From: **Bobbi Buell** bobbibuell1+yahoo.com@ccsend.com
Subject: E-Reimbursement Final Physician Fee Schedule 2017 11-11-2016
Date: November 11, 2016 at 10:01 AM
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Issue: #10, Volume 26 November 2017

Dear Jose Luis,

The FINAL Physician Fee Schedule Rule was introduced last week and here is a long summary of all provisions. The 1400+ page rule was longer than we thought it might be, but, nevertheless there is a lot of opportunity for more reimbursement in your practice and clinics in the Evaluation & Management arena.

In the next week or so, we will release our summary of the hospital outpatient rule. In addition, The Medicare Experiment on Cancer Care Final Rule may also appear now that the election is over. **Finally, we will have a final set of webinar invitations coming out very soon**. Stay tuned and watch your e-mail!

Meanwhile, this edition of our newsletter will be better than melatonin for snoozing--so read carefully and do not operate heavy machinery.

Da' Mistress

Physician Fee Schedule: The Final Rule for 2017

On November 2, 2016, the Centers for Medicare & Medicaid Services ("CMS") released the Final Rule for the 2017 Medicare Physician Fee Schedule (MPFS). This Final rule evidenced a .24% increase for Medicare Fee Schedule payments in 2017. **This teeny tiny increase is based on the 2017 MPFS conversion factor (CF) of $35.89, an increase to the**

2016 CF of $35.80. For Oncology, Radiation and Medical Oncology, there will be no change in fee schedule reimbursements overall.

- Behavioral Health Intervention ("BHI"): In the proposed rule, multiple new codes were introduced for behavioral health intervention, a service commonly provided by primary care practices, but can be used by any specialist who performs these services when patients demonstrate behavioral health issues. The first set of these codes include G0502, G0503 and G0504, which involve "psychiatric collaborative care management" between a supervising physician, a behavioral health care manager and a consulting psychiatrist. G0502 requires 70 minutes for the first month; G0503 requires 60 minutes in subsequent months; and G0504 is a 30-minute add-on code.Then, there is a new code, G0507, which covers 20 minutes of "care management services for behavioral health conditions" per month to pay for the comprehensive assessment and care planning for patients with cognitive impairment". Another new and shiny G-code, G0505 is for "Cognition and functional assessment by the physician or other qualified health care professional in office or other outpatient setting".
- Mobility Assistance: GDDD1 (G0501), was an add-on code proposed to pay physicians for the coordinating the use of items to assist patients with mobility issues. **This code was excluded for payment this year**.
- Prolonged Services: CMS also provided payment for prolonged non-face-to-face evaluation and management services, which are codes 99358, and 99359. Please make sure you carefully read the descriptions for these codes as you know they have had audits on the face-to-face codes over the years. In the Final Rule, following CPT guidance, these codes describe services "furnished during a single day directly related to a discrete face-to-face service that may be provided on a different day, provided that the services are directly related to those furnished in a face-to-face visit".
- Chronic Care Management: CMS has said that they have seen a lower-than-expected utilization for CCM services so far. So, to make life easier, on Table 11 of the Proposed Rule, CMS revealed a plethora of changes to lower the administrative burden associated with the CCM code, to include eliminating the requirement for a separate, written consent. But, you will need to document discussions about CCM with the patient, particularly that they know about out-of-pocket costs. Furthermore, two new codes for complex CCM services (99487 and 99489) will be covered in 2017, as well as a new add-on code, G0506, for payment of the CCM initiating visit. It was added because a face-to-face initiating visit "is required before CCM services can be provided," states the final rule. Now providers can use G0506 for "additional work of the billing practitioner in personally performing a face-to-face assessment" ahead of a CCM episode.
- Telehealth: CMS expanded the coverage of telehealth services, with allowing telehealth services in end-stage renal disease, advanced care planning and telehealth-specific critical care consultations, which now have new codes, G0508-G0509. Additionally, CMS revealed a new place of service code - 02 - specifically designed to report services furnished via telehealth. The originating site will get a new fee of $25.40 for 2017.
- Mammography: There are changes to the CPT codes for

mammography that would have resulted in big-time payment reductions. So, CMS came up with new descriptors, policies and rates for the existing G-codes used for mammography.

