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
P.O. Box 95
Florham Park, New Jersey 07932

Phone: 800.658.5011
E-mail: info@njsom.org

NJSOM Reimbursement E-News Issue 60 NOV 2017

USP Delays General Chapter 800

On September 29, the U.S. Pharmacopeial Convention (USP) announced it will postpone the official date of General Chapter 800, "Hazardous Drugs - Handling in Healthcare Settings," (USP 800) to December 1, 2019. USP 800 was originally scheduled to become official on July 1, 2018, but USP now plans to align the official date of USP 800 with the release of a final version of USP 797, "Pharmaceutical Compounding - Sterile Preparations," which is currently undergoing revision.

Some state enforcement agencies may require adherence to USP 800 before its official implementation date. Since USP plays no role in enforcement of its standards, the organization's decision to postpone implementation will have no impact on existing requirements unless the appropriate enforcement agencies take additional action.

ASCO previously submitted comments on the second draft of General Chapter 800, recognizing a number of positive changes (compared to the initial draft of the chapter) but also listing clarifications and revisions needed to create standards that are practical and appropriate for ensuring the safe handling of chemotherapy drugs community-based oncology practices.

NOVITAS SOLUTIONS, INC | CMS | OTHER PAYER UPDATES | OTHER NEWS | PATIENT ASSISTANCE | FREQUENTLY ASKED QUESTIONS

FRONT PAGE NEWS

Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation
- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices

See the full text of this excerpted CMS Fact Sheet (issued November 2).

FRONT PAGE NEWS

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy
- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
- ASC covered procedures list
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted CMS Fact Sheet (issued November 1).

FRONT PAGE NEWS

Quality Payment Program Rule for Year 2

On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The Final Rule Includes:

- Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%
- Raising the MIPS performance threshold to 15 points in Year 2
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the MIPS final scores of small practices
- Adding Virtual Groups as a participation option for MIPS
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries
- Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:

- Final Rule
- Fact Sheet
- Executive Summary
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- Quality Payment Program website
- Register for a webinar on November 14

FRONT PAGE NEWS

Executive Order on Access to Health Care In Fact Threatens Patient Access to High-Quality

(ASCO in Action) Oct 13, 2017- "The American Society of Clinical Oncology (ASCO) has grave concerns about the Trump Administration's executive order calling in part for federal rules to encourage association health plans."

READ ARTICLE

CMS Allows More Docs to Sit Out MACRA

(Modern Healthcare) Nov 2, 2017- The CMS has finalized a proposed rule to exempt more small providers from complying with MACRA. It also reversed course on plans to give providers a pass on gauging whether they are cutting costs under the Merit-based Incentive Payment System, or MIPS.

READ ARTICLE

COA Applauds CMS on 340B Reforms in Final Medicare Rule

(COA) Nov 1, 2017- The Community Oncology Alliance (COA) applauds the Centers for Medicare & Medicaid Services (CMS) on its recent policy change to curb abuses of the 340B Drug Discount Program. This final rule is good for patients and taxpayers and represents an important first step in stopping abuse of the program by some hospitals. It will help steer the program back to its original course — acting as a safety net to help patients in need.

READ PRESS RELEASE

NOVITAS SOLUTIONS, INC.

Medical Policy

The following JL Local Coverage Determinations (LCDs) have been revised to reflect the Annual ICD-10-CM Code Updates effective for dates of service on and after October 1, 2017:

- Biomarkers for Oncology (L35396)
- Biomarkers Overview (L35062)
- Intensity Modulated Radiation Therapy (IMRT) (L36711)
- Intravenous Immune Globulin (IVIG) (L35093)
- Thrombolytic Agents (L35428)

The following JL Local Coverage Article has been revised:

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

Part B Frequently Asked Questions (FAQs)

Have a question and not sure where to turn? Check out our FAQs for answers to your questions. READ MORE

Part B Top Inquiries / Frequently Asked Questions (FAQs) for DE, DC, MD, NJ, & PA

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for September 2017. Please take time to review these FAQs for answers to your questions. READ MORE

New Medicare Insights Podcast

In this Medicare Insights Podcast episode, we provide guidance on subscribing to our email list and staying up-to-date on Medicare news. READ MORE

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for September 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

NOVITAS SOLUTIONS, INC.

