule:

- Physicians in their first year of Medicare participation
- Participants in eligible APMs who qualify for the bonus payment
- Those below low-volume threshold.

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Question: What is HEDIS?

Answer: According to the website of the National Committee for Quality Assurance (NCQA), HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts. For more on HEDIS, [CLICK HERE](#)



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