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

2016 Will Bring Flurry of New Rules and Regulations Affecting Healthcare

By Modern Healthcare | January 2, 2016

Last year ushered in a bevy of new rules and regulations that are already affecting the healthcare industry: a fix to the sustainable growth-rate pay formula for physicians; a mandatory bundled-payment program that would affect 67 markets across the country; tweaks to the CMS’ value-based payment program; clarifications of waivers that aim to give states more flexibility in molding their Medicaid programs; and a down-to-the-wire budget deal that delayed taxes on Cadillac plans, medical devices and health insurance. But 2016 is expected to be just as eventful, with more rules and regulations expected.

READ MORE
New Chemotherapy HCPCS Codes
- J9032 – belinostat, 10 mg (Beleodaq)
- J9039 – blinatumomab, 1 mcg (Blincyto)
- J9271 – pembrolizumab, 1 mg (Keytruda)
- J9299 – nivolumab, 1 mg (Opdivo)
- J9308 – ramucirumab, 5 mg (Cyramza)

Did you Catch the Following HCPCS Code Changes?
- tbo-filgrastim, (Granix) J1446, 5 mcg has
  o CHANGED to J1447, 1 mcg
- alemtuzumab, (Lemtrada) Q9979, 1 mg & J9010, 10 mg
  o CHANGED to J0202, 1 mg

Advanced Care Planning Codes to be Reimbursed by Medicare in 2016
The ACP codes were established in 2015 however, no RVU’s ($$) were included. According to the CMS Final Rule, the codes will be reimbursed in 2016 and can be utilized by oncologists. The codes are CPT 99497 & CPT 99498. See page 9 of this newsletter for more information on billing for Advanced Care Planning.

Are You an Off Campus Outpatient Hospital Department? Make Sure to Catch These 2016 Coding Changes:

Place of service Codes (affects your CMS 1450 - UB04 claim form)
- POS 19: Off-Campus Outpatient Hospital - A portion of an off-campus hospital provider based department that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
- POS 22: On-Campus Outpatient Hospital - A portion of a hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

PO Modifier Mandated (affects your CMS1500 claim form)
Effective January 1, 2015 CMS mandates the PO modifier be appended to all claim lines for services rendered.

CMS Released the 2016 ICD-10-CM and GEMs as well as the 2016 ICD-10 Guidelines!
Available online and free – CLICK HERE
2016 - Maximum Out of Pocket REMINDER
Individuals do not have to pay the FAMILY deductible to hit maximum out of pocket!

The federal departments overseeing the Affordable Care Act (ACA) confirmed in May 2015 guidance (and again in September, 2015) that, effective for plan years beginning in 2016, nongrandfathered health plans, even self-funded plans and large-group plans, must apply an embedded self-only out-of-pocket (OOP) maximum to each individual enrolled in family coverage if the plan’s family OOP maximum exceeds the ACA’s OOP limit for self-only coverage ($6,850 for 2016).

This significant change affects the design of many employer-sponsored plans—in particular, high-deductible health plans that commonly impose a single overall family OOP limit on family coverage without an underlying self-only OOP maximum for each covered family member.

READ MORE

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GAO Report Recommends Equalizing Hospital, Physician Medicare Payment

In a Dec. 18, 2105, report “Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform,” the Government Accountability Office (GAO) recommends that payment rates be equalized between hospital outpatient departments and physician offices.

According to the GAO report, the Centers for Medicare & Medicaid Services (CMS) has said it does not have the authority to equalize payment rates between settings. View report highlights HERE.

Experts Predict Reimbursement Changes for 2016

By Aine Cryts | January 03, 2016

While the progression toward value-based care that continues among payers and providers across the country is new, the attraction to limited networks is a return to the past. In 2016, payers and providers will continue to navigate new and old ways of providing high-quality patient care, while keeping an eye on cost.

READ MORE
NJSOM MEMBERS NOTE: YOU WILL NEED TO DOWNLOAD THE NEW PHYSICIAN FEE SCHEDULE

Based on direction from CMS, the 2016 Medicare Physician Fee Schedules have been revised. Novitas should post the updated Fee Schedules to their website soon! CLICK HERE to see if it is available!