Listed are Novitas training events an oncology practice should consider!

For many more opportunities and to register...

CLICK HERE

Date	Starts (EST)	Ends (EST)	Event Name	CEUs	Media Type
Friday, November 10, 2017	11:00 AM	12:00 PM	Part B How to Avoid Top Claim Errors- Fourth Quarter This course is the second quarter series focused on educating Part B providers and staff on the how to avoid claim submission errors and how to correct errors. Topics will focus on timely filing, an overview of the claim submission process, and the top reasons for claim denials and rejections.	1.0	Webinar
Tuesday, November 14, 2017	11:00 AM	12:00 PM	**Part B 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
Tuesday, November 14, 2017	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
Thursday, November 16, 2017	2:00 PM	3:00 PM	**Part B 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

Novitas Self-Service Tools

View all Self-Service Tools

NOVITAS SOLUTIONS, INC.

Medicare Part B HOT LINKS!

- Medicare JL Part B Fee Schedule
- 2017 Physician Fee Schedule Final Rule
- 2017 Physician Fee Schedule Final Rule Fact Sheet
- Current Active Part B LCD Policies
- Current Average Sales Price (ASP) Files
- Quarterly Update to CCI Edits

2018 Proposed Final Rule

- Physician Fee Schedule
- Physician Fee Schedule Fact Sheet
- HOPPS
- HOPPS 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

Novitas Solutions e-News

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

NOVITAS SOLUTIONS

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

Novitas Solutions e-News Electronic Billing Qtly Newsletter

Current Qtly Issue Available …
CLICK HERE

Information for Providers:

- Provider Resources
- Medicaid Managed Care Contract
- Dual Eligible Special Needs Plan Contract
- Accountable Care Organizations
- Public Notices
- New Jersey Medicaid State Plan

CMS

To visit the website CLICK HERE

Important RAC Provider Updates

To educate providers on the RAC Process, HMS will partner with the Noridian JE/JF Medicare Administrative Contractor (MAC) to host a Part A and Part B Webinar on 11/16/2017. The Webinar will provide an overview of: Review Type, Performed, Medical Record Submission, Approved New Issues, Discussion Period Process, Appeal Levels, Provider Portal, HMS Contact Information, Reminders and Resources.

Please select the link below to register for the event before 11/16/2017. All registrations must be completed online. Contact the Noridian JE/JF MAC Customer Service Department for assistance with registering for this event.

JE Part A/B: 855-609-9960 - JF Part A/B: 877-908-843 -https://attendee.gotowebinar.com/register/7357290083934771969

November 2, 2017 - Developing Story: DOJ Will Dismiss Qui Tam Cases Lacking Merit

New policy changes from DOJ will impact False Claims Act cases moving forward.
By David M. Glaser, Esq. - In announcing a significant policy change, the U.S. Department of Justice (DOJ) said that when it concludes that a qui tam case lacks merit, it will file a motion to dismiss the case rather than allowing the relator to continue. READ MORE

Nothing on Healthcare Coming Out of Washington This Year? Think Again

The presence of Medicare Advantage plans in the healthcare marketplace continues to grow.
By Charles Locke, MD, CHCQM-PHYADV - Unless you have been living under a rock, you are aware that healthcare has been a topic firmly positioned at front and center in Washington, D.C. for the past nine months. This past week has been highlighted by another failed attempt by the U.S. Senate to pass legislation that would repeal and replace much of the Patient Protection and Affordable Care Act (PPACA) and the resignation of U.S. Health and Human Services Secretary Dr. Tom Price. READ MORE

Continued on next page...

CMS

Wronged by Medicare? A Doctor's Story

CMS has accused Bryan Merrick, MD of wrongful Medicare billings on 10 patients over a span of 20 months.

