

NJSOM
MISSION STATEMENT

NJSOM is committed to keeping our members informed through quarterly educational conferences, networking, and continuous updates to our website. As part of our responsibility we strive to create an environment of constant learning and improvement in the Oncology/Hematology arena. NJSOM works hard to foster a network of growth, support and collaboration among our members.

NJSOM is committed to the highest standards of ethics and integrity and strongly believes that we are responsible to our members, stakeholders, and to the community we serve. We believe that through education and commitment, NJSOM can improve the practice of Oncology in the State of New Jersey and subsequently improve the lives of cancer patients and their families.

**This Newsletter is made possible
by support from:**



**New Jersey Society
of Oncology Managers**

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The New Jersey Society of Oncology Managers (NJSOM) is a non-profit corporation of community based Oncology practice administrators and their staff, along with corporate entities involved with the treatment and care of cancer patients and their families.



CMS Withdraws Medicare Part B Payment Demonstration Proposed Rule

October 3, 2017 - Today the Centers for Medicare and Medicaid Services (CMS) published a final notice announcing the withdrawal of the proposed rule relating to the "Medicare Part B Drug Payment Model." The proposed rule was initially published on March 11, 2016. The Medicare Part B Drug Payment Model was a two-phase model administered by the Center for Medicare and Medicaid Innovation (CMMI) that would have tested "whether alternative drug payment designs will lead to a reduction in Medicare expenditures, while preserving or enhancing the quality of care provided to Medicare beneficiaries." [READ MORE](#)

Healthcare Reform Efforts Turn to Drug Pricing

September 27, 2017 - Republican efforts to repeal and replace the Affordable Care Act may have stalled once again with the failure of the [Graham-Cassidy](#) bill on Thursday, but advocacy groups intend to keep healthcare—and the high cost of prescription drugs—at the forefront of Congress' agenda. [READ MORE](#)

FRONT PAGE NEWS

REGISTER TODAY!!

October 20, 2017
8:30AM-4:30PM

NJSOM Conference

Hyatt Regency Princeton



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

For more information...
[CLICK HERE](#)

More Clouds Form Over 340B Program

Potential Medicare Cut Underlines Need to Rein In Program

Drug manufacturers, and to a lesser extent hospitals, have complained for years about the shortcomings of the 340B Drug Pricing Program, which allows nearly 3,000 hospitals and approximately 10,000 health clinics around the country to buy pharmaceuticals at a deep discount as a means of generating revenue, ostensibly to help lower-income patients and their communities. Complaints from both parties have been....[READ MORE](#)

COA Representatives Join Congressional Briefing on Personalized Medicine and the Future of Cancer Care Delivery and Payment

(COA) Sept 14, 2017 – Representatives from the Community Oncology Alliance (COA) joined other cancer stakeholders and policymakers on Capitol Hill today for a briefing on personalized medicine and the future of cancer care delivery and payment. [Read press release.](#)



CMS Urged to Ensure Fair, Adequate Medicare Reimbursement for Oncologists

(ASCO in Action) Sept 18, 2017 – In letters to the Centers for Medicare & Medicaid Services (CMS), ASCO President Bruce E. Johnson, MD, FASCO, comments on provisions in the proposed rules for the 2018 Medicare Physician Fee Schedule (MPFS) and the 2018 Hospital Outpatient Prospective Payment System (HOPPS) that will affect the delivery of oncology care in multiple settings. [READ MORE](#)

CMS's Proposed 340B Payment Cuts Draw Both Criticism and Praise

Health care organizations took up expected positions to the Centers for Medicare & Medicaid Services' (CMS's) proposed cuts to hospital 340B drug payments in comments released this week, just in time for the agency's Sept. 11 deadline. In the agency's proposed rule revising certain Medicare payment policies, promulgated in July, hospitals would be paid 22.5% less than the average sales price (ASP) under the 340B program, instead of the 6% above the ASP they are currently paid. [READ MORE](#)

FRONT PAGE NEWS**FDA simplifies Institutional Review Board review requirements
for physicians seeking individual patient expanded access - Drug Information Update**

FDA [today announced](#) updates to three final guidances, including Form FDA 3926 and its instructions, to simplify Institutional Review Board (IRB) review requirements for physicians seeking to treat an individual patient with an investigational drug under expanded access. The updates allow for a waiver of the requirement for review and approval at a convened IRB meeting if the physician instead obtains concurrence by the IRB chairperson (or a designated IRB member) before treatment use begins. Additionally, the Expanded Access to Investigational Drugs for Treatment Use – Questions and Answers Guidance has been updated to clarify what adverse event reports that occur during expanded access need to be submitted to FDA, the reason for FDA's review of these events, and the context in which FDA reviews this information. This guidance also provides updated information on the 21st Century Cures Act requirement that companies publicly post their expanded access policies and how patients and health care professionals can determine if a company will provide expanded access to an investigational drug.

