NJSOM
New Jersey Society of Oncology Managers
Reimbursement E-News ISSUE: 27 March 2015

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.

ADVERTISING OPPORTUNITIES!!

We are looking for supporters of the NJSOM Reimbursement E-News. Interested parties contact one of our Board Members…CLICK HERE

New Jersey Society of Oncology Managers
PO Box 95
Florham Park, New Jersey 07932

Phone: 800.658.5011
Fax: 973.453.8133
E-mail: info@njsom.org

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 comments, suggestions, stories and/or questions to Michelle Weiss, editor, at njsombilling@gmail.com

Oncology Care Model Introductory Webinar

A webinar introducing the core concepts of OCM, including application instructions was held on February 19, 2015. For additional information, to review webinar please visit the Oncology Model webinar page.

All practices and payers who wish to apply for participation in OCM-FFS must first submit a non-binding letter of intent (LOI). LOIs for interested payers are due by 5:00 pm EDT on March 19, 2015. LOIs for interested practices are due by 5:00 pm EDT on April 23, 2015. LOI forms are available for download (see Additional Information below), and will only be accepted through the Oncology Care Model email inbox at OncologyCareModel@cms.hhs.gov.

Oncology Care Model – CMMI Dedicated Site and additional info …

CLICK HERE

For more information on the OCM see pages 2 & 10

Front Page News

Permanent SGR 'Fix' Unlikely in Near Term

Get out the patch kit, it's SGR time again
WASHINGTON -- Another patch for the sustainable growth rate (SGR) formula for Medicare physician reimbursement is very likely on the way before the formula can be repealed for good.

READ MORE

Bringing the Oncology Care Model into Focus

(ACCCBuzz) Feb 26, 2015 - As ACCC members are well aware, on February 12, the CMS Innovation Center (CMMI) released its much-anticipated Oncology Care Model (OCM) as part of the broader effort to lower healthcare costs and tie reimbursement to quality and value. ACCC has been conducting an in-depth analysis, and, overall, the OCM generally resembles the discussion draft we saw in August; while the model contains many positive elements, other areas still need clarification.

READ ARTICLE

Important Update from ABIM about its MOC Program

February 3, 2015, the American Board of Internal Medicine, (ABIM) announced immediate changes to the Maintenance of Certification (MOC) program based on feedback they received from ASCO and other concerned organizations. Last year, ABIM released a new process for MOC that many physicians felt was onerous and lacked relevance to how physicians in practice learn today. In response, ASCO and their sister professional societies began a dialogue with ABIM to let them know our concerns. In response to those concerns, ABIM is suspending the Practice Assessment, Patient Voice, and Patient Safety requirements for at least two years. To review the AIBM apology and steps going forward

CLICK HERE

Calendar of Events

NJSOM June Conference
June 12, 2015 - Bridgewater Marriott

MARK YOUR CALENDARS!

Novitas Solutions Inc.

NJSOM
New Jersey Society of Oncology Managers

CMS Provider Education Message:
CMS Conducts Successful Medicare FFS ICD-10 End-to-End Testing Week

From January 26 through February 3, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in the first successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate all volunteers, which represented a broad cross-section of provider, claim, and submitter types.

Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by October 1, 2015.
Testing demonstrated that CMS systems are ready to accept ICD-10 claims. **View the results.**

Overall, participants in the January 26 to February 3 testing were able to successfully submit ICD-10 claims and have them processed through our billing systems. To the extent that some claims were rejected, most didn't meet the mark because of errors unrelated to ICD-9 or ICD-10.

Testing allows us to identify areas of improvement, and we will work with outside entities and stakeholders to improve those very small deficiencies identified. And, we will continue to do testing, especially in those areas we identify as needing improvement.

In addition to acknowledgement testing, which may be completed at any time, two more end-to-end testing weeks will be held before the October 1, 2015, compliance date for ICD-10:

- April 27 through May 1: Volunteers have been selected
- July 20 through July 24: Volunteer forms will be available March 13 on the MAC and CEDI websites
- Testers who participated in the January testing are automatically eligible to test again in April and July

For more information:

- **MLN Matters® Article #MM8867**, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- **MLN Matters® Special Edition Article #SE1435**, "FAQs – ICD-10 End-to-End Testing"
- **MLN Matters® Special Edition Article #SE1409**, "Medicare FFS ICD-10 Testing Approach"

Novitas Solutions Inc.

First Quarter 2015 Medicare Report

Are you wondering what's been going on with Medicare Part B since the Fourth Quarter of 2014? Wonder no more! Stay up to date with the latest Medicare Part B information by reading the First Quarter 2015 Medicare Report currently available on our website. Get caught up. Read it today!

READ MORE

Local Coverage Article Updates

The following JL Article has been revised:

- **NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions A49325**

Medical Policy Local Coverage Determination and Article Updates

The following JL Draft LCDs posted for comment on September 18, 2014 and presented at the October 2014 Contractor Advisory Committee (CAC) Meeting have been posted for notice. They will become effective April 9, 2015.