Release of LCDs and Articles Delayed

The release of the Local Coverage Determinations (LCDs) and Articles revised based on the 2016 annual coding update has been delayed. The revised LCDs and Articles will be available on January 28, 2016 on the Medicare Coverage Database and the Novitas website within the Medical Policy Center under the Active LCDs (Local Coverage Determinations) and Active Local coverage Billing & Coding Articles links. We apologize for any inconvenience.

JL - LCDs affected by the 2016 Annual HCPCS/CPT Update
(NJOSM Note: only hem/onc listed below)
- Biomarkers for Oncology (L35396)
- Biomarkers Overview (L35062)
- Hemophilia Factor Products (L35111)
- Services That Are Not Reasonable and Necessary (L35094)
- Thrombolytic Agents (L35428)

JL - Local Coverage Articles Affected by the 2016 Annual HCPCS/CPT Update
- Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53048)
- Biomarkers for Oncology (A52986)

Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 Medicare Physician Fee Schedule

On October 30, 2015, the CY 2016 Medicare Physician Fee Schedule (MPFS) final rule was published in the Federal Register. In order to implement corrections to technical errors discovered after publication of the MPFS rule and process claims correctly, Medicare Administrative Contractors will hold claims containing 2016 services paid under the MPFS for up to 14 calendar days (i.e., Friday January 1, 2016 through Thursday January 14, 2016). The hold should have minimal impact on provider cash flow as, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before Thursday Dec 31, 2015 are unaffected by the 2016 claims hold and will be processed and paid under normal procedures and time frames.

Part B Top Claim Submission Errors

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

Part B Top Inquiries FAQs

Have a question and not sure where to turn? Check out our recently updated FAQs for answers to your questions. CLICK HERE
New FAQs have been added to the Part B FAQs page to provide guidance and clarify Novitas’ position on the billing of an infusion code versus IV push & medication documentation.

If the start and stop time is not documented on an infusion, can I bill an IV push?
Since most infusion codes are time based codes, the start and stop time must be documented to support the time component and to ensure you are billing the most appropriate code. This applies to IV push as well. Remember, each encounter and drug is unique and have different administration rules; some drugs are not billable as an IV push. Therefore, recoding to an IV push may not be appropriate.

What must be included in my medical record documentation when administering medication(s)?
Medical record documentation should include the name of the medication, the dosage and the route of administration. The site of the injection should also be documented as well as any patient reactions to the medication and signature of the person administering the medication. Documentation must be maintained in the patient's chart to support the medical necessity of the injection given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.

Articles of note:

- Frustrated When a Medicare Secondary Payer (MSP) Claim Rejects?
- How to Review Pending End User Requests for Novitasphere in CMS Enterprise Portal (EIDM)

And More…
NOVEMBER Qtly Issue Available CLICK HERE

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? *

Novitas Solutions e-News Electronic Billing Qtly Newsletter

Medicare Part B - HOT LINKS!

2016 Medicare JL Part B Fee Schedule Current Active Part B LCD Policies
Current Average Sales Price (ASP) Files Quarterly Update to CCI Edits
2016 Physician Fee Schedule Final Rule
2016 CMS Physician Fee Schedule Final Rule Fact Sheet

Front Page News
Novitas Solutions Inc.
CMS Medicare
Other Payer Updates
Other News
Patient Assistance
Frequently Asked Questions
Listed are Novitas training events an oncology practice should consider!

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>EVENT</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>1/13/16</td>
<td>2:00p-3:30p</td>
<td>Part B Evaluation and Management Part 2: Introduction to the Score Sheet</td>
<td>Via Webinar</td>
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<tr>
<td>1/15/16</td>
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<td>Novitasphere Provider Portal Enrollment Overview</td>
<td>Via Webinar</td>
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<td>Signature Requirements for Medical Records</td>
<td>Via Webinar</td>
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<td>Novitasphere Claim Submission Overview</td>
<td>Via Webinar</td>
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<tr>
<td>1/20/16</td>
<td>2:00p-3:00p</td>
<td>Part B Evaluation and Management Score Sheet Part 3: Using the Score Sheet</td>
<td>Via Webinar</td>
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<td>Get Acquainted with Provider Enrollment</td>
<td>Via Webinar</td>
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<td>Via Webinar</td>
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<td>Via Webinar</td>
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<td>International Classification of Diseases, Tenth Revision (ICD-10) Post Implementation</td>
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<td>Via Webinar</td>
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<tr>
<td>2/3/16</td>
<td>10:00a-11:30a</td>
<td>Part A/B New and Small Provider Education - Part 1 Medicare Basics</td>
<td>Via Webinar</td>
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<tr>
<td>2/4/16</td>
<td>10:00a-11:00a</td>
<td>How to Avoid Top Claim Errors - First Quarter</td>
<td>Via Webinar</td>
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CLICK HERE to access the educational area of the Novitas website!
IMPORTANT PROVIDER NOTICE:
Effective 01/01/2016 - The Provider Portal is undergoing updates to include new information such as additional claim statuses, appeal statuses, correspondence received notifications, etc. The ADR Limits will be updated as soon as possible. Please use Google Chrome as your web browser to ensure proper website functionality. If you have any questions, please contact customer service at 866-201-0580.