Form FDA 3926 and Instructions:

- [Form FDA 3926](#)
- [Instructions for Filling Out Form FDA 3926 – Individual Patient Expanded Access, Investigational New Drug Application \(IND\)](#)

Guidance Documents:

- [Individual Patient Expanded Access Applications: Form FDA 3926 Guidance](#)
- [Expanded Access to Investigational Drugs for Treatment Use – Questions and Answers Guidance](#)
- [Waiver of IRB Requirements for Drug and Biological Product Studies Information Sheet](#)

NOVITAS SOLUTIONS, INC.

Evaluation and Management (E&M)

Observation Services Fact Sheet

We are pleased to introduce our Fact Sheet on Observation Services. Additional Fact Sheets will be added to the Evaluation & Management Center of our website in the near future. [READ MORE](#)

Medical Policy

The following JL Local Coverage Article has been revised:

- [Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents \(A53049\)](#)

Medical Policy

Local Coverage Determinations and Local Coverage Articles affected by the Annual ICD-10 Code Update will be revised and posted on the Novitas Website and the Medicare Coverage Database on Thursday October 5, 2017.

Modifier AI Fact Sheet

We are pleased to introduce our Fact Sheet on the AI modifier. Please take a moment to review. [READ MORE](#)

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for August 2017 in Delaware, Washington D.C., Maryland, New Jersey, and Pennsylvania are now available. Please take time to review these errors and avoid them on future claims. [READ MORE](#)

Frequently Asked Questions (FAQs)

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

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for August 2017. New questions / answers were added to the Appeals, and Eligibility categories. Please take time to review these and other FAQs for answers to your questions. [READ MORE](#)

NOVITAS SOLUTIONS, INC.

Listed are Novitas training events an oncology practice should consider!

For many more opportunities
and to register...

[CLICK HERE](#)



Date	Starts (EST)	Ends (EST)	Event Name	CEUs	Media Type	Registration
Thursday, October 12, 2017	2:00 PM	3:00 PM	Part B Novitasphere Claim Submission Overview This course will focus on how to submit claims through the Novitasphere portal. We will show you how to submit an 837 ANSI batch claim file, how to enter single claims into the Direct Data Entry feature, and how to download your electronic claim reports.	1	Webinar	Register
Friday, October 13, 2017	11:00 AM	12:30 PM	Medicare Part B Updates - 2017 Fourth Quarter This course will review the latest quarterly Medicare Part B updates. Our discussion will include current change requests from CMS, Novitas initiatives and topics of interest.	1.5	Webinar	Register
Thursday, October 17, 2017	11:00 AM	12:00 PM	Part B Evaluation and Management Score Sheet: Part Two This course is the second part of a four-part series on scoring evaluation and management services. We will introduce the Novitas tool used for scoring evaluation and management services and provide a brief overview of the key components introduced in part one.	1	Webinar	Register

Novitas Self-Service Tools

[View all Self-Service Tools](#)

[Fee Schedule Lookup ->](#)



[Enrollment Status ->](#)



[LCD / Policy Search ->](#)



[Learning Center ->](#)



NOVITAS SOLUTIONS, INC.

Medicare Part B HOT LINKS!

