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.

NJSOM
New Jersey Society of Oncology Managers

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NJSOM
New Jersey Society of Oncology Managers

Reimbursement E-News ISSUE: 57 August 2017

Welcome to this Publication of the Monthly Newsletter!!

The ***New Jersey Society of Oncology Managers Reimbursement E-News*** is a monthly publication focused on the latest reimbursement news for your Oncology Practice. You can scroll through the document a page at a time or you can use the links along the bottom to assist in quick navigation.

Please feel free to submit any questions, comments, suggestions, stories and/or questions to Michelle Weiss, editor, at Michelle@weissconsulting.org

Congress Squares Off Over Drug Pricing And A Controversial Drug Discount Program

House Democrats are calling foul on Republican assertions that cuts to a little-known discount drug program will eventually reduce skyrocketing drug prices. At a hearing Tuesday, Rep. Diana DeGette (D-Colo.) said high drug prices should be investigated separately from the focus on oversight of the drug discount program, known as 340B. READ MORE

ASCO
American Society of Clinical Oncology
Making a world of difference in cancer care

ASCO Offers Path to Addressing Affordability of Cancer Drugs in New Position Statement

Society recommends several solutions to be tested for increasing the affordability of drugs for patients and healthcare system July 19, 2017. READ MORE

Front Page News | Novitas Solutions Inc. | CMS Medicare | Other Payer Updates | Other News | Patient Assistance | Frequently Asked Questions

Front Page News

Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Proposed rule & Request for Information provide flexibility, support strong patient-doctor relationships

On July 13, CMS issued a proposed rule that would update Medicare payment and policies for doctors and other clinicians who treat Medicare patients in CY 2018. The proposed rule is one of several Medicare payment rules for CY 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

The Physician Fee Schedule is updated annually to include changes to payment policies, payment rates, and quality provisions for services furnished to Medicare beneficiaries. This proposed rule would provide greater potential for payment system modernization and seeks public comment on reducing administrative burdens for providing patient care, including visits, care management, and telehealth services. The rule takes steps to better align incentives and provide clinicians with a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program. The rule encourages competition between hospitals and physician practices by promoting greater payment alignment, and it would improve the payment for office-based behavioral health services that are often the therapy and counseling services used to treat opioid addiction and other substance use disorders. In addition, the proposed rule makes additional proposals to implement the Center for Medicare and Medicaid Innovation's Medicare Diabetes Prevention Program expanded model starting in 2018.

For More Information:
Proposed Rule
Fact Sheet

See the full text of this excerpted Press Release (issued July 13).

Front Page News

ASCO Proposes Alternative Pathway for MOC

ASCO has been working to address the concerns and burdens that are associated with the current ABIM 10-year exam for maintenance of certification. Last year, a MOC Task Force was created to develop an alternate process that is personalized, aligned with physicians' practice and knowledge needs, and integrated into ongoing physician activities. The Task Force proposal shifts the focus of the process from one that is a 10-year assessment of comprehensive knowledge in oncology, to one that focuses on continuous learning and the choice for greater sub- specialization in oncology.

The Task Force proposal for an alternate pathway for maintaining certification is composed of a core assessment and topic-based modular assessments. Content covered by the core assessment will be germane to all oncologists, regardless of practice profile. The topic-based assessments will allow diplomates to tailor learning to address specific tumor types seen in their practice. Every six years, diplomates will take the core assessment plus two topic assessments that are self-selected.
ASCO has been working with ABIM and discussions have focused on the delivery of an alternate pathway for maintaining certification that is more meaningful, less burdensome and offers greater sub-specialization.

Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes

Proposed rule and Request for Information promote improvements to quality, accessibility, and affordability of care

On July 13, CMS issued a proposed rule that updates payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule is one of several for 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility and innovation in the delivery of care.