- Endoscopy: As part of looking at procedures that are overvalued, moderate sedation is billed separately with codes that include moderate sedation in their relative values. So, to track this, CMS adopted a new endoscopy-specific moderate sedation code, G0500. It is listed as "moderate sedation services provided by the same physician ... performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time..." Because this was considered 'overvalued', CMS consequently reduced the work relative value units of hundreds of endoscopy procedures.
- Global Surgical Periods: In the past few iterations of the Fee Schedule Rules, CMS announced its intention to re-examine global surgery payment. As of July 1, 2017, surgeons performing select, high-volume, high-cost surgeries (approximately 275 CPT® codes) will be required to report the work associated with patients' post-operative care via the current code, 99024. CMS is limiting its requirement to surgeons in groups of 10 or more, located in these selected states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island. Teaching physicians will be subject to the reporting requirements in the same way as other physicians and should use the -GC or -GE modifier as appropriate to indicate the involvement of residents.
- Radiology: A drop in Medicare payment will be experienced by practices with film-based imaging. Effective January 1, 2017, the ironic modifier -FX must be used on claims for x-rays that are taken with film. The modifier will trigger a 20% reduction in payment for the x-ray service, mandated by another federal law.
- Diabetes Prevention: In the Proposed Rule, CMS announced the initiation of the Medicare Diabetes Prevention Program (MDPP), which has been a pilot program. Reimbursement won't actually start until January 1, 2018. CMS had previously proposed to improve payment opportunities for Diabetes Self-Management Training (DSMT), but balked on it in 2017.
- ACOs and PQRS: Based on the lack of control that some providers felt, CMS went with their proposal that physicians and other eligible professionals (EPs) who are members of accountable care organizations (ACOs) can separately report their PQRS measures for the 2016 performance year. Further, for EPs who were negatively impact by their ACO failing to report on behalf of them, CMS also outlined a secondary PQRS reporting period for calendar year 2015.

The day before the release of this Final Rule, **CMS confirmed the 90-day reporting period for the EHR Incentive Program in 2016**
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From: **Bobbi Buell** bobbibuell1+yahoo.com@ccsend.com
Subject: E-Reimbursement--The 2017 Edition: HOPPS 2017, CPT, HCPCS, -JW 12-1-2016
Date: December 1, 2016 at 10:33 AM
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Issue: #11, Volume 26 December 2017

Dear Jose Luis,

Let's get ready to rumble! 2017 is upon us and we have to get all of the codes under control or we will be seeing our claims bounce around until 2018. We presented Physician Fee Schedule in our last issue. In this issue we continue to give you all you need to cruise into 2017:

- The Hospital Outpatient Final Rule
- The CPT & HCPCS codes--added, changed, and deleted
- And, the Ubiquitous Modifier -JW

And, there is lots of good news--**the big thing is the Part B Drug Experiment on Cancer Care has all but disappeared**. Some Dems tried to revive its moribund soul, but there is soon going to be a new Trump in town so the Part B Experiment is toast for now. **For those of you who hate Obamacare**, the Secretary of Health Human Services will be Representative Tom Price (R-Ga) and the new Grand Wizard of Medicare will be Seema Verma. Representative Price is a long-time foe of the ACA, so there should be some major changes in or total repeal of Obamacare the near future. Whether or not this will work for cancer patients remains to be seen.

Finally, for your continued edification and preparedness for 2017, we are presenting three "lunch and Learn" Sessions before January 1. The links are in the very last article. Sign up now because space is limited!

Waiting for the world to change,

Da' Mistress

Hospital Outpatient: The Final Rule 2017

On November 1, the Centers for Medicaid and Medicare Services (CMS) released the CY 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) rule , which finalized most of the controversial "site neutral" payment policy for non-excepted Provider-Based Hospital Outpatient Departments (PBDs). Along with those provisions, the Final Rule continues the bundling trend for lab tests; adds additional measures for outpatient continuous quality improvement; shortens Electronic Health Record reporting period and establishes the final APC and drug payment rates for 2017.