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

2018 Proposed Final Rule

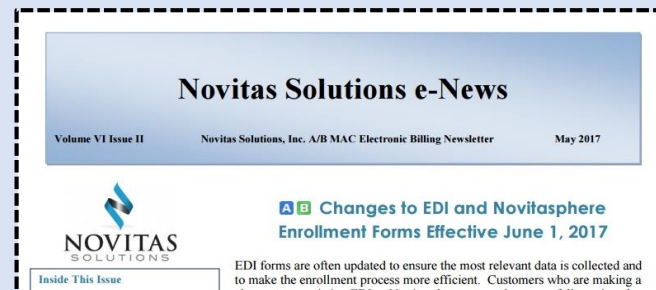
- [Physician Fee Schedule](#)
- [Physician Fee Schedule Fact Sheet](#)
- [HOPPS](#)
- [HOPPS Fact Sheet](#)

On-Demand Education

- [Weekly Audio Podcasts](#)
- [Training Modules](#)
- [Medicare Reference Manual](#)
- [Specialty Guides](#)
- [Acronyms & Abbreviations](#)
- [Frequently Asked Questions](#)
- [Evaluation & Management \(E/M\) Center](#)
- [Comprehensive Error Rate Testing \(CERT\) Center](#)

CMS Education

- [Open Payments \(Physician Payments Sunshine Act\)](#)
- [Medicare Learning Network](#)
- [National Provider Training Program](#)
- [Internet-Only Manual](#)
- [Provider Specialty Links](#)
- [Safeguarding Your Medical Identity](#)



Novitas Solutions e-News Electronic Billing Qtly Newsletter

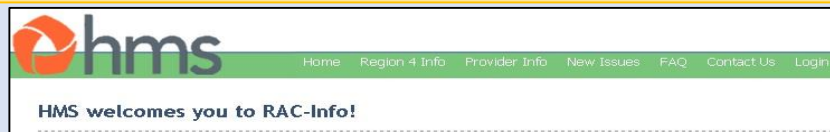
Current Qtly Issue Available ...
[CLICK HERE](#)



Information for Providers:

- [Provider Resources](#)
- [Medicaid Managed Care Contract](#)
- [Dual Eligible Special Needs Plan Contract](#)
- [Accountable Care Organizations](#)
- [Public Notices](#)
- [New Jersey Medicaid State Plan](#)

CMS



To visit the website [CLICK HERE](#)

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



Breaking: UnitedHealthcare Appears to Delay Eliminating Consultation Codes

More than three dozen advocacy groups appear to sway position of one of the nation's leading carriers.

In the June 2017 UnitedHealthcare (UHC) Bulletin, it was indicated that the carrier would no longer cover consultation services within the evaluation and management (E&M) service codes, effective Oct. 1, 2017. UHC noted that it was going to be aligning its policies on these services with the interpretations of the Centers for Medicare & Medicaid Services (CMS) formally published and implemented seven years ago.

It is interesting that UHC noted that since CMS implemented this, it had been trying to pursue "data analysis and trending" of these services to make official policy updates. Well, apparently seven years of that was just not enough, as UHC has released its October 2017 bulletin, which notes that it is delaying this policy change:

"We previously announced that certain revisions to the Consultation Services Reimbursement Policy would become effective for UnitedHealthcare Commercial members on Oct. 1, 2017. In an effort to give care providers more time to adjust to potential changes in their submission of procedure codes for consultation services, UnitedHealthcare will be delaying implementation of the revisions to the Reimbursement Policy for services reported with consultation codes 99241-99245 and 99251-99255."

[READ MORE](#)

Continued on next page...

CMS**One Claim with Multiple Denials
Calls for Smart Defense**

CERT claim review highlights need for strategic approach. How do you handle your appeals when there is more than one issue being denied? For example, if the payer denies both the medical necessity of the level of care as well as the coding of a procedure, what strategies should you.... [READ MORE](#)

HHS Secretary Price's Resignation Casts Doubt on New Initiatives

Under intense criticism and amid growing frustration by President Donald Trump, U.S. Department of Health and Human Services (HHS) Secretary Tom Price, MD resigned on Friday, creating a new air of uncertainty regarding some of his earlier proposals. [READ MORE](#)

**News Alert: Is Humana Putting Profits
Before Patient Safety?**

By Ronald Hirsch, MD, FACP, CHCQM

Late last week a case management colleague distributed an insurance company memo that had been sent to her hospital to a Recovery Audit Contractor- (RAC)-related user group. This memo required a double-take to ensure that it was not five months old, because it should have been distributed on April Fools'.... [READ MORE](#)

Copying and Pasting: The Real Rules Prevail

By Shannon Deconda, CPC, CPC-I, CEMC, CMSCS, CPMA®

In my job, I wear many hats. I am an auditor, a physician educator, a consultant, an author, and an auditing instructor. In these roles, I hear a common concern regarding the use of electronic health records (EHRs): that of cloning, or copying and pasting, records. It is important first... [READ MORE](#)

CMS**IMPORTANT – CMS MIPS Reminder****One patient, one measure, no penalty**

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

Report nothing, get penalized

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

IMPORTANT – 2016 PQRS Feedback Reports and Annual QRURs Updates

You can now look up your current and prior years' Value Modifier and PQRS payment adjustments, and find out which feedback reports are available for your practice (Annual, Mid-Year and Supplemental QRURs, PQRS Feedback Reports). View the "[Guide for Accessing the Payment Adjustment and Reports Lookup Feature](#)".