- **Hemophilia Factor Products (L33658)**
- **Hydration Therapy (L32738)**

Medical Policy Local Coverage Determination Updates

Please Note: As previously communicated Novitas will accept comments for the following draft until March 19, 2015:

- **Biomarkers Overview DL33638**

Submit Comments

Part B Top Inquiries Frequently Asked Questions (FAQs)

January FAQs are here! A new question has been added "How do we list the referring provider on the claim?" Take time to review our FAQs for answers to this and other questions.

READ MORE

Modifier 59 and New Modifiers XE, XS, XP, XU

Information specific to the -59 modifier and new X{ESPU} modifiers is available on the Novitas website. Please take a few moments to review this information.

READ MORE

Novitas Solutions Inc.

New Enterprise Identity Management (EIDM) Password Help Videos Available!

To better assist our Part B Novitasphere Portal customers with their EIDM password updates and resets, Novitas has created two step-by-step animated videos! These short animated videos will walk customers through the process of either updating or resetting their passwords within the EIDM system – without having to make a call to the Novitasphere Portal Help Desk!

Please check out these informative videos here:

- Novitasphere EIDM Password Updates
- Novitasphere EIDM Password Resets

JL Ask-the-Contractor Teleconferences Scheduled for 2015

The JL Ask-the-Contractor Teleconferences (ACT) have been scheduled for 2015. Please join us for an informative teleconference on current Medicare revisions with the ability to ask questions. Novitas Solutions hosts ACTs on a quarterly basis. Next date is 2/12/2015.

READ MORE

JL Part B Ask-the-Contractor Teleconference Meeting Minutes

The JL Part B Ask-the-Contractor Teleconference (ACT) minutes for the February 12, 2015 meeting have been posted. Please take a moment to review.

READ MORE

New Medicare Insights Weekly Podcasts Now Available!

In this week's Medicare Insights Weekly Podcast, we review our mailing list and all it has to offer.

READ MORE

Novitas Solutions e-News Electronic Billing Quarterly Newsletter

Articles of note:

- Important Information Regarding Enrollment in Novitasphere Portal
- Learn the Benefits of Electronic Remittance Advice (ERA)
- Novitasphere: Correct Claims Faster, All with Only a Couple of Keystrokes!

And More…Available CLICK HERE

Medicare Part B - H O T L I N K S !

2015 Medicare JL Part B Fee Schedule
Current Average Sales Price (ASP) Files
2015 Physician Fee Schedule Final Rule
Current Active Part B LCD Policies
Quarterly Update to CCI Edits
2015 CMS Physician Fee Schedule Final Rule Fact Sheet

Novitas Solutions Inc.

WEBINAR

Here are Upcoming Training Events You Won't Want to Miss

DATE	TIME	EVENT	LOCATION
3/5/15	10:00a-11:00a	Part B Evaluation and Management Score Sheet: Part 1 – Understand the Key Components of Evaluation and Management Services	Via Webinar
3/5/15	2:00p-3:30p	Part A/ B New and Small Provider Education- Part 1 – Medicare Basics	Via Webinar
3/10/15	2:00p-3:00p	Part B How to Avoid Top Claim Errors- First Quarter	Via Webinar
3/11/15	11:00a-12:00p	Part B Novitasphere Provider Portal Enrollment Overview	Via Webinar
3/11/15	2:00p-3:30p	New and Small Provider Education – Part 2 – Part B Claim Overview	Via Webinar
3/12/15	10:00a-11:00a	Part B Evaluation and Management Score Sheet: Part 2 – Introduction to the Score Sheet	Via Webinar
3/12/15	2:00p-3:30p	Compliance Journey	Via Webinar
3/19/15	12:00p-1:00p	JL Part B Evaluation and Management Score Sheet: Part 3- Using the Score Sheet	Via Webinar
3/24/15	2:00p-3:30p	New and Small Provider – Part 3 – Self Service	Via Webinar
3/26/15	10:00a-11:00a	Part B Evaluation and Management Score Sheet: Part 4 – Scoring Medical Records Using the Score Sheet	Via Webinar
3/26/15	2:00p-3:30p	Understanding the Local Coverage Determination (LCD) and National Coverage Determination (NCD) Process	Via Webinar

On-Demand Education

- Weekly Audio Podcasts
- Training Modules
- Medicare Reference Manual
- Specialty Guides
- Acronyms & Abbreviations
- Frequently Asked Questions
- Quick Ref. Guides & Claims Errors/Issues
- 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
- Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients *
- How CMS Is Fighting Fraud: Major Program Integrity Initiatives *
- Safeguarding Your Medical Identity *
- Are You Ready for the National Physician Payment Transparency Program? *

CMS Medicare

Performant Recovery

RAC

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

What's New!