By Mark Spivey - Bryan Merrick, MD, a physician at the Tennessee-based McKenzie Medical Center who has been practicing medicine for more than three decades, will be a central topic of conversation during the next edition of Monitor Mondays, as the Centers for Medicare & Medicaid Services (CMS) has pulled his Medicare billing privileges due to what have been described as simple clerical errors. READ MORE

IMPORTANT – CMS MIPS Reminder

One patient, one measure, no penalty

If you report the minimum data to the Centers for Medicare & Medicaid Services (CMS) this year, you can avoid any negative payment adjustment. That could include reporting one quality measure or one improvement activity from any point during the year.

Report nothing, get penalized

If you don't participate in the QPP, your practice will receive a negative 4% adjustment in 2019.
Questions or more information, visit the CMS QPP site: https://qpp.cms.gov

Medicare Basics: Parts A and B Appeals Overview Video

The new Medicare Basics: Parts A and B Appeals Overview Video is available. Learn about:

- Part A and B five levels of claim appeals
- New level three, on-the-record review
- Helpful tips for filing an appeal

How Has the OCM Evolved? Year 1 Provider Updates

(AJMC.com Managed Markets Network) Oct 24, 2017 - The 190 participating practices in CMS' Oncology Care Model (OCM) have received performance feedback from the Center for Medicare & Medicaid Innovation. READ ARTICLE

CMS

Physician Compare Preview Period Extended to December 1

Preview your 2016 performance information as it will appear on the Physician Compare website later this year. The preview period is extended to Friday, December 1 at 8 pm ET due to a technical issue that prevented the data from properly displaying in the Provider Quality Information Portal (PQIP); this display issue is now resolved. For more information, visit the Physician Compare Initiative website.

Questions:

- For assistance accessing PQIP or obtaining your Enterprise Identity Management user role, contact the QualityNet Help Desk at 866-288-8912 or qnetsupport@hcqis.org
- For questions about Physician Compare, public reporting, or the 30-day preview period, contact PhysicianCompare@Westat.com

New Medicare Card: Provider Ombudsman Announced

The Provider Ombudsman for the New Medicare Card serves as a CMS resource for the provider community. The Ombudsman will ensure that CMS hears and understands any implementation problems experienced by clinicians, hospitals, suppliers, and other providers. Dr. Eugene Freund will be serving in this position. He will also communicate about the New Medicare Card to providers and collaborate with CMS components to develop solutions to any implementation problems that arise. To reach the Ombudsman, contact: NMCProviderQuestions@cms.hhs.gov.

The Medicare Beneficiary Ombudsman and CMS staff will address inquiries from Medicare beneficiaries and their representatives through existing inquiry processes. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.

General Equivalence Mappings FAQs Booklet — Revised

A revised General Equivalence Mappings FAQs Booklet is available. Learn about:

- Use of external cause and unspecified codes in ICD-10-CM
- Background and FAQs on the conversion of ICD-9-CM codes to ICD-10-CM/PCS and ICD-10-CM/PCS codes back to ICD-9-CM

QRUR Webcast: Audio Recording and Transcript

An audio recording and transcript are 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.

CMS

Administrative Simplification Enforcement and Testing Tool

The Administrative Simplification Enforcement and Testing Tool (ASETT) has a new address. Use the tool to:

- Test electronic transactions for compliance
- File complaints about noncompliant transactions

For More Information:

- Quick Start User Guide
- FAQs
- Report on complaints submitted through the ASETT tool from January to September 2017
- Administrative Simplification webpage

ICD10monitor

CDI: Moving from Reimbursement-Based Goals to Documenting Patient Care

By Glenn Krauss, RHIA, BBA, CCS, CCS-P, CPUR, CCDS, C-CDI, PCS, FCS, C-CDAM - How CDI transforms documentation from a reimbursement perspective to a tool for patient care and support of quality-based, cost-effective, efficient healthcare. Clinical documentation improvement (CDI) programs have become deeply ingrained in most hospitals as part of a purposely directed strategy to improve financial operations. READ MORE

ICD-10-CM/PCS the Next Generation of Coding Booklet—Revised

A revised ICD-10-CM/PCS the Next Generation of Coding Booklet is available. Learn about:

- International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS), an improved classification system
- Examples
- Similarities and differences from ICD-9
- Current Procedural Terminology and HCPCS codes
- Use of external cause and unspecified codes; new features; and changes in ICD-10-CM

Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder

With Continuing Education Credit

A Diagnosis Coding: Using the ICD-10-CM Web-Based Training course is available through the Learning Management System. Learn about:

- International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) coding tips, information, and resources
- ICD-10-CM structure, format, and features
- How to find correct ICD-10-CM codes

CMS CENTERS for MEDICARE & MEDICAID SERVICES

CMS

Items and Services Not Covered under Medicare Booklet — Reminder

An Items and Services Not Covered under Medicare Booklet is available. Learn about:

- Four categories of items and services not covered under Medicare and applicable exceptions
- Advance Beneficiary Notices

Quality Payment Program in 2017: MIPS APMs Web-Based Training Course —New

With Continuing Education Credit

A new, online and self-paced course on the Quality Payment Program is now available through the Learning Management System. Learners will receive information on:

- How to recognize who is a participant in a Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM)
- Benefits of the special APM scoring standard for MIPS APM participants
- Criteria for reporting on performance

This course is the fifth course in an evolving curriculum on the Quality Payment Program. Keep checking the Learning Management System for updates on new courses. This course offers CME credit.

Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet

A Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet is available. Learn about:

- Payment for physician services in teaching settings
- General documentation guidelines
- Evaluation and Management (E/M) documentation guidelines
- Exception for E/M services furnished in certain primary care centers

Resources for Medicare Beneficiaries Booklet — Reminder

A Resources for Medicare Beneficiaries Booklet is available. Learn about:

- Medicare, Medicare supplements, and other insurance
- Medical expenses and basic needs
- Long-term care
- Informed decisions; rights and protections; notices and forms
- Fraud, waste, and abuse
- Caregiving

CMS

Quality Payment Program: New Resources

CMS posted new Merit-based Incentive Payment System (MIPS) resources:

- MIPS Quality Performance Category Claims Data Submission Fact Sheet: How to submit data through your claims for the Quality performance category, including data collection and submission tips
- MIPS Eligible Measure Applicability (EMA) Resources: Includes an overview fact sheet and supporting documents that provide details about EMA analysis and how it affects your Quality performance calculation and score

Additional resources are available on the Quality Payment Program website and MACRA webpage.

Quality Payment Program: New Resources Available

CMS posted new and updated resources on the Quality Payment Program:

- 2018 Self-Nomination Toolkit for QCDRs & Registries: Step-by-step instructions for potential Qualified Registry and Qualified Clinical Data Registry (QCDR) vendors to self-nominate to qualify for the 2018 performance period of the Merit-based Incentive Payment System (MIPS) program
- MIPS Specialty Measures Guides for Anesthesiologists and Certified Registered Nurse Anesthetists, Emergency Medicine Clinicians, Ophthalmologists, and Orthopedists: Highlights a non-exhaustive sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to these specialties in 2017
- Group Participation in MIPS 2017 Guide (Updated): An in-depth overview of how to participate as a group in MIPS
- CMS-Approved QCDR Vendor List for 2017 (Updated): Contact information for the Qualified Clinical Data Registries (QCDRs) that will be able to report data for the Quality, Advancing Care Information, and Improvement Activities performance categories in 2017
- CAHPS for MIPS CMS-Approved Survey Vendor List (Updated): Contact information for the survey vendors approved by CMS to administer the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey in 2017
- Alternative Payment Model Design Toolkit (Updated): Comprehensive set of resources to help design an Alternative Payment Model

Additional resources are available on the Resource Library webpage.

CMS

PQRS Call: Audio Recording and Transcript—New

An audio recording and transcript are available for the September 26 call on the Physician Quality Reporting System (PQRS). Learn about downward payment adjustments, feedback reports, and the informal review process for Program Year 2016 results and 2018 payment adjustment determinations.