The 2018 PQRS and Value Modifier payment adjustments shown in the 2016 reports are based on proposals included in the 2018 Medicare Physician Fee Schedule [Proposed Rule](#). We will notify practices if there is a change in their PQRS or Value Modifier payment adjustments based on policies in the final rule. The 2018 proposals included:

- Reducing by half the automatic downward Value Modifier payment adjustment for practices that did not meet the minimum quality reporting requirements
- Holding all practices that met the minimum quality reporting requirements harmless from downward Value Modifier payment adjustments
- Reducing the maximum upward Value Modifier payment adjustment for performance for large practices to align with the adjustment for small and solo practices
- Reducing the number of measures that must be satisfactorily reported for the 2016 PQRS to avoid the 2018 downward payment adjustment from 9 measures across 3 National Quality Strategy domains to 6 measures with no domain requirement

If the policies are not finalized as proposed, we will provide an update to report recipients. For more information see [last week's message](#).

CMS

2016 Annual QRURs Webcast — October 19

Tuesday, October 10 from 2-3 pm ET
[Register](#) for Medicare Learning Network events.

During this call, learn about modifications and proposed changes to the way the Quality of Patient Care star rating is calculated, including the removal of the influenza measure. CMS presents the rationale, proposed timing, and impact of the changes. A question and answer session follows the presentation. Target Audience: Medicare-certified Home Health Agencies.

Recent LearnResource & MedLearn Matters Articles

- [Quarterly Healthcare Common Procedure Coding System \(HCPCS\) Drug/Biological Code Changes - October 2017 Update \(MM 10234\)](#)
- [2017-2018 Influenza \(Flu\) Resources for Health Care Professionals \(SE 17026\)](#)
- [Annual Clotting Factor Furnishing Fee Update 2018 \(MM 10254\)](#)
- [Guidance on Coding and Billing Date of Service on Professional Claims \(SE 17023\)](#)

Quality Payment Program: New Resources Available

CMS posted new and updated resources on the [Quality Payment Program](#) website:

- [2018 Self-Nomination Toolkit for QCDRs & Registries](#): Step-by-step instructions for potential Qualified Registry and Qualified Clinical Data Registry (QCDR) vendors to self-nominate to qualify for the 2018 performance period of the Merit-based Incentive Payment System (MIPS) program
- MIPS Specialty Measures Guides for [Anesthesiologists and Certified Registered Nurse Anesthetists](#), [Emergency Medicine Clinicians](#), [Ophthalmologists](#), and [Orthopedists](#): Highlights a non-exhaustive sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to these specialties in 2017
- [Group Participation in MIPS 2017 Guide](#) (Updated): An in-depth overview of how to participate as a group in MIPS
- [CMS-Approved QCDR Vendor List for 2017](#) (Updated): Contact information for the Qualified Clinical Data Registries (QCDRs) that will be able to report data for the Quality, Advancing Care Information, and Improvement Activities performance categories in 2017
- [CAHPS for MIPS CMS-Approved Survey Vendor List](#) (Updated): Contact information for the survey vendors approved by CMS to administer the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey in 2017
- [Alternative Payment Model Design Toolkit](#) (Updated): Comprehensive set of resources to help design an Alternative Payment Model
- [Quality Performance Category Fact Sheet](#): Overview of the Quality performance category under the Merit-based Incentive Payment System, including how to submit performance data for the 2017 transition year
- [How to Design an APM Toolkit](#) (updated): Comprehensive set of resources for organizations or individuals interested in developing ideas for Alternative Payment Models (APMs)
- [Quality Payment Program Key Objectives](#) (updated): Summary of the seven strategic objectives for the Quality Payment Program

Additional resources are available on the [Resource Library](#) webpage.