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Senate Bill to Impose Significant Reforms on the Medicare Audit and Appeals Processes

Written by Andrew B. Wachler, Esq. and Jessica C. Forster, Esq. Created on Wednesday, 16 December 2015
On Dec. 8, the U.S. Senate Committee on Finance submitted a report on the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM Act), recommending that the bill be further considered by the Senate and the House of Representatives. If passed, the bill would significantly change the Medicare audits and appeals process.

READ MORE

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CMS Goes Predictive: Why Improving Intelligence Improves Outcomes

Written by Frank Cohen, MPA Created on Wednesday, 16 December 2015
Beginning in July 2011, the Centers for Medicare & Medicaid Services (CMS) entered the world of predictive analytics. According to a press release, effective June 30, 2011, a total of 100 percent of all Medicare fee-for-service claims were (and now are) passed through a complex set of predictive algorithms prior to being paid.

READ MORE
Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed on the CMS website.

We encourage you to bookmark this website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv.

CMS Expands Quality Data on Physician Compare and Hospital Compare

Updates provide more quality metrics for health care professionals and group practices

On December 10, data was refreshed on both the Physician Compare and Hospital Compare websites to improve these consumer online tools:

- New quality measures have been added to Physician Compare for group practices and Accountable Care Organizations (ACOs) and, for the first time, individual health care professionals. These measures focus on the quality of care provided by Medicare physicians and other health care professionals.
- Hospital Compare includes information on more than 100 quality measures and over 4,000 hospitals. The website has been refreshed and updated to include new data and several new measures.

For more information: See the Public Reporting of 2014 Quality Measures on the Physician Compare and Hospital Compare Websites fact sheet. See the full text of this excerpted CMS press release (issued December 10).

New MLN Provider Compliance Fast Fact

A new fast fact is available on the Medicare Learning Network Provider Compliance webpage. Bookmark this webpage for the latest Medicare Learning Network Educational Products and MLN Matters® Articles to help you understand common billing errors and avoid improper payments.
Advanced Care Planning Codes to be Reimbursed by Medicare in 2016

ACP Codes are....
CPT 99497 - Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health-care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT 99498 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health-care professional; each additional 30 minutes (list separately in addition to code for primary procedure.)

In the Final Rule, CMS provided the following directives on providing and billing for ACP, while also promising to issue further sub-regulatory guidance:

- There are no specific performance standards, special training, or quality measures a provider must satisfy to bill for ACP.
- ACP may be furnished and billed separately on the same day as an evaluation and management (E/M) visit.
- ACP is subject to cost-sharing requirements, unless furnished in conjunction with the Welcome to Medicare visit or an annual wellness visit.
- Presently, ACP is not reimbursable if furnished via telehealth.
- ACP may be furnished “incident-to,” subject to direct supervision.

Advance Beneficiary Notice of Noncoverage (ABN) Interactive Tool

CMS has announced their creation of an Advance Beneficiary Notice of Noncoverage (ABN) Interactive Tutorial Educational Tool. This tool helps users understand when an ABN is needed. In addition, interactive instructions for each field show how to properly complete the form.

What is the HIPAA Privacy Rule? Tips to Protect Your Patients' Privacy Video

This video includes basic information about the HIPAA Privacy Rule. It discusses ways in which health care professionals can protect their patients’ privacy.

CMS Provider Minute: Hospital Discharge Day Management Services Video

This video includes helpful pointers to properly bill for hospital discharge day management services. This is the first in a series of Medicare Compliance Videos.
EHR Incentive Programs: 2015 Program Requirement Resources

To help eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) successfully participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs in 2015, CMS posted new resources on the [EHR Incentive Programs](https://www.cms.gov/EHRIncentivePrograms) website.