Important Provider Notice:
CMS is currently developing additional business processes to facilitate providing all materials and information in an alternative format (e.g., Braille, large print, audio CD, data CD, and qualified reader), if requested by a beneficiary or member of the general public.

For information about the availability of auxiliary aids and services, please CLICK HERE

To get to the Performant Recovery website CLICK HERE

Some Tips for Dealing with the Early Phases of an Audit

Written by David M. Glaser, Esq. Created on Wednesday, 02/04/15
The following are a few practical tips for responding when you get a request for medical records from Medicare or a private insurer. First, make sure that whoever is opening the mail keeps the envelope. It is relatively common for the date on a letter and the date of the postmark to be extremely disparate. In one case, a letter dated July 15 was postmarked in mid-September. By keeping the envelope, you can prove when the letter was actually mailed.

READ MORE

Looming Changes Evident in Newly Unveiled Medicare Budget

Written by Amy Shaffner, RN, BSN, PHN Created on Wednesday, 02/18/15
President Barack Obama's 2016 budget report was recently released, and the news coming out of Washington, D.C. does not bode well for hospital appellants and the appeals process. The 150-page report has approximately 10 pages that are dedicated to healthcare issues. The Medicare budget includes a projected savings of $407.2 billion over 10 years and includes a $403 million mandatory multi-year investment in detecting, preventing, and prosecuting healthcare fraud.

READ MORE

CMS Medicare

MACs Heading Down Slippery Slope from Medical Necessity to Quality of Care

Written by Ronald Hirsch, MD, FACP, CHCQM Created on Wednesday, 02/1815
"Don't confuse me with the facts; my mind is already made up." This is how William Malm, the senior manager at Craneware, describes the two recent notifications by two Medicare Administrative Contractors (MACs) who have made up their minds that they need to enter the realm of risk assessment and quality of care: a territory where they do not belong.

READ MORE

A Common-Sense Medicare Solution: Site-Neutral Payment Reform | Commentary

By Barry Brooks
Imagine this basic scenario: You are out of milk. You could go to your local convenience store and purchase a gallon for $3. But instead, you drive 25 miles to buy the identical gallon of milk for $5 at a large chain grocery store.

READ MORE

Retrospective Baseline Probe Audits: Problems and Solutions to an Outdated Methodology

Written by Frank Cohen, MPA Created on Wednesday, 02/18/15
Based on surveys conducted by this author and others, it has been determined that the average large practice (greater than 150 physicians) relies upon retroactive baseline probe audits (RBPA) in order to identify patterns of compliance risk among their provider populations.

READ MORE

Hospitals Mount Campaign against Site-Neutral Medicare Payments

(ModernHealthcare) Feb 26, 2015 - Hospital leaders are working to head off any momentum in Congress toward overhauling Medicare rates to pay hospitals the same for outpatient services as the program pays for the same services in physician offices.

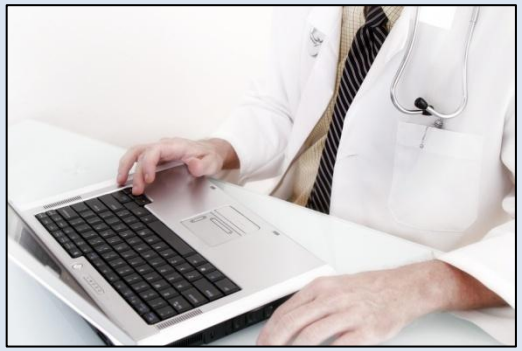
READ ARTICLE

CMS Medicare

Physician Quality Reporting Programs: Reporting Once in 2015 Registration Now Open

Wednesday, March 18; 1:30-3pm ET
To Register: Visit **MLN Connects™ Upcoming Calls**. Space may be limited, register early.

This MLN Connects™ National Provider Call provides an overview of how to report once across various 2015 Medicare Quality Reporting Programs, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, Value-Based Modifier (VM), and Medicare Shared Savings Program.



CMS Announces Extension for EPs Participating in PQRS via EHR and QCDR

Thursday, February 26, 2015 - The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the submission deadlines for the PQRS reporting methods below have been extended. All other submission timeframes for other PQRS reporting methods remain the same.

The revised submission deadline is **March 20, 2015 at 8 pm ET** for the following reporting methods:

- **EHR Direct or Data Submission Vendor** that is certified EHR technology (CEHRT)
- **Qualified clinical data registries (QCDRs) (using QRDA III format)**reporting for PQRS and the clinical quality measure (CQM) component of meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program

An Individuals Authorized Access to CMS Computer Services (IACS) account with the "PQRS Submitter Role" is required for these PQRS data submission methods. Please see the **IACS Quick Reference Guides** for specifics.

PQRS provides an incentive payment to individual eligible professionals (EPs) and group practices that satisfactorily participate or satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services. Additionally, those who do not meet the 2014 PQRS reporting requirements will be subject to a negative payment adjustment on all Medicare Part B PFS services rendered in 2016.