CMS

Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud

GAO-17-710, August 30

- Report: <http://www.gao.gov/products/GAO-17-710>
- Highlights: <http://www.gao.gov/assets/690/686848.pdf>

CMS News: Medicare offers more health coverage choices and decreased premiums in 2018

PRESS RELEASE
FOR IMMEDIATE RELEASE
September 29, 2017

Medicare offers more health coverage choices and decreased premiums in 2018
Medicare Advantage premiums decrease, choices increase, while enrollment hits an at all-time high

Today, the Centers for Medicare & Medicaid Services (CMS) announced that people with Medicare will have more choices and options for their Medicare coverage in 2018. As CMS releases the benefit and premium information for Medicare health and drug plans for the 2018 calendar year, the average monthly premium for a Medicare Advantage plan will decrease while enrollment in Medicare Advantage is projected to reach a new all-time high. Earlier this year, CMS announced new policies that support increased benefit flexibilities allowing Medicare Advantage plans the ability to offer innovative plans that fit the needs of people with Medicare. [READ MORE](#)

Medicare Clinical Laboratory Fee Schedule: Preliminary CY 2018 Payment Rates

On September 22, CMS published preliminary payment rates with the supporting data files as part of the implementation of Section 216 of the Protecting Access to Medicare Act of 2014. This section requires clinical laboratories to report how much private insurers pay for lab tests. The new private payor rate-based Clinical Lab Fee Schedule (CLFS) will go into effect on January 1, 2018. CMS worked closely with stakeholders to gather the necessary data in the least burdensome manner possible. As a result of these efforts, the data reported to CMS captures over 96% of laboratory tests on the CLFS, representing over 96% of Medicare's spending on tests in CY 2016. Laboratories from every state, the District of Columbia, and Puerto Rico reported data.

Send comments on the preliminary determinations by October 23 to
CLFS_Annual_Public_Meeting@cms.hhs.gov.

For More Information:

- [CY 2018 CLFS - Preliminary Payment Rates and Crosswalking/Gapfilling Determinations](#)
- [Applicable Information Raw Data File](#)
- [Annual Laboratory Public Meetings](#)

CMS**MIPS Eligible Measure Applicability:
New Resources Available**

Learn about the Eligible Measure Applicability (EMA) analysis for the Merit-based Incentive Payment System (MIPS) and how it affects your quality performance calculation and score:

- [MIPS Quality Performance Category EMA Fact Sheet](#)
- [2017 EMA for Claims Data Submission of Individual Quality Measures](#)
- [2017 EMA for Registry Data Submission of Individual Quality Measures](#)
- [MIPS Overview](#) webpage
- [Quality Measures](#) webpage

For questions about EMA, contact the Quality Payment Program at 866-288-8292 (TTY 877-715-6222) or gpp@cms.hhs.gov.

**PRESS RELEASE - FOR IMMEDIATE RELEASE
September 14, 2017*****CMS Reveals New Medicare Card Design***

Removing Social Security numbers strengthens fraud protections for about 58 million Americans

Today, the Centers for Medicare & Medicaid Services (CMS) gave the public its first look at the [newly designed Medicare card](#). The new Medicare card contains a unique, randomly-assigned number that replaces the current Social Security-based number. [READ MORE](#)

**Clinicians:
Medicare Part B Crossover
Claims
Issue Tied to Error Code
H51082**

In recent weeks, you may have received a notice from your Medicare Administrative Contractor (MAC) containing error code H51082—"The ICD-10 code (e.g., 'M4806') must be coded to the highest specificity." The notice indicated that the claims listed could not be crossed over due to claim data errors. Most of the Part B claims that received the H51082 code were rejected in error; the ICD-10 diagnosis codes that received the H51082 were still valid through September 30, 2017. On September 20, CMS asked the MACs to repair these claims and resend them to the Benefits Coordination & Recovery Center. Direct your vendors not to bill your patients' supplemental insurers for balances remaining until October 6 to allow the claims to be crossed over.