Recent LearnResource & MedLearn Matters Articles

- Clinical Laboratory Fee Schedule Not Otherwise Classified, Not Otherwise Specified or Unlisted Service or Procedure Code Data Collection *(MM 10232)*
- Pharmacy Billing of Immunosuppressive Drugs *(SE 17032)*
- Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program *(Revised SE 1128)*
- Guidance on Coding and Billing Date of Service on Professional Claims (Rescinded SE17023)
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 24.0, Effective January 1, 2018 (MM 10306)

New Medicare Card Web Updates

CMS updated the New Medicare Card Overview webpage:

- Find Project Milestones
- Learn about updated Fee-For-Service exception span-dates for home health Request for Anticipated Payments

The "How do providers use MBIs?" section of the Provider webpage was also updated:

- Find the Medicare Beneficiary Identifier (MBI) on the remittance advice
- Use of qualifiers for beneficiary eligibility

Medicare offers improved access to high-quality health coverage choices in 2018

Agency releases Star Ratings for 2018 health and drug plans in advance of Medicare Open Enrollment

Today, the Centers for Medicare & Medicaid Services (CMS) released the Star Ratings for the 2018 Medicare health and drug plans. With the release of the Star Ratings, people with Medicare will have improved access to high-quality health choices for their Medicare coverage in 2018. This news comes on the heels of the recent release of the benefit and premium information for Medicare health and drug plans which shows that there will be more health coverage choices and decreased premiums in 2018. READ MORE

OTHER PAYER UPDATES - HORIZON

Quarterly Update to Injectable Medication Fee Schedule: Q1 2018

Horizon Blue Cross Blue Shield of New Jersey will update our fee schedule for injectable medications on **February 1, 2018**.
READ MORE

Value-Based Programs Continue to Show Improvement

Horizon BCBSNJ's collaborations with patient-centered doctors continue to improve care and control health care costs

More than 1.5 million Horizon BCBSNJ members currently participate in one of our patient-centered, value-based programs. READ MORE

Molecular and Genomic Testing Program Update

Effective **November 15, 2017**, additional diagnostic tests will be included as part of our Molecular and Genomic Testing Program
READ MORE

Use Current Agreements When Adding New Practitioners

When submitting information for us to credential physicians and/or other health care professionals for participation in our network(s), it's important that you use the most current versions of our Agreement(s).
READ MORE

Horizon

Oncology Related Medical Policy Updates

For all policy updates CLICK HERE

- NEW Olaratumab (Lartruvo)
- NEW Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- NEW Fulvestrant (Faslodex)
- NEW Ocrelizumab (Ocrevus)
- NEW Gemtuzumab Ozogamicin (Mylotarg)
-
- REVISED Granulocyte Colony Stimulating Factor (G-CSF - Neupogen, Neulasta, Granix, Zarxio) and Granulocyte-Macrophage Colony Stimulating Factor (GM-CSF - Leukine)
- REVISED Omalizumab (Xolair)
- REVISED Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- REVISED Radiation Treatment of Bone Metastases
- REVISED Computed Tomography (CT) Perfusion Imaging of the Brain

OTHER PAYER UPDATES - AMERIHEALTH

Updates to Most Cost-Effective Setting Program for injectable and infusion therapy drugs

AmeriHealth wants to ensure that our members receive injectable/infusion therapy drugs in a setting that is both safe and cost-effective for their clinical condition. READ MORE

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

As of January 1, 2018, the drugs that will require precertification approval for setting are:*

- Actemra® (tocilizumab)
- Aralast NP® (alpha-1 proteinase inhibitor [human])
- 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)
- Lumizyme® (alglucosidase alfa)
- Neulasta® (pegfilgrastim)
- Neulasta® (pegfilgrastim) Onpro® (pegfilgrastim)
- Nucala® (mepolizumab) – **NEW FOR 2018!**
- Ocrevus™ (ocrelizumab) – **NEW FOR 2018!**
- Orencia® (abatacept)
- Prolastin® (alpha-1 proteinase inhibitor [human])
- Prolia® (denosumab)
- Radicava™ (edaravone) – **NEW FOR 2018!**
- Remicade® (infliximab)
- Renflexis® (infliximab-abda)
- andostatin® LAR Depot (octreotide aetate)
- Simponi Aria® (golimumab)
- Soliris® (eculizumab)
- Somatuline® Depot (lanreotide) – **NEW FOR 2018!**
- 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.

