NJSOM
New Jersey Society of Oncology Managers

Reimbursement E-News ISSUE: 30 June 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.

NJSOM
New Jersey Society of Oncology Managers

SAVE THE DATE

NJSOM Annual Fall Conference
October 2, 2015 – Ocean Place Resort

MARK YOUR CALENDARS!

New Jersey Society of Oncology Managers
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Florham Park, New Jersey 07932

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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

340B drug pricing debate pits hospitals against doctors against big pharma

May 21, 2015
Depending on how much the program is reformed, it could mean the difference of hundreds of millions of dollars for participating hospitals. READ MORE

Read other articles on 340B on page 16

New Medicare Data on MDs and Hospitals Released by CMS

Tuesday, June 02, 2015 - From CMS… As part of the Administration's efforts to promote better care, smarter spending, and healthier people, today CMS is posting the third annual release of the Medicare hospital utilization and payment data (both inpatient and outpatient) and the second annual release of the physician and other supplier utilization and payment data. The announcement was made at the annual Health Datapalooza conference in Washington, DC.

READ MORE

Front Page News

Medicare Updates Data on Pay to Individual Physicians

Medscape Robert Lowes, June 01, 2015
With its second annual release today of fee-for-service payment data for individual physicians, Medicare is providing a little more context for inquiring minds.

READ MORE *(free subscription required)*

CMS Clarifies "Out of Pocket" Limits for Individuals Enrolled in Family Plans

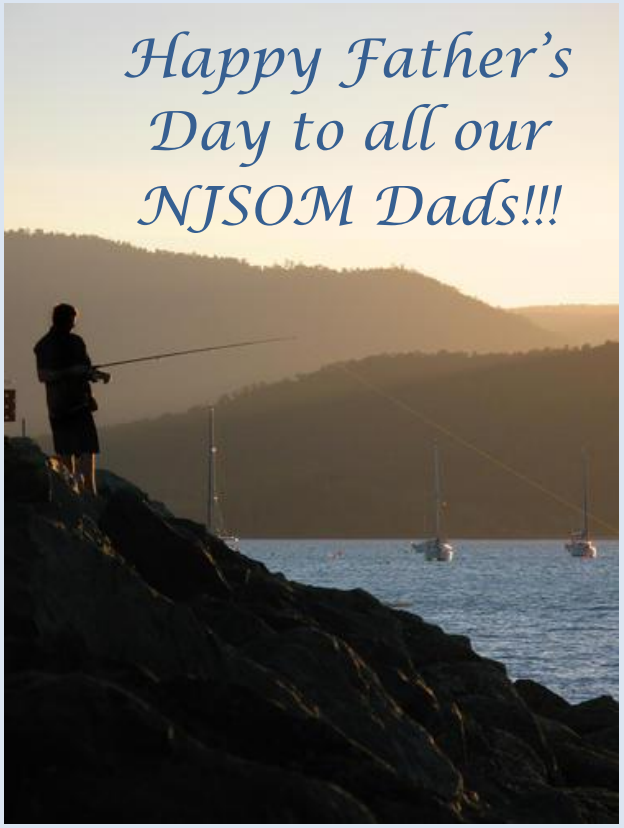
By Meir Rinde, Thursday, April 2, 2015
The Centers for Medicare & Medicaid Services (CMS) issued guidance affirming the annual cost-sharing limitation for individuals, regardless of whether enrolled in an individual or family plan. In 2016, the individual out-of-pocket (OOP) maximum will be $6,850 and the family OOP maximum will be $13,700.

In February, CMS issued the final HHS Notice of Benefit and Payment Parameters for 2016. Within the document the parameters related to the OOP limits were established. Whether a plan could require a beneficiary to meet the family OOP, even as an individual was still confusing.

Last month, the "I Am (Still) Essential" Coalition, a broad group of patient and community organizations, wrote HHS Secretary Sylvia Burwell expressing concerns that some plans might require individuals to continue paying OOP for services beyond the individual OOP maximum until the higher family maximum is reached.

GREAT NEWS - the CMS FAQ released on May 8, 2015 clarified that insurers must limit each person's OOP costs to the ACA's individual limit, even if he or she is enrolled in a family plan that has a higher OOP cost cap.

To view the CMS FAQ - **CLICK HERE**



Novitas Solutions Inc.