- What You Need to Know for 2015: [Eligible Professionals](https://www.cms.gov/EHRIncentivePrograms/EligibleProfessionals.html) and [Eligible Hospitals/CAHs](https://www.cms.gov/EHRIncentivePrograms/EligibleHospitalsCAHs.html):
- Overview of the EHR Incentive Programs in 2015-2017
- What’s Changed for the EHR Incentive Programs in 2015-2017
- Attestation Worksheets: [Eligible Professionals](https://www.cms.gov/EHRIncentivePrograms/EligibleProfessionals.html) and [Eligible Hospitals/CAHs](https://www.cms.gov/EHRIncentivePrograms/EligibleHospitalsCAHs.html)
- Alternate Exclusions and Specifications Fact Sheet
- Objectives and Measures Tables: [Eligible Professionals](https://www.cms.gov/EHRIncentivePrograms/EligibleProfessionals.html) and [Eligible Hospitals/CAHs](https://www.cms.gov/EHRIncentivePrograms/EligibleHospitalsCAHs.html)
- Specification Sheets: [Eligible Professionals](https://www.cms.gov/EHRIncentivePrograms/EligibleProfessionals.html) and [Eligible Hospitals/CAHs](https://www.cms.gov/EHRIncentivePrograms/EligibleHospitalsCAHs.html)

Hospital Compare Website Refresh

On December 10, CMS refreshed the [Hospital Compare](https://www.hospitalcompare.hcup-us.ahrq.gov/) website. See the [announcement](https://www.cms.gov/EHRIncentivePrograms/Announcements.html) for information on the updates to measure sets and new measures.

CMS Hospital-Acquired Conditions Reduction Program: FY 2016 Results

In FY 2016, 758 out of 3,308 hospitals subject to the Hospital-Acquired Condition (HAC) Reduction Program are in the worst performing quartile and will have a one percent payment reduction applied to all Medicare discharges occurring between October 1, 2015, and September 30, 2016. In FY 2015, 724 hospitals were subject to a payment reduction. CMS estimates that the total savings in FY 2016 will be $364 million.

The fact sheet includes information on:
- Public reporting
- Measure selection and calculation
- Scoring methodology

Additional information about the HAC Reduction Program is available on [QualityNet](https://www.qualitynet.org/). See the full text of this excerpted CMS fact sheet (issued December 10).

Health Care Professional Frequently Used Web Pages Educational Tool

A revised [Health Care Professional Frequently Used Web Pages](https://www.cms.gov/EHRIncentivePrograms/EligibleProfessionals.html) Educational Tool is available. Learn how to navigate the CMS website and find information on key topics, including:
- Coverage
- Billing and payment
- Contracting

Front Page News
Novitas Solutions Inc.
CMS Medicare
Other Payer Updates
Other News
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Frequently Asked Questions
2016 Deductible and Coinsurance

Information about 2016 Medicare costs, including deductible and coinsurance, is available on the [Medicare.gov](https://www.medicare.gov) website.

**Reading a Professional Remittance Advice Booklet**

A revised [Reading a Professional Remittance Advice Booklet](https://www.medicare.gov) is available. Learn about:

- Reading a professional Electronic Remittance Advice (ERA)
- Reading a Standard Paper Remittance Advice (SPR)
- Balancing the ERA or SPR so provider records are consistent with Medicare’s records

**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](mailto:Michelle@weissconsulting.org)

**Recent LearnResource & MedLearn Matters Articles**

- [Summary of Policies in the Calendar Year (CY) 2016 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount](https://www.medicare.gov)
- [January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)](https://www.medicare.gov)
- [Calendar Year (CY) 2016 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](https://www.medicare.gov)
- [New Influenza Virus Vaccine Code](https://www.medicare.gov)
Medical Policy Updates

- New! Mepolizumab (Nucala)
- New! Elotuzumab (Empliciti)
- New! Daratumumab (Darzalex)
- Revised! Radiation Treatment of Bone Metastases

Quarterly Claim Editing Update:
1st Quarter 2016

Posted on Wednesday December 30 2015
Horizon BCBSNJ will implement a quarterly update to our claim editing rules and processes. Read about the changes effective February 1 and April 1, 2016.