The OPPS and ASC payment system are updated annually to include changes to payment policies, payment rates, and quality provisions for those Medicare patients who receive care at hospital outpatient departments or receive care at surgical centers. Among the provisions in this rule, CMS is proposing to change the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B program. The proposed rule also includes a provision that would alleviate some of the burdens rural hospitals experience in recruiting physicians by placing a two-year moratorium on the direct supervision requirement currently in place at rural hospitals and critical access hospitals. In addition, CMS is releasing within the proposed rule a Request for Information to welcome continued feedback on flexibilities and efficiencies in the Medicare program.

For More Information:
Proposed Rule
Fact Sheet

See the full text of this excerpted Press Release (issued July 13).

Novitas Solutions Inc.

Novitas Self-Service Tools

View all Self-Service Tools

Revised CMS-588: Electronic Funds Transfer Authorization Agreement

Providers and suppliers must use the revised CMS-588 form (Electronic Funds Transfer Authorization Agreement) beginning January 1, 2018. The revised form will be posted on the CMS Forms List (https://go.usa.gov/xX3Sa) by early summer. Medicare Administrative Contractors will accept both the current and revised versions of the CMS-588 through December 31, 2017. Visit the Medicare Provider-Supplier Enrollment webpage for more information about Medicare enrollment and the Electronic Funds Transfer (EFT) requirements.

Changes to the form include:

- New indicator shows if the EFT is for an individual or a group/organization/corporation in Parts 1 and 2 (Reason for Submission and Account Holder Information)
- Now optional to list the financial institution's contact person
- Four digits added to the "Provider's/Supplier's/Indirect Payment Procedure Entity's Account Number with Financial Institution," making it consistent with the industry standard

E&M Service-Specific Coding Instructions - Physician Care Plan Oversight Services

Updates have been made to the billing requirements for Physician Care Plan Oversight Services. READ MORE

Frequently Asked Questions: Accuracy Matters

Do you have questions regarding our "Accuracy Matters" campaign? Take a moment to read these Frequently Asked Questions (FAQs). READ MORE

New Version of Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131

Are you aware there is a renewed version of the Advance Beneficiary Notice of Noncoverage (ABN) Form (CMS-R-131)? The new form was effective for use on or after June 21, 2017, and has an expiration date of March 2020. If you have not already done so, please begin using the new form. READ MORE

Novitas Solutions Inc.

Qualified Medicare Beneficiary Indicator in the Claims Processing System

The Centers for Medicare & Medicaid Services added a QMB status indicator to Medicare's claims processing systems for claims processed on or after October 2, 2017. This system enhancement will trigger notification to providers (through the Provider Remittance Advice) and beneficiaries (through the Medicare Summary Notice) reflecting that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Please review our article for further information. READ MORE

Comprehensive Error Rate Testing (CERT) Program New Processes

The CERT Documentation Office wants to make you aware of new processes.

- Documentation request letters are sent to addresses on file with Novitas
- Providers who have at least ten (10) PTAN numbers can designate a single point of contact
- CERT contractor group calls so that a single contact can be made with the provider

READ MORE

If you receive CERT requests, please review the complete article for details. Questions about your CERT cases can be emailed to QuestCERT@novitas.solutions.com.

Oncology Related Medical Policy

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

- Biomarkers for Oncology (L35396)

Denial of G9678 for Care in an Inpatient Setting

Are you receiving an incorrect denial of G9678 (Oncology Care Model Service) when your patient is an inpatient in a facility? Please review our article for updates on these claim denials to be implemented after October 1, 2017. READ MORE

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for June 2017 are now available. Please take time to review these errors and avoid them on future claims. READ MORE

Novitas Solutions Inc.