Reminder: Utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests

READ MORE

CRNP policies expanded to include physician assistants

AmeriHealth is expanding its policies on reimbursing certified registered nurse practitioners (CRNP) to include physician assistants (PA). The following policies were posted as Notifications on November 1, 2017, and will go into effect **December 1, 2017**: READ MORE

ICD-10 in Action: Coding guidelines and conventions

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

OTHER PAYER UPDATES - AMERIHEALTH

Providers must obtain precertification for certain items and/or services when required

New denial notification procedure

AmeriHealth has discontinued sending letters to notify providers of denials for procedures, services, items, and specialty drugs due to of lack of preapproval/precertification within the specified time frame.

Instead, denial notifications due to lack of preapproval/precertification within the specified time frame will be communicated to providers via telephone. The denial decision is final, and there will be no opportunity to appeal. *Note:* This does ***not*** apply to denials for medical necessity. READ MORE

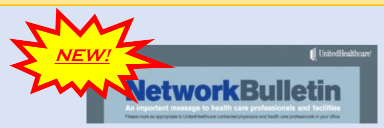
New medical and pharmacy product portfolios available for 2018

AmeriHealth has introduced new medical and pharmacy product portfolios that will be available to large group (51+) commercial fully insured and self-funded customers for 2018. The new portfolio options will be offered to new and renewing customers beginning with January 1, 2018, effective dates. 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

OTHER PAYER UPDATES



A Few Articles You Won't Want to Miss:

Front & Center
- Improvements to Our Provider Administrative Guides
- Review at Launch Drug Program for UnitedHealthcare Commercial and Community Plan Members – Update to Pathway for Requesting Pre-Determination

UnitedHealthcare Commercial
- Medical Record Review – ACA-Covered Commercial Plans for 2017 Dates of Service
- Reminder, Genetic and Molecular Testing Requires Prior Authorization

Doing Business Better
- Medical Records Standards

And Much More...NOVEMBER
Monthly Issue Available HERE

Oncology Related Articles You Won't Want to Miss:

Medical Benefit Drug Policy Updates

New:
- Review at Launch for New to Market Medications - Effective Jan. 1, 2018

Utilization Review Guideline Updates

Revised:
- Site of Service Guidelines for Certain Outpatient Surgical Procedures - Effective Jan. 1, 2018
- Specialty Medication Administration – Site of Care Review Guidelines - Effective Jan. 1, 2018

NOVEMBER
Monthly Issue Available HERE

aetna

A Few Articles You Won't Want to Miss:

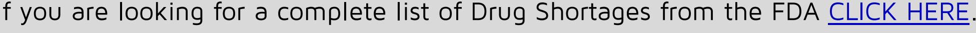
- Updates to our Participating Provider Pre certification List
- Clinical payment, coding and policy changes
- How to update data about your office
- Changes to commercial drug lists start on January 1, 2018

And Much More….

SEPTEMBER
Northeast Region
Qtly 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 granted regular approval to alectinib (ALECENSA, Hoffmann-La Roche, Inc./Genentech, Inc.) for treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC), as detected by an FDA-approved test. More Information. November 6, 2017
- FDA granted regular approval to vemurafenib (ZELBORAF, Hoffmann-La Roche Inc.) for the treatment of patients with Erdheim-Chester Disease (ECD) with BRAF V600 mutation. More Information. November 6, 2017
- FDA granted accelerated approval to acalabrutinib (Calquence, AstraZeneca Pharmaceuticals Inc. under license of Acerta Pharma BV) for treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. More Information. October 31, 2017
- FDA Approval of Varubi IV for delayed nausea and vomiting associated with cancer chemotherapy. More Information. October 25, 2017
- FDA granted regular approval to axicabtagene ciloleucel (YESCARTA, Kite Pharma, Inc.) for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high-grade B-cell lymphoma, and DLBCL arising from follicular lymphoma. More Information. October 18, 2017
- FDA approved abemaciclib (VERZENIO, Eli Lilly and Company) in combination with fulvestrant for women with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy. More Inforrmation. September 28, 2017
- FDA granted accelerated approval to nivolumab (OPDIVO, Bristol-Myers Squibb Co.) for the treatment of hepatocellular carcinoma (HCC) in patients who have been previously treated with sorafenib. More Information. September 22, 2017
- FDA granted accelerated approval to pembrolizumab (KEYTRUDA, Merck & Co., Inc.) for patients with recurrent locally advanced or metastatic, gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 as determined by an FDA-approved test. More Information. September 22, 2017