OTHER PAYER UPDATES - HORIZON

New Medicare Advantage Plan: Horizon Medicare Blue Advantage (HMO)

Horizon BCBSNJ will offer the Horizon Medicare Blue Advantage (HMO) plan to Medicare-eligible beneficiaries during open enrollment with an effective date of **January 1, 2018**. Additionally, as of **January 1, 2018**, Horizon BCBSNJ will no longer offer the Horizon Medicare Blue Patient-Centered w/Rx (HMO) plan based on market demand in New Jersey. [READ MORE](#)

Appealing Claims Denied for Post-Service Medical Necessity

Members, physicians and other health care professionals on behalf of the member, and with the member's written consent, generally have the right to pursue an appeal of any adverse claim determination involving a post-service medical necessity decision made by Horizon Blue Cross Blue Shield of New Jersey. Read about how to appeal... [CLICK HERE](#)

Quarterly Claim Editing Update: 4th Quarter 2017

Horizon Blue Cross Blue Shield of New Jersey will implement a quarterly update to our claim editing rules and processes. Please review our [Quarterly Claim Editing Update Report](#) that identifies the changes that will be implemented as noted below.

- On **November 1, 2017** we will implement the claim editing rules identified in the [report](#) that will enable us to process claims in accordance with nationally recognized coding and code editing changes.
- On **January 1, 2018** we will implement the claim editing rules identified in the [report](#) that reflect Change Healthcare Inc.'s ongoing review of current claim processing/claim editing practices.

Read more about these changes... [CLICK HERE](#)

Additional Medication to be Added to Our Medical Injectables Program

Effective **October 15, 2017**, the additional injectable medication listed below will be included as part of our Medical Injectables Program (MIP) administered by Magellan Rx ManagementSM.

Brand Name	Generic Name	HCPCS Code	Effective Date
RITUXAN HYCELA™	RITUXIMAB/HYALURIDASE	J9999	October 15, 2017

Beginning with services to be provided on and after **October 15, 2017**, Magellan Rx Management will conduct medical necessity and appropriateness reviews (MNARs) for this additional injectable medication (recently approved by the FDA) when administered in a freestanding or hospital-based dialysis center, an outpatient facility, a patient's home, or a physician's office.¹

Review the [complete list of injectable medications that currently require MNAR as part of the MIP](#).

OTHER PAYER UPDATES - AMERIHEALTH

Select chemotherapy-induced nausea and vomiting drugs to require precertification

Effective January 1, 2018, the following injectable antiemetic prophylaxis agents for chemotherapy-induced nausea and vomiting (CINV) will require precertification approval for all AmeriHealth members:

- Emend® for injection (fosaprepitant)
- Sustol® (granisetron extended release)
- Cinvanti™ (aprepitant) – *pending FDA approval*
- Varubi® (rolapitant) – *pending FDA approval*

[READ MORE](#)

Important information regarding our transition to a new medical management system

In early October, AmeriHealth will transition to a new medical management system for processing authorization requests. To ensure a smooth transition, please read this communication in its entirety as there are changes to several administrative procedures.

NaviNet® enhancements

The Authorizations transaction on the NaviNet web portal will be upgraded. Enhancements will include the following: [READ MORE](#)

Upcoming changes to specialty drugs requiring precertification

Effective January 1, 2018, AmeriHealth will make the changes detailed below to specialty drugs requiring precertification.

Includes; Avastin, Herceptin, Neulasta and many more ... [CLICK HERE](#) for update.

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

Last year, AmeriHealth introduced a new utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests for all commercial members. We are working with CareCore National, LLC d/b/a eviCore healthcare (eviCore), a specialty benefit management company, to manage precertification and/or prepayment coverage reviews for these tests. [READ MORE](#)



OTHER PAYER UPDATES - AMERIHEALTH

New AmeriHealth New Jersey policy regarding CPT® consultation codes



Based on a review of the Centers for Medicare & Medicaid Services (CMS) standards, AmeriHealth New Jersey has created a new policy outlining its reimbursement position on Current Procedural Terminology (CPT) consultation codes. Claim Payment Policy #00.01.64: Consultation Codes was posted as a Notification on October 3, 2017, and will go into effect for AmeriHealth New Jersey members **January 1, 2018**.

For dates of service on or after January 1, 2018, AmeriHealth New Jersey will align with CMS's position and will no longer recognize the following CPT consultation codes as eligible for reimbursement:

99241	99251
99242	99252
99243	99253
99244	99254
99245	99255

When rendering services to AmeriHealth New Jersey members, report the appropriate level of evaluation and management service that represents where the visit occurred and identifies the complexity of the visit performed. [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

NEW!