Part B Frequently Asked Questions (FAQs)

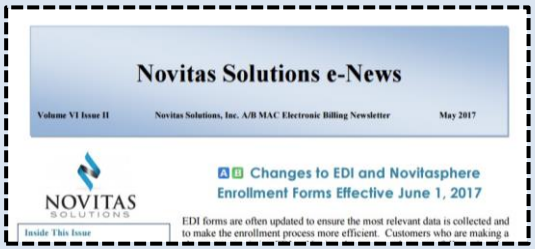
Have a question and not sure where to turn? Check out our FAQs for answers to your questions. READ MORE

Part B Top Inquiries Frequently Asked Questions (FAQs)

Our Part B Top Inquiries FAQs have been reviewed for June 2017. Please take time to review these FAQs for answers to your questions. READ MORE

Novitas Solutions e-News Electronic Billing Qtly Newsletter

Current Qtly Issue Available … CLICK HERE



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

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
Quarterly Update to CCI Edits
Current Average Sales Price (ASP) Files

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

State of New Jersey Department of Human Services

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

Novitas Solutions Inc.

Listed are Novitas training events an oncology practice should consider!

Date	Starts (EST)	Ends (EST)	Event Name	CEUs	Media Type
Tuesday, August 1, 2017	11:00 AM	12:00 PM	**Part B Novitasphere Portal Overview** This course is an introduction to the Novitasphere portal for Part B customers. We will present an overview on how to access Novitasphere and explore the many features this program has to offer. These features include: eligibility inquiry claim submission, electronic remittance advice, claim correction, and more!	1.0	Webinar
Wednesday, August 2, 2017	11:00 AM	12:00 PM	**Ambulance Prior Authorization Non-Affirmed Reasons and Sources** This course is for JL providers enrolled as an independent ambulance supplier that bills for repetitive scheduled non-emergent ambulance transports. We will review the common reasons you might receive a non-affirmed decision letter, while recapping the documentation guidelines.	1.0	Webinar
Thursday August 3, 2017	2:00 PM	3:00 PM	**Part B Psychiatric Services** This course will enhance your Part B knowledge of coverage and documentation requirements for the psychiatric diagnostic evaluation, psychological and neuropsychological testing, and psychotherapy services. This class is designed for Physicians, Psychiatrists, Clinical Psychologists, Clinical Social Workers, Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, Certified Nurse-midwives, compliance officers, billing professionals, and coding professionals who have a basic knowledge of psychiatric services.	1.0	Webinar

For many more opportunities and to register…

CLICK HERE

CMS Medicare

To visit the website
CLICK HERE

07/05/2017: HMS Provider Portal Contact Customization

The HMS Provider Portal is available for all Region 4 Providers in the JL, JE and JF MAC Regions to customize their contact information. Provider Portal User Guides are available on the homepage, under Links and Resources, to assist Providers with establishing their user credentials and customizing their contact information. Providers may also contact HMS' Provider Relations Department for assistance.

HMS has received CMS approval to initiate review in the Novitas JL MAC Region

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RACmonitor.com

2018 OPPS Proposed Rule: Provider-Based Clinics

Since the December 2015 passage of Section 603 of the Bipartisan Budget Act of 2015, dealing with new, off-campus, provider-based clinics/operations has become challenging. The basic idea of Section 603 is that these new off-campus clinics should be paid at a site-neutral level, which involves the Medicare Physician Fee Schedule (MPFS). Of course, the devil is in the details. READ MORE

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When is a Patient Not a Patient?

"Admit as inpatient" are probably the most valuable words written or electronically entered by physicians. And to be honest, I think the Centers for Medicare & Medicaid Services (CMS) has a little too much psychological and physical dependence on these words. READ MORE

RAC Monitor continued on next page…

CMS Medicare

Aftershocks of the Feds' Big Bust: Lessons Learned

Once a year, for the past eight years, the U.S. Attorney General has announced his or her annual healthcare fraud enforcement efforts in the form of the U.S. Department of Justice's (DOJ) "National Health Care Fraud Takedown." READ MORE

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More than 400 Charged in Massive Federal Healthcare Fraud Bust