There is still time to register for our upcoming 2015 Medicare Symposiums!

Join us for our symposium in **State College, PA** on **Tuesday, June 9**! This event will be held at the **Ramada Conference Center Hotel**.

Learn what is changing and trending now in Medicare. Participants will have the opportunity to interact with the Novitas Solutions Provider Outreach and Education team and network with their colleagues.

Find out what the Novitas Solutions symposiums have to offer by reviewing our course listings and agenda in the **2015 Medicare Symposium brochure** on our website.

Registration is available for other symposiums, including:

- Fort Lee, NJ
- Philadelphia, PA
- Ocean City, MD
- Greenbelt, MD
- East Windsor, NJ

We look forward to seeing you at an upcoming symposium event!

READ MORE

Join the Centers for Medicare & Medicaid Services on June 18 for a call on Preparing for Implementation and New ICD-10-PCS Section X

It's not too late to get ready for ICD-10 implementation on October 1, 2015. During this MLN Connects National Provider Call, CMS subject matter experts will present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals.

REGISTRATION IS OPEN

Part B Top Inquiries Frequently Asked Questions (FAQs)

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

READ MORE

The First 2015 Quarterly Report of Common CERT Errors is Now Available

Take a few moments to review the quarterly report of common CERT errors. Learn more about the top CERT claims errors and how you can avoid these errors in your facility or practice.

If you have comments or questions about these reports, please email QuestCERT@novitas-solutions.com. We value your feedback.

READ MORE

Novitas Solutions Inc.

JL Part B Ask the Contractor Teleconference Meeting Minutes

The JL Part B Ask the Contractor Teleconference meeting minutes from the May 14, 2015 meeting have been posted. Please take a minute to review.

READ MORE

Updates

CID Tool Updates

The CERT Identification Online Tool has been updated with the most recent claim sampling, which includes claims sampled in May 2015. You can find this tool on the CERT Center under "Interactive Tools". Simply enter the CID number and click the "search CID" button to obtain a status of your CERT sampled claim. Providers can find the CID number assigned to the claim under review on the letter from the CERT Documentation Contractor.

READ MORE

IMPORTANT!

New Reimbursement

The Medicare Access and CHIP Reauthorization Act of 2015 allowed a zero percent update for dates of service January 1, 2015 to June 30, 2015 and a 0.5 percent update from July 1, 2015 to December 31, 2015. The fee schedules currently posted remain in effect from January 1, 2015 to June 30, 2015 with the exception of procedure codes 88366 and 88366 TC. The Practice Expense Relative Value Units were revised with the July 1, 2015 Medicare Physician Fee Schedule Update resulting in new Medicare Fee Schedule allowances.

The new fees for dates of service January 1, 2015 to June 30, 2015 are listed below. **These changes become effective on July 6, 2015**.

- DC Jan 2015 disclosure
- DE Jan 2015 disclosure
- NJ Jan 2015 disclosure
- PA Jan 2015 disclosure
- MD Jan 2015 disclosure

READ MORE

Novitas Solutions Inc.

New Medicare Insights Podcast now available!

In this Medicare Insights Podcast, we review the International Classification of Diseases, Tenth Revision (ICD-10) implementation.

READ MORE

In this Medicare Insights Podcast, we review the Novitas Educational Tips and Tools documents.

READ MORE

The following Oncology Related JL Local Coverage Determinations (LCDs) has been revised

- Hemophilia Factor Products (L33658)

Top Claim Submission Errors (Medicare Part B)

The April Top Claim Submission Errors and resolutions are now available. Please take a moment to review these errors and avoid them on future claim submissions.

READ MORE

Additional Part B Educational Event Added to June Calendar!

New session added to the June JL Part B Calendar of Events!

- 6/4/2015 - Overview Of Drugs and Biologicals

Please visit the Education and Training page of the website today and register for this new event!