A Few Articles You Won't Want to Miss:

Front & Center

- Delay in Implementation of the Revision to the Consultation Services Reimbursement Policy
- Review at Launch Drug Program for UnitedHealthcare Commercial and Community Plan Members – Effective Jan. 1, 2018
- Outpatient Injectable Chemotherapy Prior Authorization Program for All Savers Members Small Group Fully Insured and Self-Funded

UnitedHealthcare Commercial

- Site of Service Review for Ipilimumab (Yervoy, J9228)

UnitedHealthcare Community Plan

- Reminder on Prior Authorization Requirements for Medical Injectable Drugs

And Much More...

OCTOBER

Monthly Issue Available [HERE](#)



Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

New:

- Carrier Testing for Genetic Diseases - Effective Nov. 1, 2017
- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions - Effective Nov. 1, 2017

Revised:

- Genetic Testing for Hereditary Cancer - Effective Nov. 1, 2017

Retired/Replaced:

- Molecular Profiling to Guide Cancer Treatment - Effective Nov. 1, 2017

Medical Benefit Drug Policy Updates

New:

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

Updated:

- Infliximab (Remicade®, Inflectra™, Renflexis™) - Effective Oct. 1, 2017

Revised:

- Maximum Dosage - Effective Nov. 1, 2017
- Ocrevus™ (Ocrelizumab) - Effective Nov. 1, 2017
- Oncology Medication Clinical Coverage - Effective Nov. 1, 2017
- Orencia® (Abatacept) Injection for Intravenous Infusion - Effective Nov. 1, 2017
- Xolair® (Omalizumab) - Effective Dec. 1, 2017

Utilization Review Guideline Updates

Revised:

- Immune Globulin Site of Care Review Guidelines for Medical Necessity of Hospital Outpatient Facility Infusion - Effective Nov. 1, 2017

OCTOBER Monthly Issue Available [HERE](#)



A Few Articles You Won't Want to Miss:

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

And Much More....

SEPTEMBER
Northeast Region
Qtly Issue
Available [HERE](#)

OTHER NEWS



DRUG SHORTAGES –



If you are looking for a complete list of Drug Shortages from the FDA [CLICK HERE](#).



RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES



- FDA approved abemaciclib (VERZENIO, Eli Lilly and Company) in combination with fulvestrant for women with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy. [More Information](#). September 28, 2017
- FDA granted accelerated approval to nivolumab (OPDIVO, Bristol-Myers Squibb Co.) for the treatment of hepatocellular carcinoma (HCC) in patients who have been previously treated with sorafenib. [More Information](#). September 22, 2017
- FDA granted accelerated approval to pembrolizumab (KEYTRUDA, Merck & Co., Inc.) for patients with recurrent locally advanced or metastatic, gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 as determined by an FDA-approved test. [More Information](#). September 22, 2017
- FDA approved a lower dose of cabazitaxel (20 mg/m² every 3 weeks) (JEVTANA, Sanofi-Aventis) in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer previously treated with a docetaxel-containing treatment regimen. Cabazitaxel (25 mg/m² every 3 weeks) was approved for this indication in 2010. [More Information](#). September 14, 2017
- FDA granted accelerated approval to copanlisib (ALIQOPA, Bayer HealthCare Pharmaceuticals Inc.) for the treatment of adult patients with relapsed follicular lymphoma who have received at least two prior systemic therapies. [More Information](#). September 14, 2017
- FDA approved Mvasi (bevacizumab-awwb, Amgen Inc.) as a biosimilar to Avastin (bevacizumab, Genentech Inc.). Mvasi is the first biosimilar approved in the U.S. for the treatment of cancer. [More Information](#). September 14, 2017

OTHER NEWS

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

South San Francisco, CA -- September 28, 2017 --

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

Biosimilars Poised to Save Billions in Cancer Treatment

By Megan Garlapow, PhD

Estimates predict biosimilars could save the U.S. healthcare system anywhere between \$44.2 and \$250 billion between 2014 and 2024.^{1, 2} To date, only two biosimilars are on the U.S. market (for filgrastim and infliximab), with three more FDA-approved but not yet on the market (etanercept, adalimumab, and another infliximab biosimilar). [READ MORE](#)

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

Publish Date: Thursday, September 21, 2017

To increase patient access to biosimilars and ensure that the marketplace can expand, the Biosimilars Council is urging the Centers for Medicare and Medicaid Services (CMS) to revise its current reimbursement policy for biosimilars in Medicare Part B. [READ MORE](#)

Cancer Care Costs 60% Higher at Hospitals Vs Independent Orgs

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

OTHER NEWS

*By Gloryanne Bryant, RHIA,
CDIP, CCS, CCDS, AHIMA-
Approved ICD-10-CM/PCS
Trainer*

Now it's just a little less than three weeks until the beginning of October and when the fiscal year (FY) 2018 changes for ICD-10-CM take effect.