More than 400 people across the country have been charged in connection with $1.3 billion in healthcare fraud losses as part of what the federal government has labeled the largest enforcement action of its kind in U.S. Department of Justice (DOJ) history. READ MORE

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CMS Opens Up on Improving Medicare Appeals Process, Launching Statistical Sampling Initiative

The Centers for Medicare & Medicaid Services (CMS) held an MLN Connects national provider call on June 29 to educate providers and interested parties on the U.S. Department of Health and Human Services (HHS) final rule to improve the Medicare appeals process. CMS and the Office of Medicare Hearings and Appeals (OMHA) additionally recently released details on a new statistical sampling initiative. READ MORE

New Practice Engagement Program Connects Practices to Specific Resources to Adapt to Health Care Changes

(ASCO in Action) July 24, 2017 - ASCO is launching its new Practice Engagement Program to help administrators, physicians, and other members of the care team navigate ASCO tools, programs, and resources available to help oncology practices respond to the changes occurring in the cancer care delivery system. READ ARTICLE

CMS Medicare

Hospital Discharge Day Management Services CMS Provider Minute Video

Avoid delays. Bill it right the first time. The CMS Provider Minute: Hospital Discharge Day Management Services video includes helpful pointers to properly bill for these services. Learn about:

- Appropriate Healthcare Common Procedure Coding System (HCPCS) codes
- Who can submit a bill

This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New

With Continuing Education Credit

A new Quality Payment Program 2017 Merit-based Incentive Payment System (MIPS): Improvement Activities Performance Category Web-Based Training (WBT) course is available through the Learning Management System. Learn about:

- Improvement Activities performance category requirements
- How this category fits into the larger Quality Payment Program
- Steps you need to take to report Improvement Activities data to CMS
- Basics about scoring

Quality Payment Program: Explanation of Special Status Calculation

CMS has new information on the Quality Payment Program website that indicates whether clinicians have "special status" and can be considered exempt from the Quality Payment Program. These circumstances are applicable for rural, non-patient facing and hospital-based clinicians, as well as clinicians in Health Professional Shortage Areas and small practices.

Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New

A new Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool is available.

Learn about:

- How to avoid common billing errors and other erroneous activities
- How to address and avoid the top issues of this quarter

CMS Medicare

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the *Medicare Claims Processing Manual*, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-mongh basis, effective every January and July 1. Effective, July 1, 2017, the interest amount is 2.375%.

For additional information about when interest is paid on a claim, and how to calculate the interest, refer to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2) CLICK HERE, on the Centers for Medicare & Medicaid Services (CMS) website. Current and past interest rate amounts can be viewed at http://fms.treas.gov/prompt/rates.html on the Treasury Department website.

Quality Payment Program: View Recent Webinar Recordings

Unable to participate in a recent Quality Payment Program webinar? View webinar recordings, presentations, and transcripts on the Events webpage:

- Quality Payment Program Year 2 Proposed Rule Listening Session — June 26
- Participation Criteria for the Quality Payment Program – May 22
- Merit-based Incentive Payment System (MIPS) Group Participation 101 – May 11
- Listening Session: Cost Measure Development – April 5
- MIPS Advancing Care Information Deep Dive Webinar – April 4
- Virtual Group Participation in the Quality Payment Program – March 16

Appeals Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the June 29 call on Improvements to the Medicare Claims Appeal Process and Statistical Sampling. During this call, CMS and the Office of Medicare Hearings and Appeals discuss the HHS Medicare Appeals Final Rule.

AMA Video on Avoiding Negative Payment Adjustment

Physicians can avoid a negative 4-percent payment adjustment in 2019. A new short video developed by the AMA offers step-by-step instructions on how to report so as to avoid a negative payment adjustment in 2019. On this website, ama-assn.org/qpp-reporting, there are also links to CMS' quality measure tools and an example of what a completed 1500 billing form looks like.

CMS Medicare

Evaluation and Management Services Web-Based Training Course — New

With Continuing Education Credit
A new Evaluation and Management Services Web-Based Training course is available through the MLN LMS.