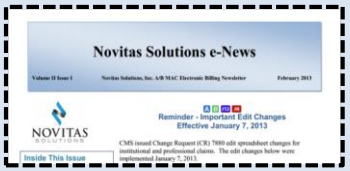
READ MORE

Novitas Solutions e-News Electronic Billing Quarterly Newsletter

Articles of note:

- Reminder – International Classification of Diseases, Tenth Revision (ICD-10) Acknowledgement Testing Week: June 1-5, 2015
- Notice of Change Regarding Access to Novitas Solutions, Inc.'s Novitasphere Portal
- Claims Correction Quick Reference Now Available
- Correct Reporting of Medicare Secondary Payer (MSP) Type on Electronic Claims

And More…MAY Issue 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
6/4/15	2:00p-3:00p	Part B Overview of Drugs and Biologicals	Via Webinar
6/9/15	8:00a-4:00p	2015 Medicare Symposium - State College, PA	In Person
6/12/15	1:00p-2:00p	Novitasphere Claims Correction Overview	Via Webinar
6/17/15	10:00a-11:30a	New and Small Provider Education - Part 2 Part B Claim Overview	Via Webinar
6/18/15	1:00p-2:00p	Novitasphere Provider Portal Enrollment Overview	Via Webinar
6/19/15	11:00a-12:00p	Part B How to Avoid Top Claim Errors - Second Quarter	Via Webinar
6/23/15	1:00p-2:00p	Novitasphere Direct Data Entry (DDE) Overview	Via Webinar
6/24/15	10:00a-11:30a	New and Small Provider Education - Part 3 Self Service	Via Webinar
6/25/15	10:00a-11:00a	Novitasphere Claims Correction Overview	Via Webinar
6/26/15	10:00a-11:00a	Initial Inpatient Services	Via Webinar
6/30/15	10:00a-11:00a	Part B Subsequent Hospital Care Rules and Coding	Via Webinar
6/30/15	1:00p-2:00p	PC-ACE Pro32	Via Webinar
7/29/15	8:00a-4:00p	2015 Medicare Symposium - Fort Lee, NJ	In Person
8/5/15	8:00a-4:00p	2015 Medicare Symposium - Philadelphia, PA	In Person

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

RACmonitor.com

The Insurance Contracting Pitfalls that Finance Executives Need to Know

Written by Ronald Hirsch, MD, FACP, CHCQM
As Medicare Advantage (MA) penetration increases arithmetically, now reported nationwide at over 30 percent of providers, the frustrations felt by hospital case management staff increases exponentially – and usually without any awareness by the people in the hospital that are responsible for negotiating those contracts. Unbeknownst to the hospital's finance staff....

READ MORE

RACmonitor.com

We Get What We Pay For

Written by Bob Soltis
U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell recently told Congress that the agency's plans to reduce the growing backlog at the Office of Medicare Hearings and Appeals (OMHA) include charging a refundable filing fee, hiring more administrative law judges (ALJs), and opening more field offices.

READ MORE

CMS Medicare

Physician Compare Virtual Office Hour Session

Tuesday, June 23; 1-2pm ET

CMS will host a one-hour Virtual Office Hour session via WebEx to discuss the Physician Compare website. During this session, CMS will answer stakeholders' questions about Physician Compare and public reporting. Anyone interested in participating can register by sending an email to the Physician Compare support team. You can also include up to three questions (one primary and two secondary) with your registration or send them separately. All questions must be received by 5pm ET on Monday, June 15. For more information about Physician Compare, visit the Physician Compare Initiative web page.

New Video on PQRS and the Value-Based Payment Modifier

CMS has released the following MLN Connects® video: **The Physician Quality Reporting System & the Value-based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2015**. This MLN Connects video presentation provides an overview of the Physician Quality Reporting System (PQRS) and how your participation in 2015 will determine how the Value-Based Payment Modifier will be applied to your reimbursement in 2017. Run time: 45 minutes: 10 seconds.

For a list of videos on PQRS and the Value-based Payment Modifier, as well as videos on a variety of other Medicare topics, visit **MLN Connects Videos**. For more information, visit the PQRS and Medicare FFS Physician Feedback Program/Value-Based Payment Modifier web pages.

"Medicare Appeals Process" Fact Sheet

The "**Medicare Appeals Process**" Fact Sheet (ICN 006562) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the five levels of claim appeals in Original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers, in addition to including more information on available appeals-related resources.

2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline

Groups have 4 weeks to register to participate in the 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) via the Physician Value - Physician Quality Reporting System (PV-PQRS) Registration System. PQRS GPRO is an option available to groups with 2 or more eligible professionals (EPs). Groups must meet the satisfactory reporting criteria through the PQRS GPRO in order to avoid the -2.0% CY 2017 PQRS payment adjustment. More information is available on the **PQRS Payment Adjustment Information** web page.