Note: The deadline listed above does apply to individual EPs and Group Practices participating in other CMS programs such as the Medicare EHR Incentive Program and Comprehensive Primary Care Initiative that are utilizing the reporting methods listed above. Additionally, CMS has extended the deadline for EPs wishing to attest to meaningful use for the EHR reporting period in 2014 for the Medicare Electronic EHR Incentive Program to March 20, 2015. Please be on the lookout for a separate listserv with information regarding the attestation extension.

For questions, please contact the QualityNet Help Desk **1-866-288-8912** or via email at **Qnetsupport@hcqis.org** from 7:00 a.m. - 7:00 p.m. Central Time. Complete information about PQRS is available…**CLICK HERE**

CMS Medicare

New Affordable Care Act Initiative to Encourage Better Oncology Care

On February 12, HHS announced a new multi-payer payment and care delivery model to support better care coordination for cancer care as part of the Department's ongoing efforts to improve the quality of care patients receive and spend health care dollars more wisely, contributing to healthier communities. The Oncology Care Model encourages participating practices to improve care and lower costs through episode-based, performance-based payments that financially incentivize high-quality, coordinated care. Participating practices will also receive monthly care management payments for each Medicare Fee-For-Service beneficiary during an episode to support oncology practice transformation, including the provision of comprehensive, coordinated patient care.

Physician group practices and solo practitioners that provide chemotherapy for cancer and are currently enrolled in Medicare may apply to participate. Other payers, including commercial insurers, Medicare Advantage plans, state programs, and Medicaid managed care plans, are also encouraged to apply. To be considered,

- Interested payers must submit a letter of intent through the Oncology Care Model inbox at **OncologyCareModel@cms.hhs.gov** by 5pm ET on March 19, 2015
- Interested practices must submit letters of intent through the Oncology Care Model inbox at **OncologyCareModel@cms.hhs.gov** by 5pm, ET on April 23, 2015
- Payers and practices that submit a timely letter of intent will be sent an authenticated web link and password with which to submit an electronic application. Applications must be submitted by 5pm ET on June 18, 2015

For more information:

- **Fact Sheet**
- **Oncology Care Model** website

Full text of this excerpted **CMS press release** (issued February 12).

CMS to Release Comparative Billing Report in March on Modifier 25: Nurse Practitioners

CMS will be issuing a national provider Comparative Billing Report (CBR) on nurse practitioners' use of Modifier 25 in March 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on nurse practitioners and will contain data-driven tables and graphs with an explanation of findings that compare these providers' billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only accessible to the providers who receive them; they are not publicly available.

Providers are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRs. Providers should contact the CBR Support Help Desk at 800-771-4430 or **CBRsupport@eglobaltech.com** if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk or visit the CBR website.

CMS Medicare

Medicare Learning Network® (MLN) Suite of Products & Resources for Billers and Coders

EXCELLENT RESOURCE FOR BILLERS AND CODERS – MULTIPLE PAGES AVAIABLE: CLICK HERE

"Chronic Care Management Services" Fact Sheet — Released

"Chronic Care Management Services" Fact Sheet (ICN 909188) was released and is now available in downloadable format. This fact sheet is designed to provide background on the separately payable Chronic Care Management (CCM) services for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. It includes information on eligible providers and patients, Physician Fee Schedule billing requirements, and a table aligning the CCM Scope of Service Elements and billing requirements with the Certified Electronic Health Record or other electronic technology requirements.

COA Announces Oncology Medical Home Pilot Program Launch

Wednesday, February 25, 2015

Ten community oncology practices across the country will begin the accreditation process to become recognized as official oncology medical homes.

READ MORE

CMS Medicare

House Energy & Commerce Committee to Hold 340B Drug Pricing Program Hearing

Congressman Joe Pitts (R-PA), Chair of the House Subcommittee on Health, Energy and Commerce Committee, scheduled a hearing for March 5 on the 340B program. According to the hearing notice, "subcommittee members will review the functionality of the program to ensure it is meeting its goal of improving access to prescription drugs for needy patients at facilities serving these populations." Witnesses will include staff from the Health Resources and Services Administration (HRSA), the agency that administers the program, the Government Accountability Office, and the HHS Office of the Inspector General.

Update for Pharmacists Prescribing Part D Drugs

CMS values the role that pharmacists play in our health care system today. CMS is aware that in many states, pharmacists are allowed to write or modify prescriptions in certain circumstances. A CMS **final rule** published May 23, 2014, included a requirement that Medicare Part D plan sponsors and their Pharmacy Benefit Managers (PBMs) deny coverage for prescriptions written by prescribers who:

- Are not enrolled in Medicare in an approved status or
- Do not have a valid opt-out affidavit on file

However, the Medicare statute does not include pharmacists among the types of eligible professionals who can enroll in Medicare or opt out. CMS is considering various approaches for addressing pharmacists' concerns with this enrollment requirement. Consistent with the Medicare statute and CMS requirements, pharmacists should not attempt to enroll in or opt out of Medicare. CMS will continue to update the pharmacist community on this issue.