Learn about:

- Medical record documentation
- Billing and coding considerations
- 1995 and 1997 documentation guidelines

Suite of Products & Resources for Billers & Coders Educational Tool — Reminder

A revised Medicare Learning Network Suite of Products & Resources for Billers & Coders Educational Tool is available.

Learn about:

- Claims submission
- Federal initiatives and incentive programs

Evaluation and Management: Correct Coding

In a study report, the Office of the Inspector General (OIG) noted that 42 percent of claims for Evaluation and Management (E/M) services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted, respectively), and 19 percent were lacking documentation. A number of physicians increased their billing of higher level, more complex and expensive E/M codes. Many providers submitted claims coded at a higher or lower level than the medical record documentation supports. Use the following resources to bill correctly for E/M services:

- OIG Report: Improper Payments for Evaluation and Management Services
- Claims Processing Manual: Chapter 12, Section 30.6
- E/M Services Guide
- 1995 Documentation Guidelines for E/M Services
- 1997 Documentation Guidelines for E/M Services
- Frequently Asked Question on Use of 1995 and 1997 Guidelines
- Provider Compliance Tips for Evaluation and Management (E/M) Services
- Evaluation and Management Services Web-Based Training course available through the MLN LMS

Recent LearnResource & MedLearn Matters Articles

- October 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM 10187)
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Edits, Version 23.3, Effective October 1, 2017 (MM 10183)
- Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System (Revised MM 9911)

Horizon Payer Updates

NJSOM New Jersey Society of Oncology Managers

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

Medical Policy Revision: Gene Expression-Based Assays for Cancers of Unknown Primary

Effective October 30, 2017, Horizon Blue Cross Blue Shield of New Jersey will change the way we consider certain claims for gene expression profiling using the Pathwork® Tissue of Origin test. READ MORE

Use Updated 2017 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), please make sure to use the updated **2017** versions of the following Agreement(s): READ MORE

NJ'S TOP COURT RULES HORIZON MUST DIVULGE DETAILS OF 'SECRET' OMNIA PLAN

Decision suggests Appellate Division overstepped in protecting Horizon's privacy regarding its Omnia tiered insurance network. READ MORE

Medical Policy Revision: Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer

Effective October 30, 2017, Horizon Blue Cross Blue Shield of New Jersey will change the way we consider certain claims for the use of the 21-gene reverse transcriptase-polymerase chain reaction (RT-PCR) assay (i.e., Oncotype DX®) to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy in women with primary, invasive breast cancer. READ MORE

Medical Policy Updates

- **NEW** - Olaratumab (Lartruvo)
- **NEW** - Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- **NEW** - Fulvestrant (Faslodex)
- **NEW** - Ocrelizumab (Ocrevus)
- **REVISED** - Granulocyte Colony Stimulating Factor (G-CSF - Neupogen, Neulasta, Granix, Zarxio) and Granulocyte-Macrophage Colony Stimulating Factor (GM-CSF - Leukine)
- **REVISED** - Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
- **REVISED** - Radiation Treatment of Bone Metastases
- **REVISED** - Gene Expression-Based Assays for Cancers of Unknown Primary
- **REVISED** - Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer

AmeriHealth Payer Updates

Recent AmeriHealty Articles that may be of interest to an oncology practice

Reminder: LabCorp named exclusive nationally based outpatient laboratory provider for AmeriHealth New Jersey as of May 1, 2018

As previously communicated, **beginning October 1, 2017,** AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) will begin a phased approach to make Laboratory Corporation of America® Holdings (LabCorp) the exclusive nationally based provider of outpatient laboratory services for AmeriHealth New Jersey as of May 1, 2018. READ MORE

ICD-10 in Action: Coding sequence and coding specificity/unspecified codes

READ MORE

Update: Our policy on credentialing providers still in training

As of July 17, 2017, AmeriHealth updated its requirements related to credentialing and contracting providers who render services to our members. READ MORE