READ MORE

CMS Medicare

EHR Incentive Program: Deadline for Eligible Professional Hardship Exception is July 1

Payment adjustments for eligible professionals who did not successfully participate in the Medicare Electronic Health Record (EHR) Incentive Program in 2014 will begin on January 1, 2016. Medicare eligible professionals can avoid the 2016 payment adjustment by applying for a 2016 hardship exception by July 1. The hardship exception applications and **instructions** for an **individual** and for **multiple** Medicare eligible professionals are available on the **EHR Incentive Programs** website. They outline the specific types of circumstances that CMS considers to be barriers to achieving meaningful use and how to apply.

CMS updates Medicaid managed care organization rules

First update since 2002 seeks better alignment with Medicare Advantage, CHIP, private insurance market
May 26, 2015 | By Brian Eastwood
The Centers for Medicare & Medicaid Services (CMS) has released its long-awaited **proposed rule** that updates its Medicaid managed care organization (MCO) regulations. **READ MORE**

2014 Mid-Year QRURs Available

CMS has released the 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) to physician solo practitioners and groups of physicians nationwide, including those who participated in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014.

The 2014 MYQRURs were made available for informational purposes only and contain information on a subset of the measures used to calculate the 2016 Value Modifier. The MYQRUR provides interim information about performance on the six cost and three quality outcomes measures that CMS calculates from Medicare claims. These are some of the measures used in the calculation of the Value Modifier. The information in the MYQRUR is based on care provided from July 1, 2013, through June 30, 2014, a period that precedes the actual 2014 performance period for the 2016 Value Modifier. More information is available on the **2014 MYQRUR** web page.

The 2014 MYQRUR can be accessed on the **CMS Enterprise Portal**, using a valid Individuals Authorized Access to the CMS Computer Services (IACS) account. For more information, visit **How to Obtain a QRUR**.

"Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" MLN Matters® Article

MLN Matters® Special Edition Article #SE1516, "Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" has been released and is now available in downloadable format. This article is designed to provide education on Medicare's requirement for 24/7 access by individuals furnishing CCM services to the electronic care plan, rather than the entire medical record. It includes FAQs regarding billing CCM services to the Physician Fee Schedule (PFS) and Hospital Outpatient Prospective Payment System (OPPS) under CPT code 99490.

CMS Medicare

ASCO and ACCC Host Tutorial Webinar on June 4th Applying for the Medicare Oncology Payment Model

The American Society of Clinical Oncology (ASCO) and the Association of Community Cancer Centers (ACCC) are pleased to offer, "The OCM Application: Getting it Done," a tutorial webinar on completing the application for the Center for Medicare and Medicaid Innovation's (CMMI) Oncology Care Model (OCM) before the submission deadline on June 18, 2015. The webinar, scheduled for June 4 at 4:00 p.m. EDT, will focus on completing the OCM application package. Eligible providers may register for the event today. **READ MORE**

CMMI Releases OCM Practice Letter of Intent Submission List

The Center for Medicare and Medicaid Innovation (CMMI) released the list of physician practices who submitted Letters of Intent (LOIs) to participate in CMS' first-ever oncology-specific payment reform model, the Oncology Care Model. The list includes 443 diverse practices. , Final applications are due June 18th. According to CMS, they hope to enroll 100 diverse practices.

For more information and to download the list **CLICK HERE**. **List of practices (XLS)**

Take Action by July 1 to Avoid 2016 Medicare Payment Adjustment

Payment adjustments for eligible professionals that did not successfully participate in the Medicare EHR Incentive Program in 2014 will begin on January 1, 2016. Medicare eligible professionals can avoid the 2016 payment adjustment by taking action by July 1 and applying for a 2016 hardship exception.

The hardship exception applications are available on the EHR Incentive Programs website, and outline the specific types of circumstances that CMS considers to be barriers to achieving meaningful use, and how to apply. Please see instructions on how to file a hardship exception and provide supporting documentation for certain hardship exception categories. The application must be submitted electronically or postmarked no later than 11:59 PM ET on July 1, 2015 to be considered. If approved, the exception is valid for the 2016 payment adjustment only. If you intend to claim a hardship exception for a subsequent payment adjustment year, a new application must be submitted for the appropriate year.

For more news and updates, please visit the **EHR Incentive Programs website**.