- CMS is updating OPPS payment rates by 1.65 percent and estimates a 1.7 percent increase for hospitals paid under the OPPS in 2017. This may differ depending upon the mix of services billed and the hospital's quality reporting status.
- Drug Payment---Drugs paid separately will continue to be paid at ASP plus 6%. Those that are under $110 per day as per CMS' calculations are now bundled.
- "Site Neutral" Payment Policy Changes Payment Rates for Certain HOPDs from OPPS to the Medicare Physician Fee Schedule--The CY 2017 OPPS rule finalizes interim final payment rates from the infamous Section 603 of the Bipartisan Budget Act of 2015 (BiPA) of for non-excepted items and services furnished by provider-based (PBD) off-campus hospital outpatient departments (HOPDs) under the Medicare Physician Fee Schedule (MPFS). **The controversial "site neutral" payment policy is expected to reduce incentives for hospitals to acquire independent physician practices and convert them to receive payment under OPPS, which pays a facility fee in addition to the physician fee for the same services**. CMS finalized Section 603 which makes off-campus HOPDs that executed a provider agreement after November 2, 2015 (effective date of BiPA) ineligible for payment under the OPPS as of January 1, 2017 ("non-excepted" outpatient departments). CMS also finalizes several policies relating to which off-campus Provider-based Departments ("PBDs") and which items and services are "excepted" from the payment changes being made in the rule. CMS also finalizes several policies relating to which off-campus PBDs and which items and services are "excepted" from the payment changes being made in the rule for applicable provider-based practices or departments.
    - Certain PBDs May Continue to be Paid Under OPPS for Excepted Items and Services--Consistent with the 2017 OPPS proposed rule, the following off-campus PBDs are not subject to the payment changes and may continue to be paid under the OPPS for excepted items and services:
        - By a dedicated emergency department;
        - By an off-campus PBD that was billing for covered OPD services furnished prior to **November 2, 2015**, (which is the date of enactment of Section 603 of the Bipartisan Budget Act of 2015) that has not impermissibly relocated or changed ownership; or

        - In a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital. This provision has been around almost as long as I have
    - Limitations Imposed Excepted PBDs Permitted to Receive Payment Under the OPPS for Excepted Items and Services--CMS proposed several limitations on the items and services that an excepted off-campus PBD could continue to bill under the OPPS as of January 1, 2017:
        - CMS is **not** finalizing the proposed limitation on service expansion in an excepted Off-Campus PBD which would exclude from regular hospital outpatient payment, items and services not within the same clinical families of services for which an excepted PBD billed and received payment before November 2, 2015. So, if a hospital expanded their cancer services after November 2, 2015, they would still be excepted, which was not true in the proposed rule. CMS said they will monitor the expansion of clinical service lines by excepted off-campus PBDs and may consider implementing a limitation on such expansion in the future.
        - CMS is finalizing the proposal that an excepted PBD may receive payment under the OPPS only for those items and services furnished and billed at the same physical address that was used as of November 2, 2015, with a big old exception that was not in the proposed rule:
            - In response to lots of comments about the proposed limitation, CMS will permit an excepted PBD to relocate temporarily or permanently without loss of its excepted status due to "extraordinary circumstances" outside the hospital's control, such as natural disasters. CMS outlined that such exceptions are expected to be rarely made, and will be determined by the applicable CMS Regional Office.
            - CMS codifies its proposal to allow an off-campus PBD to maintain its excepted status if the hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from the prior owner.
    - In a separate rule, CMS Establishes MPFS Payment Rates for Non-excepted Items and Services Furnished by an Off-Campus PBD of a Hospital; Estimates Overall Increase in Payments--Hospitals will bill for these services (except the professional fees, which will be paid under the Physician Fee Schedule) using the institutional claim (the UB-04 AKA CMS-1450) with a new modifier, "PN," which indicates that an item or service is a non-excepted item or service and therefore payable under the MPFS, rather than OPPS. For CY 2017, the MPFS payment rate for these services will generally be 50 percent of the OPPS rate, with some notable exceptions, including payment for separately payable drugs, which will not be reduced, since drugs are paid the same in both settings. However, other existing OPPS policies, such

as packaging and others will continue to apply to these services.