Updates to the policy on Modifier 25 reporting and reimbursement

As previously communicated, AmeriHealth has updated its policy on Modifier 25 reporting and reimbursement. Claim Payment Policy #03.00.06n: Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service was posted as a Notification on May 1, 2017, and will go into effect **August 1, 2017.** 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

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:

Front & Center

- Revamped Prior Authorization and Notification App Coming Soon
- Colony-Stimulating Factors Will Require Prior Authorization

UHC Commercial

- UnitedHealth Premium® Designation Program – August 2017 Updates
- Site of Service Requirement for Chemotherapy Requests for ipilimumab (Yervoy, J9228)
- UnitedHealthcare Genetic and Molecular Testing Prior Authorization/Notification Requirement
- UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

UHC Commercial Reimbursement Policies

- CCI Editing Policy Coding Reminder

UHC Affiliates

- Oxford Medical and Administrative Policy Updates

And Much More…
AUGUST Monthly Issue Available HERE

UnitedHealthcare
Medical Policy Update
Bulletin

NEW!

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

Updated:

- Chemosensitivity and Chemoresistance Assays in Cancer - Effective Sep. 1, 2017

Revised:

- Apheresis - Effective Oct. 1, 2017
- Omnibus Codes - Effective Oct. 1, 2017
- Proton Beam Radiation Therapy - Effective Sep. 1, 2017

Medical Benefit Drug Policy Updates

New:

- White Blood Cell Colony Stimulating Factors - Effective Sep. 1, 2017

Revised:

- Clotting Factors and Coagulant Blood Products - Effective Sep. 1, 2017
- Infliximab (Remicade®, Inflectra™, Renflexis™) - Effective Sep. 1, 2017

Utilization Review Guideline (URG) Updates

Revised:

- Specialty Medication Administration – Site of Care Review Guidelines - Effective Sep. 1, 2017

AUGUST Monthly Issue Available HERE

aetna℠

A Few Articles You Won't Want to Miss:

- Updates to our national participating provider precertification list
  - Additional site of care precertification requirements
- Learn about our NaviNet® webinars
- Aetna Open Access® HMO plans don't need PCP or referrals
- Changes to commercial drug lists begin on October 1, 2017

And Much More….
JUNE 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 enasidenib (IDHIFA, Celgene Corp.) for the treatment of adult patients with relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test. More Information. August 1, 2017
- FDA approved Opdivo (nivolumab) injection for intravenous use for the treatment of adult and pediatric (12 years and older) patients with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (mCRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. More Information. August 1, 2017
- FDA approved neratinib (NERLYNX, Puma Biotechnology, Inc.) for the extended adjuvant treatment of adult patients with early stage HER2-overexpressed/amplified breast cancer, to follow adjuvant trastuzumab-based therapy. More Information. July 17, 2017
- FDA approved blinatumomab (BLINCYTO, Amgen Inc.) for the treatment of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) in adults and children. More Information. July 11, 2017
- FDA approved L-glutamine oral powder (Endari, Emmaus Medical, Inc.) for oral administration to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years and older. More Information. July 7, 2012

FDA approves first subcutaneous C1 Esterase Inhibitor to treat rare genetic disease

June 22, 2017 - The U.S. Food and Drug Administration today approved Haegarda, the first C1 Esterase Inhibitor (Human) for subcutaneous (under the skin) administration to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients. The subcutaneous route of administration allows for easier at-home self-injection by the patient or caregiver, once proper training is received. READ MORE

Other News

Information from Merck about EMEND® (fosaprepitant dimeglumine) – Availability of a New NDC

Merck has received FDA approval for a new formulation of EMEND for injection that has a lower concentration of edetate disodium (EDTA), an inactive ingredient. This new formulation (5.4 mg EDTA, NDC 0006-3061-00) will replace the existing formulation (18.8 mg EDTA, NDC 0006-3941-32). The purpose of this formulation change is to support ongoing regulatory activities for EMEND.