OTHER NEWS

FDA Grants Priority Review for Genentech's Perjeta® (Pertuzumab) for Adjuvant Treatment of HER2-Positive Early Breast Cancer

South San Francisco, CA -- September 28, 2017 --
Genentech, a member of the Roche Group (SIX: RO, ROG; OTCQX: RHHBY), today announced the U.S. Food and Drug Administration (FDA) has accepted the company's supplemental Biologics License Application (sBLA) and granted Priority Review for Perjeta® (pertuzumab), in combination with Herceptin® (trastuzumab) and chemotherapy (the Perjeta-based regimen), for adjuvant (after surgery) treatment of HER2-positive early breast cancer (EBC). The FDA is expected to make a decision on approval by January 28, 2018. READ MORE

FDA is pleased to announce the release of new educational materials for health care professionals about biosimilar and interchangeable products.

The agency developed these educational materials to help increase understanding about these important new types of medication among health care professionals. The materials include four fact sheets and graphics for health care professionals that:

- Provide the basic definitions of terms like: biological drugs, reference products, biosimilar, interchangeable; and other terms to facilitate understanding the relationship between biosimilars and their reference products;
- Describe the rigorous standards any biosimilar must meet prior to approval and explain how the FDA approval pathway works for these products; and,
- Contain details about the data and information FDA reviews to determine biosimilarity, and how to find more information.
- Provide information about prescribing biosimilar and interchangeable products

Continued on next page...

OTHER NEWS

FDA also developed tools to help professional societies and stakeholder organizations share information about biosimilars with their colleagues and members. These tools include social media posts for Twitter, Facebook and LinkedIn, an infographic and infogifs, and drop-in newsletters and/or blog content. These stakeholder resources can be found in the Patient and Prescriber Outreach Materials web section.

Visit FDA's newly updated biosimilars webpage for more information and to access the campaign materials. New resources and information will also be available in the coming months, so please check back often.

Council Urges CMS to Revise Biosimilar Reimbursement Policy in Medicare Part B

Publish Date: Thursday, September 21, 2017
To increase patient access to biosimilars and ensure that the marketplace can expand, the Biosimilars Council is urging the Centers for Medicare and Medicaid Services (CMS) to revise its current reimbursement policy for biosimilars in Medicare Part B. READ MORE

Update on IV Fluid Shortage

(ASCO in Action) Nov 2, 2017 - ASCO is aware of the growing IV fluid shortage, along with other drugs in short supply. READ ARTICLE

OTHER NEWS

National Comprehensive Cancer Network Hits One Million Registered Users Accessing the NCCN Guidelines® and Related Content

Growing registration numbers help ensure that new cancer treatment developments reach patients worldwide.
FORT WASHINGTON, PA [October 25, 2017] — The National Comprehensive Cancer Network® (NCCN®) announces today that their registration count has grown to more than one million users. By registering on the NCCN website, users are able to view and download all of the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) free of charge for non-commercial use. According to the latest count, the number of registered users has grown to 1,013,449. READ MORE

FDA clears common blood cell count test that offers faster results for patients and providers

The U.S. Food and Drug Administration today cleared a complete blood cell count (CBC) test that, based on its categorization, can be run in more health care settings, including physicians' offices, clinics or other types of health care facilities, by a wider range of personnel (e.g. support staff). This broadened test access will allow for faster availability of results. READ MORE

Cancer Care Costs 60% Higher at Hospitals Vs Independent Orgs

September 28, 2017 - Hospital-based cancer care for patients undergoing chemotherapy was 60 percent more expensive compared to the same treatment at community-based oncology practices, according to a recent study by Xcenda and Lucio Gordan, MD, Medical Director in the Division of Quality and Informatics at Florida Cancer Specialists and Research Institute. READ MORE

Many Cancer Patients Skip Treatments Due to Cost

(WebMD/HealthDay News) Oct 24, 2017 - The high cost of cancer care in the United States has led more than one-quarter of patients to cut back on some part of their treatment, a new survey reveals. READ ARTICLE