Other Payer Updates

No Oncology Related Policy Updates

You Can Now Request Authorizations Online

CareAffiliate. Fast. Easy. Secure …LEARN MORE

Referring Your Patients for Ancillary Services?

We have made updates to our Ancillary Claims Processing Rules. Find out how this affects claims filing and processing.

READ MORE

Electronic Claim Transaction Update

Posted on Friday May 15 2015
Review this important information about 837P transactions to help ensure timely and accurate claims processing.

READ MORE

New to our network?

Find out what's available for participating physicians.

LEARN MORE

QUICKLINK
Horizon Medical Policy Manual

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

Horizon Blue Cross Blue Shield of New Jersey

The following are currently scheduled events.

Seminar Date	Seminar time	Facility Name
06/10/2015	8:30 a.m. - 10:30 a.m.	Inspira
07/09/2015	9 a.m. - 11 a.m.	Centra State Medical Center
07/15/2015	9 a.m. - 11 a.m.	Saint Clare's Hospital
09/30/2015	9 a.m. - 11 a.m.	Ocean Medical Center

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

aetna℠

Tidbit

Update to our National Precertification List

Granulocyte-colony stimulating factor (GCSF) drugs/medical injectables won't require precertification until January 1, 2016. We originally communicated that GCSF would require precertification on July 1, 2015.

Humana is Said to Consider Sale of Company

HUMANA Guidance when you need it most

By Michael J. de la Merced and Julie Creswell.
May 29, 2015 - NYtimes

Humana, one of the country's largest health insurers, is weighing a potential sale of itself after having been approached by several competitors, people briefed on the matter said on Friday. **READ MORE**

IMPORTANT!

UnitedHealthcare

Injectable Chemotherapy Prior Authorization Program Update

UnitedHealthcare will expand its prior authorization program Starting June 1, 2015, UnitedHealthcare will expand its prior authorization (PA) program for injectable chemotherapy administrated in an outpatient setting and use an online application to manage the program. **CLICK HERE** for more information.

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

Other Payer Updates

NJSOM
New Jersey Society of Oncology Managers

A Few Articles You Won't Want to Miss:

- ✓ Charging Medicare Advantage Members for Non-Covered Services: Additional Information Regarding the Written Consent Requirement
- ✓ Overpayment Notifications
- ✓ UnitedHealthcare Oxford Injectable Chemotherapy Prior Authorization Program

And Much More…
JUNE Monthly
Issue Available HERE

NEW!

A Few Articles You Won't Want to Miss:

- ✓ Updates to our National Precertification List…pg 1
- ✓ Policy and coding updates…pg 2
- ✓ Our response time to appeals is changing…pg 3
- ✓ Use our new national network for BRCA testing services…pg 4
- ✓ New and updated courses for physicians, nurses and office staff…pg 8
- ✓ Note these 2015 CMS compliance requirements…pg 8

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

A Few Articles You Won't Want to Miss:

NEW!

- ✓ Coming soon: Easy to use online peer-to-peer request form
- ✓ Reminder: Transitioning outstanding Accounts Receivable balances to new platform
- ✓ Professional Injectable and Vaccine Fee Schedule updates effective July 1, 2015
- ✓ Clarification: AmeriHealth guidelines for submitting authorizations and referrals
- ✓ Upcoming changes to the enforcement of medical and claim payment policy for AmeriHealth New Jersey members
- ✓ Medical and claim payment policy activity posted from April 25 – May 22, 2015

And Much More – JUNE Monthly.....**CLICK HERE**
To visit their Provider pages….CLICK HERE

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**.

U.S. Drug Shortages Frustrate Doctors, Patients

By Peter Loftus - May 31, 2015

Drugs in short supply include cancer treatments and antibiotics; manufacturing snafus

Robin Miller, a 62-year-old oncologist in Atlanta with bladder cancer, was scheduled to receive a potentially lifesaving drug in December. **READ MORE**

RECENT FDA APPROVALS/CHANGES

No New Oncology Specific FDA Drug Approvals for the month of May

High Prices for Drugs Attacked at Meeting

By Joseph Walker - Updated June 1, 2015 - Wall Street Journal

CHICAGO—In a sign of growing frustration with rising drug prices, a prominent cancer specialist on Sunday sharply criticized the costs of new cancer treatments in a high-profile speech at one of the largest annual medical meetings in the U.S. **READ MORE**

Drug Revenues May Migrate to Specialty Pharma

Tony Hagen - Published Online: Thursday, May 14, 2015

The rising number of oral oncology drugs that can be supplied through pharmacy networks rather than administered in clinical settings, such as intravenous drugs, has many physicians worried that they are losing control of an important part of the therapeutic process.