- X-Rays--CMS adopted its proposal to require hospitals to use a modifier on claims for X-rays that are taken using film; use of the modifier would result in a 20 percent payment reduction for the X-ray service.
- Bundling Continues with Lab Tests and New Comprehensive APCs--CMS is continuing to shift Medicare payment policy towards "bundling" with two separate provisions under next year's OPPS payment rules:
    - Lab Tests Bundled-In 2014, CMS finalized a policy to package payment for lab tests into payment for the associated services. However, the agency continued separate payment in certain instances-- when a lab test was "unrelated" to other services included on the same claim, and ordered for a different diagnosis and/or a different practitioner that ordered the other services. To be paid separately, the hospital would apply modifier -L1. Hospitals complained that the exception was vague and it was difficult to tell when a test met the requirements. For 2017, CMS finalized the proposal to eliminate the exemption and instead package payment for lab tests when those tests are billed on the same claim as any other outpatient service. Lab tests that are the only services on a claim, or are considered preventative services, will continue to be paid separately. Molecular pathology tests had also been excluded from the laboratory packaging policy because these tests may have a different pattern of clinical use than more conventional laboratory tests, which may make them less tied to a primary service in the hospital outpatient setting than the more common and routine laboratory tests that are packaged. CMS is finalizing its proposal to expand this exemption to include Advanced Diagnostic Lab Tests ("ADLTs"), which is a very narrow swath of tests.
    - Addition of 25 New Comprehensive APCs for 2017. CMS is finalizing the proposal to add an additional 25 new comprehensive APCs (C-APCs), increasing the number of C-APCs to a grand total of 62 C-APCs. The new procedures include biopsy, endoscopy, musculoskeletal procedures, and upper gastrointestinal procedures. Payment for all items, services and procedures will be packaged into payment for the primary APC.
        - C-APC for Bone Marrow Transplants (BMT) to be developed. CMS is finalizing a proposal to develop a C-APC as well as a dedicated cost center for BMT. The creation of a new C-APC for BMT would allow all the costs for services on the same OPPS claim as a BMT to be packaged in one comprehensive rate. This would also allow for the payment for the BMT to be representative of payment for all services that are associated with the BMT procedure along with the BMT procedure itself. This is consistent with commercial case rate payments, which have been around for years.
- CMS finalizes seven additional outpatient quality measures-Similar to physician offices, the quality of outpatient care is assessed by a unique reporting program, the Hospital Outpatient Quality Reporting

(OQR) Program. The OQR program is modeled after the inpatient reporting program, but as with MIPS, CMS expresses a goal of more closely aligning various quality/value programs. Two of the proposed measures are based on claims data, with the other five drawn from Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) surveys. Although the OAS CAHPS was finalized in 2015, this will be the first time that these measures have been formally used to assess hospital performance in a manner which generates incentives and penalties. This final rule finalizes all seven measures as proposed, with performance assessment beginning January 1, 2018. Applicable to Oncology is this one:

    - Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy (claims)--Designed to reduce admissions and ED visits due to predictable and manageable side effects from chemotherapy treatment
        - Includes anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis within 30 days of outpatient chemotherapy treatment
        - Excludes leukemia patients
- CMS is finalizing its proposals to publicly display OQR data on the Hospital Compare website as soon as it is received, but they will afford hospitals 30 days to review their results.
- CMS Allows a 90-day Reporting Period in 2016 and 2017 for EHR Incentive Program; All-or-Nothing Structure Remains for Hospitals (as opposed to practices under MIPS)
    - For 2016 and 2017, CMS finalized a shortened 90-day EHR reporting period for all new and returning eligible professionals (EPs), eligible hospitals, and CAHs.
    - For hospitals in 2017 and subsequent years, CMS finalized eliminating the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures. CMS also reduced the measure threshold of the Modified Stage 2 View Download Transmit (VDT) Measure and the measure thresholds of the seven Stage 3 measures. Removing the CPOE and CDS measures brings the hospital's Meaningful Use program in line with the provider's MIPS Advancing Care Information category which also removed those measures.
    - Although the Modified Stage 2 requirements and Stage 3 requirements were supposed to bring the hospital and provider requirements in line and reduce program complexity, with the final rule the programs are beginning to diverge again.
        - CMS reduced the number of EHR measures for providers from eleven to five in 2017 (unless a practice wants extra credit) but hospitals only saw a reduction from fifteen to thirteen - with thresholds lowered for 7 of those remaining measures
        - CMS deleted the all-or-nothing structure for providers with MIPS, but this problematic structure remains for hospitals.