"Internet-based PECOS Contact Information" Fact Sheet-Reminder

The "**Internet-based PECOS Contact Information**" Fact Sheet (ICN 903766) is available in a downloadable format. This fact sheet is designed to provide contact information for technical assistance with Internet-based Provider Enrollment, Chain and Ownership System (PECOS). It includes a list of contacts and other resources.

CMS Medicare

CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015

CMS intends to engage in rulemaking this spring to help ensure providers continue to meet meaningful use requirements. In response to input from health care providers and other stakeholders, CMS is considering the following changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- Shortening the 2015 reporting period to 90 days to address provider concerns about their ability to fully deploy 2014 Edition software
- Realigning hospital reporting periods to the calendar year to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other quality programs
- Modifying other aspects of the programs to match long-term goals, reduce complexity, and lessen providers' reporting burden

These proposed changes reflect the HHS commitment to creating a health information technology infrastructure that elevates patient-centered care, improves health outcomes, and supports the providers who care for patients. While CMS intends to pursue these changes through rulemaking, they will not be included in the pending Stage 3 proposed rule. CMS intends to limit the scope of the pending proposed rule to Stage 3 and meaningful use in 2017 and beyond.

For more information:

- Read Dr. Conway's blog: **CMS intends to modify requirements for Meaningful Use**
- Visit the **EHR Incentive Programs website**

Additional Guidance on Electronic Signatures is Available

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Provider who need additional information on the guidelines for using an electronic signature may reference CMS' **Medicare Program Integrity Manual** (PDF, 573 KB) (Pub. 100-08), Chapter 3, Sections 3.3.2.4.E-F.

Eligible Professionals Hit With $200M in EHR Penalties

Wednesday, February 11, 2015
Eligible professionals this year will pay about $200 million in penalties for failing to meet Medicare meaningful use requirements, according to new data from the Office of the National Coordinator for Health IT, *Health Data Management* reports (Slabodkin [1], *Health Data Management*, 2/11).

READ MORE

CMS Medicare

2015 Medicare Final Rules

Medicare released the 2015 Final Rules for both the Physician Fee Schedule and Outpatient Hospitals that lay the groundwork for Medicare reimbursement in 2015. Below you will find links to summaries of the rule(s) from many of our national organizations;

ASCO's PFS Analysis

ACCC's PFS Analysis

ACCC's HOPPS Analysis

ASH's PFS & HOPPS Analysis

Link to HOPPS Final Rule

CMS Fact Sheet PFS

CMS Fact Sheet HOPPS

Link to PFS Final Rule

Recent LearnResource & MedLearn Matters Articles

- Automation of the Request for Reopening Claims Process
- Healthcare Provider Taxonomy Codes (HPTCs) April 2015 Code Set Update
- Clinical Laboratory Fee Schedule - Medicare Travel Allowance Fees for Collection of Specimens
- Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492
- Reporting Force Balance Claim Payment on the Electronic Remittance Advice (ERA) 835 and Cross Over Beneficiary (COB) 837 Claim Transactions

Other Payer Updates

Office Manager Seminars

Join us for an Office Manager Seminar. We make doing business with us easier.
Topics include:

- 2015 new Horizon BCBSNJ products, policies & procedures
- ICD10 update
- Provider Reference Materials redesign.
- CareAffiliate - the new online Prior Authorization Tool
- Risk adjustment and what it means to your office.
- Clear Claim ConnectionTM - the online code editing tool
- Estimator Cost Tool - the online member tool
- Referenced Based Benefits
- Member FAQ

The following are currently scheduled events.

Seminar Date	Seminar time	Facility Name
4/27/2015	11am – 1pm	Hoboken University Medical Center 308 Willow Avenue Hoboken, NJ 07030
5/14/2015	9am – 11am	Hackettstown Regional Medical Center 651 Willow Grove Street Hackettstown, NJ 07840
7/15/2015	9am – 11am	Saint Clare's Hospital 25 Pocono Road Denville, NJ 07834
9/30/2015	9am – 11am	Ocean Medical Center 425 Jack Martin Boulevard Brick, NJ 08724

If you have questions about the seminar, please call 1-973-466-5573 or e-mail **Physician_seminars@HorizonBlue.com**.

To register, email **Physician_seminars@HorizonBlue.com** with your name, practice name, Tax ID number and preferred date and location. You can also fax the registration form to 1-973-274-4049.

Oncology Related Medical Policies Updates

- New! **Nivolumab (Opdivo)**
- New! **Blinatumomab (Blincyto)**
- New! **Lemtrada (Alemtuzumab)**
- Revised! **Ipilimumab (Yervoy) and Pembrolizumab (Keytruda)**

Modifier Policies to be Implemented

Posted on Monday March 02 2015

Effective June 1, 2015, we will change the way we process and reimburse certain claims that include procedure codes appended with modifiers 52, 53, 54, 55, 56 and 73.