Please ensure that your systems and processes are updated with the new NDC.

Before prescribing EMEND® (fosaprepitant dimeglumine) for injection, please read the accompanying Prescribing Information (5.4 mg EDTA formulation). The Patient Information also is available.

ODAC gives its seal of approval to two more biosimilars

Despite struggling with extrapolation, the FDA's Oncologic Drugs Advisory Committee (ODAC) unanimously supported approval of two biosimilars referencing RocheHolding AG's Avastin and Herceptin.

READ MORE

Middlemen are not passing on drug discounts intended for patients

More than 400,000 Americans with cancer suffer from a second disease: "financial toxicity." The symptoms include missed mortgage and rent payments, raided retirement accounts and decisions about whether to take medicines as prescribed or ration them to save money. Such choices can be deadly. READ MORE

GAO U.S. Government Accountability Office

Drug Discount Program: Update on Agency Efforts to Improve 340B Program Oversight

GAO-17-749T, July 18

- Testimony: http://www.gao.gov/products/GAO-17-749T
- Highlights: http://www.gao.gov/assets/690/685904.pdf

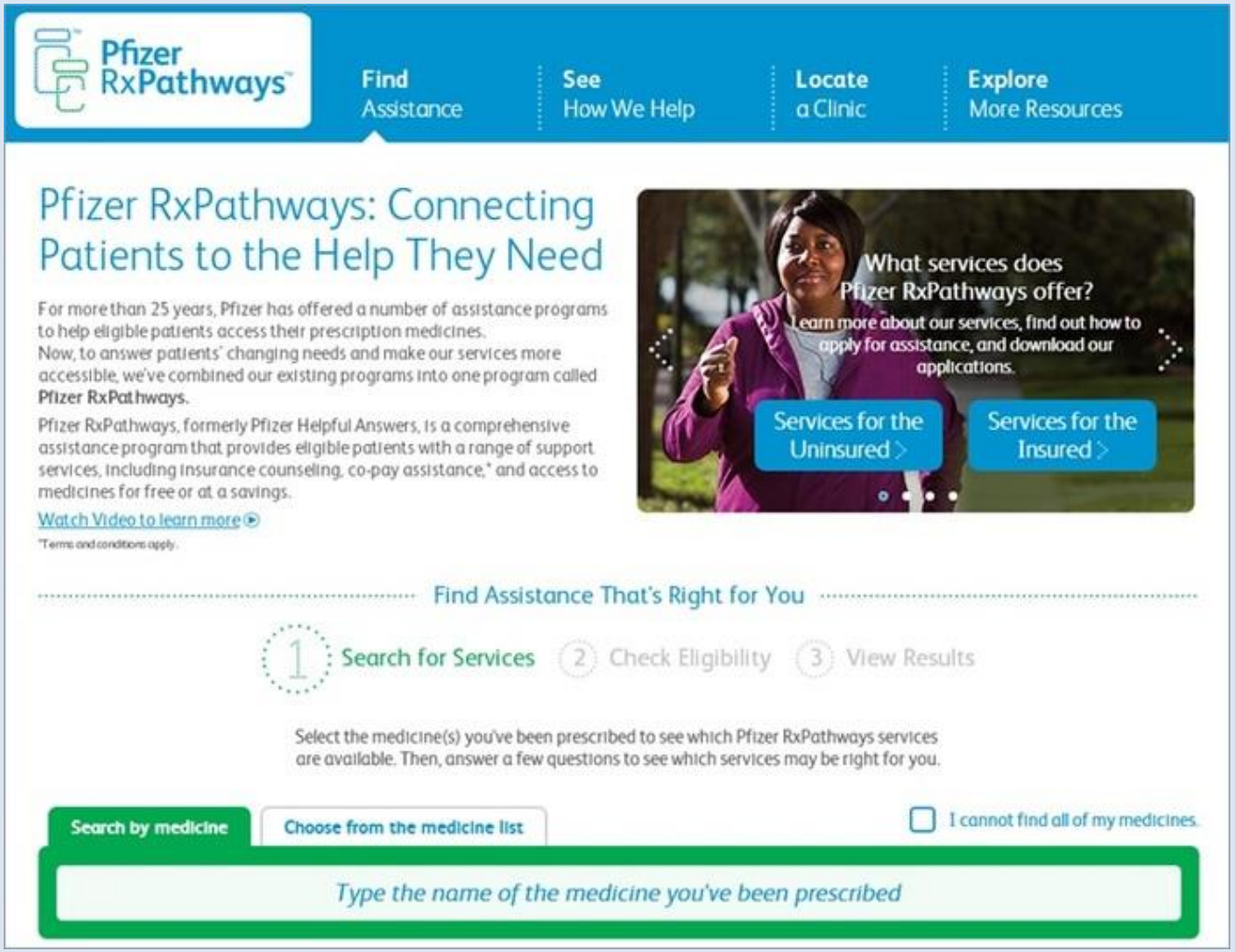
Democratic Leaders Push Christie to Fill 6 Vacant Seats on NJ Nursing Board