CLICK HERE

Reminder: Referrals No Longer Required for Medicare Advantage Members

Posted on Tuesday December 22 2015
Effective January 1, 2016, referrals will not be required for members enrolled in any Horizon BCBSNJ Medicare Advantage HMO plans.

READ MORE
Other Payer Updates

A Few Articles You Won’t Want to Miss:

- Updates to Eligibility and Benefit EDI Transactions (270/271)
- Changes to 2016 Out-of-Pocket Maximum Limits

And Much More…
JANUARY Monthly Issue Available [HERE](#)

A Few Articles You Won’t Want to Miss:

- Reminder: Changes to precertification requirements for 2016
- Precertification changes for AmeriHealth Pennsylvania non-emergent outpatient radiation therapy services
- View up-to-date policy activity on our Medical Policy Portal
- 2015 Provider Publication Cumulative Index

And Much More…DECEMBER Monthly……..[CLICK HERE](#)
To visit their Provider pages…. [CLICK HERE](#)

AmeriHealth.

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
RECENT FDA
ONCOLOGY RELATED APPROVALS/CHANGES

- FDA expanded the label to include the approval of pembrolizumab (Keytruda Injection, Merck Sharp & Dohme Corp.) for the treatment of patients with unresectable or metastatic melanoma. This expansion now includes the initial treatment of patients with unresectable or metastatic melanoma with pembrolizumab. More Information. December 18, 2015

- FDA granted accelerated approval to alectinib (ALECENSA capsules, Hoffmann-La Roche Inc.) for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib. More Information. December 11, 2015

- FDA granted approval to uridine triacetate (VISTOGARD granules, Wellstat Therapeutics Corporation) for the emergency treatment of adult and pediatric patients:
  - following a fluorouracil or capecitabine overdose regardless of the presence of symptoms, or
  - who exhibit early-onset, severe or life-threatening toxicity affecting the cardiac or central nervous system and/or early-onset, unusually severe adverse reactions (e.g., gastrointestinal toxicity and/or neutropenia) within 96 hours following the end of fluorouracil or capecitabine administration. More Information. December 11, 2015

- FDA approved Vonvendi, von Willebrand factor (Recombinant), for use in adults 18 years of age and older who have von Willebrand disease (VWD). Vonvendi is the first FDA-approved recombinant von Willebrand factor, and is approved for the on-demand (as needed) treatment and control of bleeding episodes in adults diagnosed with VWD. More Information. December 8, 2015

- FDA approved elotuzumab (EMPLICITI, Bristol-Myers Squibb Company) in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received one to three prior therapies. More Information. November 30, 2015
F.D.A. Regulator, Widowed by Cancer, Helps Speed Drug Approval

By Gardiner Harris. January 2, 2016

BETHESDA, Md. — Mary Pazdur had exhausted the usual drugs for ovarian cancer, and with her tumors growing and her condition deteriorating, her last hope seemed to be an experimental compound that had yet to be approved by federal regulators.

READ MORE
CMS Releases

Medicare Drug Spending Dashboard

On Dec. 21, 2015, the Centers for Medicare & Medicaid Services (CMS) released a new online dashboard to look at Medicare prescription drugs for both Part B and Part D. The [website](#) includes "drugs with high spending on a per user basis, high spending for the program overall, and those with high unit cost increases in recent years," the agency said.

For the dashboard, CMS identified 80 drugs using 2014 data: 40 drugs provided through the Medicare Prescription Drug Program under Part D and 40 drugs administered by physicians and other professionals in the Medicare fee-for-service program under Part B.

The dashboard allows consumers, policy makers, manufacturers, purchasers, and other stakeholders to see six lists — three lists for Medicare Part B and three for Medicare Part D, sorted by the:

- Top 15 drugs by total annual cost,
- Top 15 drugs by the highest spending per Medicare user, and
- Top 10 drugs with the highest annual increase in cost in 2014.

Access the [Medicare Drug Spending Dashboard](#). [Read the CMS blog](#) highlighting topline findings from the dashboard.

How Physicians Can Combat Criminal Fraud Investigations

A novel way to challenge the government's use of incriminating statements at trial. [Read the advice](#)

Mastering The Struggle for Patient Record Ownership

In-depth looks into how physicians can understand legal nuances, preserve patient relationships, and control record access. [Read the story](#)

Incident-To Billing: Clearing Up the Confusion

Incident-to billing is a way of billing outpatient services provided by a non-physician practitioner, but it can be confusing. [Here's what you need to know](#)
THE MERCK PATIENT ASSISTANCE PROGRAM

The Merck Access Program representatives can refer patients to the Merck Patient Assistance Program.