Change to the Amendment to our Horizon PPO Network Agreement

Posted on Thursday February 26 2015

We are modifying our enforcement of one aspect of the amended language provided in our recently distributed PPO network Amendment.

QUICKLINK
Horizon Medical Policy Manual

Other Payer Updates

NJSOM
New Jersey Society of Oncology Managers

NEW!

UnitedHealthcare
NetworkBulletin
An important message to health care professionals and facilities

A Few Articles You Won't Want to Miss:

- ✓ Injectable Chemotherapy Prior Authorization Requirement for Commercially Insured
- ✓ UnitedHealthcare Medical Policy, Drug Policy, Coverage Determination Guideline and Utilization Review Guideline Updates

And Much More…
MARCH Monthly
Issue Available HERE

NEW!

aetna

A Few Articles You Won't Want to Miss:

- ✓ Updates to our National Precertification List…pg 1
- ✓ Office Manual available on our public website…pg 1
- ✓ New and updated courses for physicians, nurses and office staff…pg 7
- ✓ New ID cards for accountable care plans…pg 7
- ✓ Changes to pharmacy precert for certain specialty drugs…pg 9

And Much More….MARCH Northeast Region
Qtly Issue Available HERE

Notice…
If there is a specific Payer you would like included in this newsletter, please email njsombilling@gmail.com

A Few Articles You Won't Want to Miss:

NEW!

- ✓ Updated AmeriHealth New Jersey Provider Manual now available
- ✓ Professional Injectable and Vaccine Fee Schedule updates effective April 1, 2015
- ✓ Important billing information for modifiers 25 and 59
- ✓ Changes coming to NaviNet in March
- ✓ Billing procedures for credentialed Certified Registered Nurse Practitioners
- ✓ Prescription drug updates

And Much More – MARCH Monthly.....CLICK HERE

To visit their Provider pages….CLICK HERE

AmeriHealth

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES

Information for Providers: Contracts, Legal Notices

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

Other News

DRUG SHORTAGES –

If you are looking for a complete list of Drug Shortages from the FDA CLICK HERE.

RECENT FDA APPROVALS/CHANGES

FDA Approves Farydak for Treatment of Multiple Myeloma

02/23/ 2015 - The U.S. Food and Drug Administration today approved Farydak (panobinostat) for the treatment of patients with multiple myeloma. Farydak is the first HDAC inhibitor approved to treat multiple myeloma. It is intended for patients who have received at least two prior standard therapies, including bortezomib and an immunomodulatory agent. Farydak is to be used in combination with bortezomib and dexamethasone.

READ MORE

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FDA Approves Ibrance for Postmenopausal Women with Advanced Breast Cancer

02/03/2015 - The U.S. Food and Drug Administration today granted accelerated approval to Ibrance (palbociclib) to treat advanced (metastatic) breast cancer.

READ MORE

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FDA Approves Lenvima for a Type of Thyroid Cancer

02/13/2015 - The U.S. Food and Drug Administration today granted approval to Lenvima (lenvatinib) to treat patients with progressive, differentiated thyroid cancer (DTC) whose disease progressed despite receiving radioactive iodine therapy (radioactive iodine refractory disease).

READ MORE

Other News

Can Money Really Be No Object When Cancer Care Is the Subject?

February 27, 2015
Drug prices are the most rapidly increasing component of American health care costs, and cancer drugs in particular have been leading this meteoric rise.

READ MORE

What Does the Future Hold For the Cancer Drugs Fund?

(The Guardian [UK]) Feb 27, 2015 - When the government created the Cancer Drugs Fund (CDF) in 2010 to pay for cancer drugs rejected by the National Institute for Care and Health Excellence (Nice), it was intended as a short-term stopgap until a longer-term solution to the problem of evaluating and funding cancer drugs for terminally ill patients could be developed.

READ ARTICLE

Medical Economics
SMARTER BUSINESS. BETTER PATIENT CARE.

Improving the Claims Management Process: Preventing Payer Denials

7 strategies to improve your practice's claim denial rates.

LEARN MORE

Top 5 Health Care Trends to Watch in 2015

February 25th, 2015
With a new Congress, health care is once again an issue of tremendous scrutiny and debate. Many of the federal policy debates in 2015 will be largely symbolic, resulting in little more than tweaks to existing law.

READ MORE

Other News

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Why Switching EHRS May Be the Best Change Your Practice Ever Makes

Changing electronic health record vendors can be a costly process that drains productivity, but it still may be the right thing to do.

Switching your **electronic health record** (EHR) system is expensive, time-consuming, and disruptive to your practice. But if, as a physician, you are stuck with a system that has become unmanageable or negatively impacting your operations, converting could be the right solution no matter the cost.