It's time to eliminate the secretive Pharmacy Benefit Manager pricing practices

With federal lawmakers introducing a variety of bipartisan, bicameral legislation throughout 2017 aimed at eliminating opaque and secretive Pharmacy Benefit Manager (PBM) pricing practices, the increasingly controversial middlemen in the national drug pricing chain now find themselves the target of new state laws passed to end so-called "clawbacks," which retroactively extract dollars from consumers months after a transaction. READ MORE

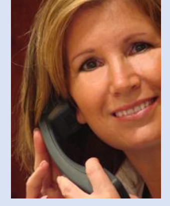
PATIENT ASSISTANCE

NJSOM Featured Corporate Sponsor Assistance Program

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

To access their website…CLICK HERE

FREQUESTLY ASKED QUESTIONS



Reimbursement Questions & Answers

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

Question: Does Medicare have any guidelines for hospital standing orders for medication administration?

Answer: The Centers for Medicare & Medicaid Services (CMS) last updated the survey guidelines for medication administration guidance for the *Medicare State Operations Manual for Hospitals* in December 2011. It now includes requirements for facility use of standing orders for medication administration.

If the hospital uses standing orders, it must have current policies and procedures that address "the process by which a standing order is developed; approved; monitored; initiated by authorized staff; and subsequently authenticated by physicians or practitioners responsible for the care of the patient."

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Question: If the units of a drug given exceed the size of the units field on the claim, how should the remaining be billed?

Answer: According to *Medicare Claims Processing Manual* (chapter 17, section 70), if the units provided exceed the size of the units field, or require more characters to report than spaces available in the format, providers should repeat the HCPCS or national drug code (NDC) on multiple lines until all units can be reported.

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Question: Does the JW modifier apply to drug overfill?

Answer: No, the JW modifier must not be used to report overfill wastage. Beginning January 1, 2011, Medicare issued regulations expressly prohibiting billing for overfill, which is any amount of drug greater than the amount identified on the package or label. Additional information on the overfill policy is available in the Physician Fee Schedule Final Rule published in the November 29, 2010 Federal Register (75 FR 73466-70) available at https://www.federalregister.gov/articles/2010/11/29/2010-27969/medicare-program-payment-policies-under-the-physician-fee-schedule-and-other-revisions-to-part-b-for.

Continued on next page...

FREQUESTLY ASKED QUESTIONS

Question: Can you confirm or deny that when putting ICD 10 code for encounter for antineoplastic chemotherapy can be used by the physician seeing patient prior to actual chemo in the clinic, or should this code only be used by the nurses or hospital when billing administration of chemo?

Answer: I assume you are referring to the ICD-10 code, Z51.11, "Encounter for antineoplastic chemotherapy."

When a physician is seeing a patient for an E & M visit, the ICD-10 code must reflect the condition(s) of the patient on the day of the visit.

I would never see a Z51.11 as a REASON for a visit with a physician unless it is a day that the patient is seen the same day as chemo, the visit is NOT significantly identifiable (therefore without a modifier 25). In this case the visit would not be reimbursed.

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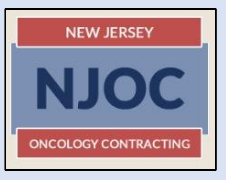
Question: We are performing intrathecal chemo administration and assigning code 96450. We are also doing fluoro for needle guidance, which would be assigned 77003. However, with the new 2017 CPT® guideline, 96450 is not a primary procedure code to 77003. How should we bill for the fluoro guidance?

Answer: Currently, because of the 2017 CPT guideline, fluoro is considered included in 96450 (chemotherapy administration, into CNS [e.g., intrathecal], requiring and including spinal puncture) and no longer separately billable. The 2018 CPT manual includes 96450 as a primary code for 77003, so beginning on January 1, 2018, you should be able to report 77003 with 96450 again.

CPT® is a registered trademark of the American Medical Association.

THANK YOU

Happy Thanksgiving to all of our NJSOM Members



CLICK HERE
to find out more information about the group purchasing program.

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