The Community Oncology Alliance (COA) is stepping into the fray by forming a pharmacy association that will strive to represent the interests of oncology practices, particularly those that already have dispensaries or that intend to set them up. - **READ MORE**

Other News

340B "Mega-Guidance" Under Review at OMB

The much anticipated Health Resources and Services Administration (HRSA) "mega-guidance" around the 340B Drug Pricing Program is now under review at the Office of Management and Budget (OMB). The document, listed as "340B Program Omnibus Guidelines," could include topics such as patient definition, hospital eligibility, contract pharmacy, and audits. While OMB typically has up to 90 days to review submissions, the guidance could be released as early as June. ACCC is monitoring this closely; stay tuned.

Congress waking up to 340B corporate slush fund

By Ellen Weaver and Lindsay Boyd |May 26, 2015, 10:00 am
The 340B program, created by Congress over two decades ago, was originally intended to help vulnerable and uninsured patients gain access to prescription medicines. Since then....
READ MORE

Hospitals Urge Congress to Protect 340B Program

05.20.15 by Bill Santamour H&HN Managing Editor
Savings allow safety net hospitals to provide care to the neediest patients in their communities. **READ MORE**

Cancer Charities Scam: 5 Reasons Why It Took the Feds So Long to Catch On

(Washington Post/To Your Health) May 20, 2015 - The Federal Trade Commission's civil complaint against a group of four cancer philanthropies alleging that they bilked donors out of $187 million sent a chill through the nonprofit community.

READ ARTICLE (free registration required)

How EHR note cloning can get you in trouble

EHR note cloning can lead to sloppy notes, fraudulent claims and audit scrutiny.

READ MORE

Improving claim denial management

Learn strategies to engage your staff and prevent avoidable denials to capture more revenue. **READ MORE**

Other News

A Physician Roadmap to ICD-10

Written by Donald Bialek, MD, MPH and Tom Ormondroyd | Monday, 01 June 2015

With the sustainable growth rate (SGR) bill now signed into law, it is time for physicians to really focus on their preparations for the upcoming ICD-10 implementation. ICD-10 will affect every aspect of a physician's practice, including patient encounters, clinical and financial workflow, as well as compensation and reimbursement. It requires more accurate documentation and gives physicians more diagnostic choices to capture new data in order to ensure they are paid for the complex work being performed. **READ MORE**

The ICD-10 transition: Avoiding revenue disruptions

Physicians can take steps, ranging from documentation training to taking out a line of credit, to keep their practice financially healthy during the transition to ICD-10. **READ MORE**

ICD-10 Preparing for Implementation and New ICD-10 PCS Section X

Register now: Thursday, June 18; 1:30 – 3:oo PM ET

It's not too late to get ready for ICD-10 implementation on October 1, 2015. During this MLN Connects® National Provider Call, CMS subject matter experts present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. A question and answer session follows the presentations. Details & Registration **CLICK HERE**

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

- Insurance Coverage and Reimbursement
- Prior Authorizations
- Financial Assistance
- Appeals
- Prescription Process
- Tools and Resources

Welcome to Celgene Patient Support®

At Celgene Patient Support®, your passion and commitment to your patients is something we strive to replicate. That's why you and your staff will have a dedicated Celgene Patient Support® Specialist working to get your patients access to the Celgene medications they need.

No matter what your patient's insurance situation, a range of options are available that may help pay for their Celgene medication. Your Celgene Patient Support® Specialist will explore all the options to get the information and support you need. We can even help locate transportation assistance to help patients with the cost of traveling to and from your office.

Personal support from a single source

Our Specialists include nurses, pharmacy technicians, and social workers who come from diverse backgrounds. They understand your regional reimbursement and access challenges. Together, we can help determine which resources are available for your patients:

Financial Assistance

- Celgene Commercial Co-pay Program*
- Financial assistance through third-party organizations
- Celgene Free Medication Program*
- Transportation assistance for patients

Insurance Services

- Benefits investigation
- Help with prior authorization/precertification
- Appeals assistance

* Subject to eligibility requirements.