State says vacancies aren't affecting board function, industry strength, or patient care. 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

Frequently Asked Questions

Reimbursement Questions & Answers

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

Question: What Medicare rules must be followed to correct a paper medical record?

Answer: According to the Centers for Medicare & Medicaid Services (CMS), the following principles apply:

- Use a single line strike through so the original content is still readable.
- The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. They may be initialed and dated if the medical record contains evidence associating the provider's initials with their name. For example, if the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information, the reviewer shall accept the entry.

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Question: We have been confused about billing Medicare for Advanced Care Planning. Can you provide any resources for us to reference?
Answer: Sure, CMS has an updated Fact Sheet and a FAQ. You will find the links below:

Fact Sheet FAQ

Guidelines from a private payer (just to give you an idea and reminder that private payers may have their own policy, possibly more restrictive than Medicare). http://www.priorityhealth.com/provider/manual/billing-and-payment/services/advance-care-planning

Continued on next page…

Frequently Asked Questions

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Question: My question is about Medicare's definition of a new patient. Would a patient still be considered "new" if only a diagnostic test was performed?

Answer: Here's what CMS says about this. *"If a professional component of a previous procedure is billed in a three-year time-period (e.g., a lab interpretation is billed and no evaluation and management [E&M service or other face-to-face service), then this individual remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E&M service or other face-to-face service with the patient does not affect the designation of a new patient."*

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Question: What are Medicare rules on documentation of physician-patient telephone calls?

Answer: From a medical malpractice perspective, documenting telephone conversations with patients or their family is just as important as documenting face-to-face encounters.

When the physician or any member of the staff talks to a patient regarding a clinical issue, document the following:

- The date of the call
- The time of the call
- The patient's chief complaint
- Any additional information received from the patient to elucidate his/her condition
- Any treatment recommendation (e.g., coming to the office, presenting to the emergency room, contacting another physician)
- Any medications (over-the-counter or prescription)
- The date and time a prescription was called in and the phone number of the pharmacy
- The date that the patient is to return for care
- The name and signature of the individual who performed the service.

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Thank You

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Question: Dr. wanted me to contact you regarding Herceptin (J9355), our office received a audit regarding this code for 2015. My question is; Was Herceptin's NDC Qty. ml or units for 2015?

Answer: The NDC billing unit did not change. Herceptin is a reconstituted powder solution, which is a multi dose vial and used to administer the drug to more than one patient.

When submitting NDCs:

- The submitted units must be in milliliters (ML) when the NDC is for a liquid medication.
- The submitted units must be in units (UN) when the NDC is for a medication in powder form.

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