To read the entire rule plus Appendices, click right here.

New Drug Admin and Drug Code Changes 2017

New Drug/Admin and Drug Code Changes 2017

It is so very rare that we get a new procedure code in Oncology that is BIG News! Yes, friends, effective for dates of service starting January 1, 2017, you can use 96377. The description of this code in CPT® 2017 is "Application of on-body injector (includes cannula insertion) for timed subcutaneous injection".

New Level II HCPCS codes that you can use this coming year with their date range and status codes, include the following. Remember C-codes are used mostly in the hospital outpatient. Status codes are "A" for added; "C" for changed; and "D" for deleted:

C9140	Injection, factor viii (antihemophilic factor, recombinant) (afstyla), 1 i.u.	20170101	20170101		A
C9482	Injection, sotalol hydrochloride, 1 mg	20161001	20161001		A
C9483	Injection, atezolizumab, 10 mg	20161001	20161001		A
J0570	Buprenorphine implant, 74.2 mg	20170101	20170101		A
J0883	Injection, argatroban, 1 mg (for non-esrd use)	20170101	20170101		A
J0884	Injection, argatroban, 1 mg (for esrd on dialysis)	20170101	20170101		A
J1130	Injection, diclofenac sodium, 0.5 mg	20170101	20170101		A
J1942	Injection, aripiprazole lauroxil, 1 mg	20170101	20170101		A
J2182	Injection, mepolizumab, 1 mg	20170101	20170101		A
J2786	Injection, reslizumab, 1 mg	20170101	20170101		A
J2840	Injection, sebelipase alfa, 1 mg	20170101	20170101		A
J7175	Injection, factor x, (human), 1 i.u.	20170101	20170101		A
J7179	Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco	20170101	20170101		A
J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	20170101	20170101		A
J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.	20170101	20170101		A
J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.	20170101	20170101		A

J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg	20170101	20170101		A
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	20170101	20170101		A
J7342	Installation, ciprofloxacin otic suspension, 6 mg	20170101	20170101		A
J8670	Rolapitant, oral, 1 mg	20170101	20170101		A
J9034	Injection, bendamustine hcl (bendeka), 1 mg	20170101	20170101		A
J9145	Injection, daratumumab, 10 mg	20170101	20170101		A
J9176	Injection, elotuzumab, 1 mg	20170101	20170101		A
J9205	Injection, irinotecan liposome, 1 mg	20170101	20170101		A
J9295	Injection, necitumumab, 1 mg	20170101	20170101		A
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	20170101	20170101		A
J9352	Injection, trabectedin, 0.1 mg	20170101	20170101		A

Codes that were **changed** this year include:

J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	20150101	20170101	C
J1745	Injection, infliximab, excludes biosimilar, 10 mg	20000101	20170101	C
J3357	Ustekinumab, for subcutaneous injection, 1 mg	20110101	20170101	C
J7201	Injection, factor ix, fc fusion protein, (recombinant), alprolix, 1 i.u.	20150101	20170101	C
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	20160101	20170101	C
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	20160101	20170101	C
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg	20140101	20170101	C
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml	20160101	20170101	C
J9033	Injection, bendamustine hcl (treanda), 1 mg	20090101	20170101	C

Codes that were deleted include:

C9121	Injection, argatroban, per 5 mg	20030101	20170101	20161231
C9137	Injection, factor viii	20160401	20170101	20161231