READ MORE

U.S. Department of Health & Human Services
Office of Inspector General
U.S. Department of Health & Human Services

February 27, 2015

- **Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2013** (OEI-03-14-00520)

February 11, 2015

- Updated Civil Monetary Penalties: **False and Fraudulent Claims Kickback and Physician Self-Referral**

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EHR Best Practices: Making Your System Work for Your Practice

Strategies to maximize your EHR system's features.

Functionality and expenses are the two biggest sore spots most physicians feel regarding their **EHR choice**—*Medical Economics* found that **70% of doctors** feel that their EHR system wasn't worth the cost or effort. By now, you are aware of your **EHRs perks and problems**. But there may still be more ways to maximize your system, with the goal of doing business more efficiently. Your staff may need more training, and your workflow processes may need to be evaluated to work more in your favor.

Here are tips to fine-tune your EHR to fit seamlessly into your practice workflow:

READ MORE

Other News

Two New ICD-10 Videos

CMS has released two animated shorts that explain key ICD-10 concepts. The videos are less than 4 minutes each and available on the **Provider Resources** web page:

- **Introduction to ICD-10 Coding** gives an overview of ICD-10's features and explains the benefits of the new code set to patients and to the health care community
- **ICD-10 Coding and Diabetes** uses diabetes as an example to show how the code set captures important clinical details

Keep Up to Date on **ICD-10** Visit the ICD-10 website for the latest news and resources to help you prepare.

CMS Conducts Successful Medicare FFS ICD-10 End-to-End Testing Week

From January 26 through February 3, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in the first successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate all volunteers, which represented a broad cross-section of provider, claim, and submitter types.

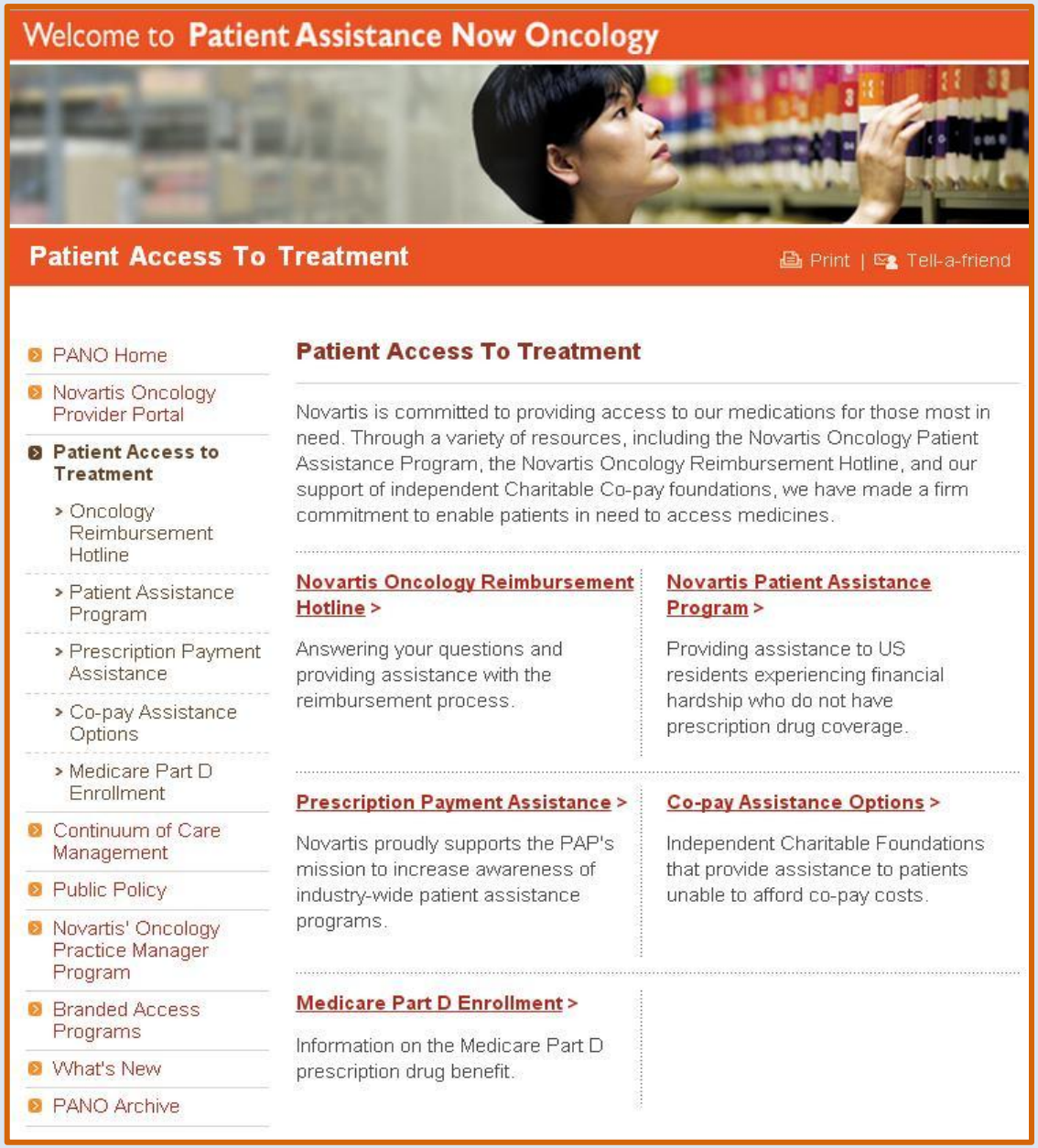
Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by October 1, 2015.