Who is the program for?
Patients who do not have insurance or whose insurance does not cover KEYTRUDA may be eligible for free product, including product replacement, from the Merck Patient Assistance Program if they meet certain financial and medical criteria.

For more information on the program’s eligibility requirements, please visit www.merckhelps.com.

Getting started is simple
1. Download and complete the appropriate sections of the enrollment form OR use the electronic enrollment form.
2. Print and fax the completed form to 855-755-0518.
3. A program representative will contact your patient and your office.

To request an appointment with a Nurse Educator, please call 855-257-3932.

Continued on next page...
CODING UPDATE

J Code for KEYTRUDA® (pembrolizumab) Available!

KEYTRUDA has been assigned a permanent HCPCS* code, effective January 1, 2016.

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>J9271</td>
<td>Injection, pembrolizumab, 1 mg</td>
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</table>

* For dates of service prior to January 1, 2016, use the appropriate unspecified HCPCS code to bill for KEYTRUDA.

If you have questions about KEYTRUDA, please contact your Merck representative. If you have questions or need additional information about coding and reimbursement related to KEYTRUDA, please contact The Merck Access Program.

The Merck Access Program for KEYTRUDA is available online

(www.merckaccessprogram-keytruda.com).

You may also call toll-free (855-257-3932) between 8:00 AM and 8:00 PM ET, Monday through Friday.

To get more information and visit their website

CLICK HERE
Reimbursement Questions & Answers

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

Question: We have a couple of Medicare Advantage plans that are not paying timely and rejecting claims that regular Medicare is reimbursing. Most of the problem has been since October. We've tried to resolve this with them but just continue to get the runaround. Who/how do we report them to someone at a higher level?

Answer: In my opinion the best resource would be the SBA Ombudsman and reporting is actually online and very easy to do. I have supplied the link to their complaint form (below). Simply click where it says, “Submit the form directly online” and complete the form. The Federal Agency Name would be the name of the Advantage plan you are referencing. Provide any contact information for that organization you have. At the bottom you will use the box provided to BRIEFLY state the issue. The box is very small so just provide a highlight of the problem and let the Ombudsman know that you will submit additional information, like a copy of the claim(s) showing the problem and maybe something from WPS traditional Medicare showing they pay for this service. Submit the form.

Within a couple of days you will receive a confirmation of receipt and within a few days more a case number will be assigned and you will receive another email and will have an opportunity to submit any additional information.

The Ombudsman will step in on your behalf. Their turnaround time has been less than 45 days.

Here is a link to the Ombudsman form http://www.sba.gov/ombudsman/comments

Continued on next page...
Here is the mission statement from the National Ombudsman's office site......

Mission Statement

The National Ombudsman's mission is to assist small businesses when they experience excessive or unfair federal regulatory enforcement actions, such as repetitive audits or investigations, excessive fines, penalties, threats, retaliation or other unfair enforcement action by a federal agency.

Question: What is an IRS Form CP 575?

Answer: The IRS Form CP 575 is an Internal Revenue Service generated letter you receive from the IRS granting your Employer Identification Number (EIN) linking it with your legal business name (LBN). A copy of your CP 575 may be required by the Medicare contractor to verify the provider or supplier’s EIN and LBN. Any other IRS document showing the provider or supplier's EIN and LBN is also acceptable for enrollment purposes.

Question: Can you provide an example of how CMS defines a “new patient”?

Answer: 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 with the patient is performed), this patient remains “new” 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.

Question: What is the rule, if any, regarding a physician in the same specialty practice, same group practice regarding signing each other's chart notes if the author is on vacation?

Answer: The IOM, Medicare Integrity Manual, Publication 100-08, Chapter 8, Section 3.4.1.1 states that attestation statements from someone other than the author of the medical record entry in question is not valid, even in cases where two individuals are in the same group. One provider may not sign for the other in medical record entries or attestation statements. A "substitute" signature is not valid.
Question: When a locum tenens physician provides services, what are the signature guidelines?

Answer: Locum tenens physicians are identified by the use of the Q6 modifier as they bill under the physician they are substituting for. The locum tenens physician should be identified within the records and the signature should be that of the locum tenens physician.