[Read the full story →](#)



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

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

PATIENT ASSISTANCE

This is intended for US Healthcare Professionals



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Please see [Full Prescribing Information](#), including **Boxed WARNINGS**, for Vectibix® (panitumumab).

Billing Professionals
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FREQUENTLY ASKED QUESTIONS



Reimbursement Questions & Answers

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



Question: Medicaid HCPCS and NDC units - do you have any information or website on the billing of the unit of measure? We are starting to have problems with one of the Medicaid insurances. We bill with NDC on every J code. Horizon Medicaid is taking money back stating unit of measure is invalid They are stating we need to calculate the NDC units. I am trying to figure out if we are billing that correctly. I hope I am making sense this whole thing has me a bit confused.

Answer: Well, this is a first that I have seen but apparently Horizon Medicaid is processing the claims by NDC. I have done some research and found the following:
<http://www.horizonnjhealth.com/for-providers/medicaid-reimbursement-and-billing>

HERE IS THEIR HANDOUT reviewing the requirements:
http://www.horizonnjhealth.com/sites/default/files/J_and_Q_Code_Billing_Provider_Update.pdf

I think reviewing their presentation should answer your questions on how to bill. If you have any questions after your review this, please let me know!!!

Question: Our providers have a question on when to use the diagnosis code Z51.11 - *Encounter for antineoplastic chemotherapy*. If the provider is in the hospital for chemotherapy and is being seen for the initial and subsequent inpatient visits, should the first listed diagnosis code be Z51.11, or is this code for the actual encounter of receiving treatment and solely for this encounter of receiving chemotherapy? For the inpatient visit, should the principal diagnosis be the malignancy with the Z51.11 coded second.

Answer from the ICD-10 Manual: If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

Continued on next page...

FREQUENTLY ASKED QUESTIONS

Question: I am confused about the effective date of the new modifier ZC (Merck/Samsung Bioepis) for the modifier to report when billing for the biosimilar drug infliximab. Can you tell me if it is July 1, 2017 or October 1, 2017? Can you verify?

Answer: CMS has published two different effective dates for new modifier ZC in two different transmittals that were issued on the same date of August 25, 2017. It is likely that CMS will issue a clarification in the near future.

#1 - Transmittal 3853 (CR 10236) includes the following information: Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017. The table accompanying this directive also lists July 1, 2017 as the effective date for modifier ZC.

For the above, go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017-Transmittals-Items/R3853CP.html>

#2 - Transmittal 3850 (CR 10234) states the following:

The ZC modifier will become effective (that is, valid) for claims submitted beginning October 1, 2017 and applies retroactively to dates of service on or after July 24, 2017. Contractors shall add modifier ZC (Merck/Samsung Bioepis) to the required modifiers that must be used when HCPCS code Q5102 is billed on a claim.

A second biosimilar version of infliximab was marketed on July 24, 2017, creating a situation where products from two manufacturers may appear on claims. In order to allow the identification of the manufacturer of the specific biosimilar biological product that was administered to a patient, either existing HCPCS modifier ZB, or new modifier ZC is required when HCPCS code Q5102 is billed on a claim that is submitted after October 1, 2017.

For this information, go to

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3850CP.pdf>

Note: When billing the biosimilar, Q5102 (effective April 5, 2016) is should be reported with the modifier to identify which manufacture product you are using. You would use either the existing modifier ZB (Pfizer/Hospira) or ZC (Merck/Samsung Bioepis).



THANK YOU

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Question: We prepared a patient dose from a single-dose vial containing 100 mg, and the HCPCS descriptor was 100 mg. The administered dose was 75 mg, so the discarded waste was 25 mg. What would be the billing unit?

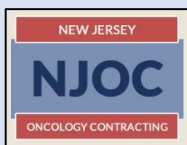
Answer: The total of the administered plus discarded waste is equal to the HCPCS billed unit of one. Billing another unit of service on a separate line item with a HCPCS code and modifier JW appended for the discarded 25 mg of drug is not permitted because it would result in overpayment.

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