Testing demonstrated that CMS systems are ready to accept ICD-10 claims. **View the results.**

ICD-10 References:

- CMS – **"ICD-10-CM/PCS Myths and Facts"** Fact Sheet - REVISED
- CMS - **"ICD-10-CM/PCS The Next Generation of Coding"** Fact Sheet - REVISED
- CMS - **"ICD-10-CM Classification Enhancements"** Fact Sheet - REVISED
- CMS - **"General Equivalence Mappings Frequently Asked Questions"** Booklet - REVISED
- CMS - **ICD-10 Website**
- ASCO - **Introduction, Anatomy of an ICD-10 Code, Finding an ICD-10 code, General Equivalence Mappings, Transition Timeline**
- ICD10 Monitor.enews - **ICD-10 News and Information**

Patient Assistance



NJSOM Featured Corporate Sponsor Assistance Program

NJSOM will profile a different Corporate Sponsor Assistance Program each Reimbursement E-News

NOVARTIS ONCOLOGY

Patient Assistance Now Oncology
To access this website:
CLICK HERE

Frequently Asked Questions

Reimbursement Questions & Answers

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

QUESTION: We have been getting some denials on Procrit patients and when I spoke to Medicare, the rep informed me that the HCT that we are billing with is too high. In all the documentation that I have read, only the HGB was mentioned. Have you heard of any changes in the way Procrit is being processed? I was unable to find any updates with Medicare. Any information would be greatly appreciated.

ANSWER: You can report EITHER the HCT or HGB. One or the other must meet the criteria. This national policy has not changed.

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QUESTION: We are trying to find information from CMS on the requirements for a "Provider Based" clinic. Where can we find this information?

ANSWER: While there is much information on the internet, I recommend reviewing the CMS Program Memorandum Transmittal A-03-030 dated April 18, 2013. This document goes into detail the specifics and includes the Attestation form which also lays out much of the criteria. CLICK HERE to review this document.

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QUESTION: I have been "told" over and over that our physicians cannot bill for an office visit on the same day as chemotherapy using modifier 25 unless they see the patient for non-chemo related issues. Where can I find more information on this – I need a resource to show our physicians.

Continued on next page…

Frequently Asked Questions

ANSWER: There are many references available however; I have found a report by the Office of Inspector General to be an excellent resource. Whether the procedure is a surgery or an administration code, the rules related to the use of the 25 modifier and billing services ABOVE what is included in the paid procedure are the same. Take a look at this report and let me know if you have additional questions or need more info for your team. **CLICK HERE**

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QUESTION: I listened to a Medicare update on the new X-modifiers and I am more confused than ever! If a patient is here for chemo and has to get an Aranesp or Xgeva would we use the XU code? If it is an office visit and an injection only would we use the XE, XU, or continue using the 59?

ANSWER: I was on a call with CMS today and they pointed out that we are not REQUIRED to use the new x-modifiers yet. CMS will be providing additional instruction and examples on the utilization of the modifiers in the future. In the meantime CMS referenced the MedLearn Matters article that clearly states providers are allowed to continue to use the 59 modifier until CMS provides further instruction. **CLICK HERE**

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QUESTION: I'm hoping you can help me with a question regarding the Review of Systems portion of the History on an E&M visit. Medicare guidelines state "At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented". Am I interpreting this correctly to mean that if the provider did do a 10 system review, they can mention the positive or pertinent negatives in the Interval History, and then have a statement such as "A 10-point review of systems was assessed; all systems were negative except per Interval History"? I would appreciate your interpretation of this guideline, and any suggestions you have on how to list the system review in the dictation. I realize this is a "grey" area and probably is interpreted different ways by coders.

ANSWER: You are correct. Reviewing the "Auditor's Worksheet", within the HISTORY section it says *Complete ROS: 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative". Therefore, that statement WILL count for a complete ROS!

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Continued on next page…

Thank You

QUESTION: I heard a rumor that a CHONC certified coder will have to take a proficiency ICD-10 exam in order to maintain the certification. Is this true? If so, where do I find that information?

ANSWER: Yes, according to the AAPC, you must pass an ICD-10 Proficiency Assessment by 12/31/2015 in order to maintain your credentials. The Exam is not Hem/Onc specific. There are two options for taking the exam: Option 1 "At Your Own Pace" and Option 2 "Timed Assessment". AAPC also offers many training opportunities. **CLICK HERE** for more information.

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