Financial help

Explore options that can help your patient pay for a Celgene medication.

Learn more

Need further assistance?

Find Your Dedicated Celgene Patient Support® Specialist

Enter zip code:

Search

Contact us at 1-800-931-8691
or send us an e-mail
Fax us at 1-800-822-2496

A phone call to Celgene Patient Support® is free, personal, and confidential.

Frequently Asked Questions

Learn more about Celgene Patient Support®, insurance, and different financial help options.

Get Answers

NJSOM Featured Corporate Sponsor Assistance Program

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

To access their website and get details
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 saw a patient that was dehydrated and nauseous. Primarily they were here because they needed hydration so I picked a hydration code as my "initial code", 96360, and then billed a 96367 for the infusion of the antiemetic medication. I was rejected for the 96367. What did I do wrong?

ANSWER: Within CPT there is a rule about hierarchy of the codes. While it states this rule only applies to the facility setting, some payers have incorporated this into their edits for private practice as well. CPT guidelines state that a facility should follow a strict hierarchy of coding regarding injections and infusions, whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which in turn are primary to hydration services. Infusions are primary to pushes, which in turn are primary to injections. Therefore, you should bill the initial codes as the therapeutic, 96365 and then 96361 for the hydration.

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QUESTION: We put on a pump for a patient receiving 5fu on Monday. On Wednesday we are taking it off and will be flushing the port. It is the only thing we will be doing to the patient on Wednesday. CPT says we can bill the port flush if it is the only thing we do. Can report this code? Is this appropriate?

ANSWER: No. You are correct about the CPT rules for 96523 – to bill this you cannot report "in conjunction with other services". However, when you bill for the pump initiation, 96416 – "initiation of prolonged chemotherapy infusion (more than 8 hours), requiring the use of a portable or implantable

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Frequently Asked Questions

pump", you bill an administration code and therefore, another CPT rule applies. You are not allowed to bill separately for a flush at the conclusion of infusion. Since the 96416 is an administration code, this applies to this code as well. The flush at conclusion of infusion is paid for when you are paid for the 96416.

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QUESTION: We gave our patient an infusion (high dose electrolytes) and then later gave the SAME therapeutic infusion. Since the 96367 says "additional sequential infusion of a NEW drug, I know we can't bill that code. What do we bill when we give an infusion of the same medication later?

ANSWER: Take a look at the CPT code 96366, "each additional hour". Under that code CPT indicates, "Report 96366 in conjunction with 96365 to identify each second and subsequent infusions of the same drug/substance.

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QUESTION: I remember seeing an article some time ago about a document from CMS that had a bunch of information on billing. It was like a quick reference guide. Do you know where to find it?

ANSWER: Yes, CMS did publish a Medicare Learning Network Suite of Products and Resources for Billers and Coders. You can find this document by **CLICKING HERE**

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QUESTION: Do you have any material on charging of drugs when they are mixed, but patient had reaction or refused drug billing? For example, a patient came in and the chemotherapy was mixed and their levels were too high to administer, are we able to charge for the drug since was mixed? If you have any documentation or article on this, or can direct me where to look I would appreciate it. Even if the article or document states we can't bill I would still like to have it for our records.

ANSWER: I have never been able to find anything in writing except in the Medicare Online Manual it states they will cover waste from a SINGLE DOSE VIAL - and in order to bill for that waste part of the vial must have been administered to the patient.

Other than that, the only experience I have with questions like yours is when I asked my Medicare MAC directly. Essentially we have been told that if the

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Thank You

patient's count was too low or the patient decided they did not want treatment, you cannot bill the insurance company for the mixed medications. They stated that you had control of the situation (the count should have been verified before the drugs were mixed) and therefore you cannot bill, or the patient would be responsible if they refused treatment after drug was mixed.

I have received approval in a situation where a patient was receiving a medication and during the administration they had a reaction and the remainder of the drug they were receiving had to be thrown away – CMS stated it would be very difficult to tell how much the patient received vs how much was wasted and directed us to document what happened and be sure to notate the remainder of the "bag" or drug had to be thrown away. In this type of situation we would be allowed to bill for THAT medication - if other medications were already mixed and waiting - we were not allowed to bill for those - same concept - "we should have waited before mixing the other medications". I hope this helps.

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