	Injection, factor viii (antihemophilic factor, recombinant) pegylated, 1 i.u.			
C9138	Injection, factor viii (antihemophilic factor, recombinant) (nuwiq), 1 i.u.	20160401	20170101	20161231
C9139	Injection, factor ix, albumin fusion protein (recombinant), idelvion, 1 i.u.	20161001	20170101	20161231
C9349	Puraply, and puraply antimicrobial, any type, per square centimeter	20150101	20170101	20161231
C9458	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	20160101	20160701	20160630
C9459	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	20160101	20160701	20160630
C9461	Choline c 11, diagnostic, per study dose	20160401	20170101	20161231
C9470	Injection, aripiprazole lauroxil, 1 mg	20160401	20170101	20161231
C9471	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	20160401	20170101	20161231
C9472	Injection, talimogene laherparepvec, 1 million plaque forming units (pfu)	20160401	20170101	20161231
C9473	Injection, mepolizumab, 1 mg	20160401	20170101	20161231
C9474	Injection, irinotecan liposome, 1 mg	20160401	20170101	20161231
C9475	Injection, necitumumab, 1 mg	20160401	20170101	20161231
C9476	Injection, daratumumab, 10 mg	20160701	20170101	20161231
C9477	Injection, elotuzumab, 1 mg	20160701	20170101	20161231
C9478	Injection, sebelipase alfa, 1 mg	20160701	20170101	20161231
C9479	Instillation, ciprofloxacin otic suspension, 6 mg	20160701	20170101	20161231
C9480	Injection, trabectedin, 0.1 mg	20160701	20170101	20161231
C9481	Injection, reslizumab, 1 mg	20161001	20170101	20161231
J0760	Injection, colchicine, per 1 mg	19820101	20170101	20161231
J1590	Injection, gatifloxacin, 10 mg	20020101	20170101	20161231

For a complete list, go to the Alpha Numeric HCPCS Table.

Reminder: Modifier -JW

Remember that you must use Modifier -JW for

Remember that you must use Modifier -JW for discarded drugs starting January 1, 2017. Since you will be hung over that day, it will probably be used upon your return on January 3, 2017 which is actually the first 'official' day. Why is this being done to your practice or clinic? Remember: Medicare will consider payment for the unused and discarded portion of a *single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition.* This applies to drugs priced through the Average Sales Price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a way that **maximizes efficiency of therapy in a clinically appropriate manner**. But, be careful about charging Medicare for full vial; then administering wastage to another patient, and, billing for it. Big no-no!

If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate and necessary for a Medicare patient, **the program provides payment for the entire portion of drug or biological indicated on the vial or package label**. So, when there is wastage after January 3, 2017, the amount given to the patient will be billed on one claim line with the amount wasted on the next line. Modifier -JW will be applied to the wasted portion J-code on the second line. Drugs, like 5-FU, with large J-code denominations may be too large to report waste. For example, the J-code descriptor of its units is 500 mg and the patient uses 400 mg; this means you bill for 500 mg whether you wasted the 100 mg or not. There is no requirement to split J-code units.

If less than a complete single dose vial is administered at the time of service, the unused portion is discarded and then billed, drug wastage must be documented in the **patient's medical record with the date, time (for some MACs like FCSO and NGS), and quantity wasted**. In an retrospective or prepayment audit, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. Again, the amount billed as "wastage" must not be administered to another patient or billed again to Medicare, which may not be as simple as it sounds. At this time, you DO NOT need to send this documentation with the claim.

For more information about our new/old friend, -JW, see this Medlearn Matters.

Get Ready! Get Set for 2017~

For your education and continuing edification, we are presenting our webinar to get you ready for 2017. Agenda will include:

- Physician Fee Schedule 2017
- Hospital Outpatient 2017
- All The New Codes for 2017
- MIPS/MACRA/OCM

Title	Date & Time (EDTI	Registration Link

		Link
Get Ready!	12/16/2016 @ 12:00 EDT (1.0 hours)	Reg Link 12/16/2016
Get Ready!	12/22/2016 @ 12:00 PM (1.0 hour)	Reg Link 12/22/2016
Get Ready!	12/29/2016 @ 3:00 PM (1.0 hour)	Reg Link 12/29/2016

This is a free webinar, but we reserve the right to limit sessions. We also have space for just 250 attendees for each webinar--so, sign up ASAP

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