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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

CELEBRATING 25 YEARS 1994-2019

Issue 79 NOVEMBER '19

ACTIVE LEADERSHIP AND UNITY FOR ALL MEMBERS TO THRIVE IN THE EVOLVING HEMATOLOGY ONCOLOGY COMMUNITY

INSIDE THIS ISSUE | POHMS newsletter Issue 70 | NOVEMBER '19

25 YEARS OF FOSTERING GROWTH

Proud to celebrate our 25th Anniversary of providing education, support, and innovation dedicated to nurture and enhance community-based oncology/hematology practices.

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ATTENTION CORPORATE SPONSORS ADVERTISING OPPORTUNITY

We are looking for supporters of the POHMS Newsletter. Interested parties contact one of our board members ...

CLICK HERE

Editor: Michelle Weiss, Weiss Oncology Consulting - Michelle@WeissConsulting.org

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Despite Court Ruling, CMS Presses on with 340B Programs Cuts

WASHINGTON -- The Centers for Medicare and Medicaid Services (CMS) continued with its move to slash payments to the 340B drug program, in spite of court rulings against such actions, according to a final rule.

Also, CMS will push forward with a site-neutral approach in reimbursement for outpatient services, according to the rule released Friday. READ MORE

CMS Releases Physician Fee Schedule and Outpatient Hospital Final Rules!

- Physician Fee Schedule and Quality Payment Program:
  - Final Rule
  - Press Release
  - Physician Fee Schedule Fact Sheet
  - Quality Payment Program Fact Sheet
- Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems:
  - Final Rule
  - Fact Sheet

Community Needs More Time to Assess and Comment on CMMI's Proposed Oncology Care First Model

(COA) Nov 5, 2019 - On Friday afternoon, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) released an informal request for information for a new model for value-based payments in oncology known as the "Oncology Care First" (OCF) model.

READ PRESS RELEASE

Oncologists Call on Pennsylvania Lawmakers to Enact Legislation to Curb Payer Delays on Cancer Care

(ASCO) Oct 29, 2019 - Today the Pennsylvania Society of Oncology and Hematology (PSOH) and the American Society of Clinical Oncology (ASCO) came out in strong support of HB 1194, proposed legislation to promote transparency in prior authorization and step therapy policies, which would put in place important safeguards to ensure that patients get the care they need. READ PRESS RELEASE

CMS Finalizes Updates to E&M Codes, Establishes MIPS Value Pathways

(ASCO in Action) Nov 1, 2019 – On November 1, the Centers for Medicare & Medicaid Services (CMS) released its final rule for the 2020 Medicare Physician Fee Schedule (MPFS) and other changes to Medicare Part B reimbursement policies, including proposals related to the Quality Payment Program (QPP). READ ARTICLE

HHS Proposal to Reform Stark Law and Anti-Kickback Statute is Good First Step, But More Changes Needed

Oct 10, 2019 – The Community Oncology Alliance (COA) applauds the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) for today's announcement proposing changes to modernize the Physician Self-Referral Law (the Stark Law) and the Federal Anti-Kickback Statute.

READ PRESS RELEASE

ASCO in Action

ASCO in Action Brief: Co-pay Accumulators and Co-pay Maximizers

(ASCO in Action) Sept 20, 2019 – An overview of ASCO's position.

READ ARTICLE

Online Registration Available for November 15, 2019, Open Meeting and Proposed LCDs Now Posted

Online registration for the November 15, 2019, Open Meeting is now available and will close at 3:00 PM Eastern Time (ET) on Tuesday, November 12, 2019, or before November 12th if room capacity is filled. The Novitas Solutions proposed LCDs are now posted.

Important: The Open Meeting will be held at Novitas Solutions, 2020 Technology Parkway, Mechanicsburg, PA 17050 at 10:00 AM ET. Due to limited room capacity, registered presenters will be given priority for seating and registered observers will be accepted until remaining seats are filled.

Open Meetings are for the specific purpose of discussing the proposed LCDs. Anyone is welcome to present information related to the proposed LCDs that are in the 45-day draft comment period. Interested parties may also request to attend as an observer. If you are interested in attending as a presenter or observer, please view our Proposed Local Coverage Determination Open Meetings page for specific guidelines and other helpful information.

The following Local Coverage Determinations (LCDs) have been revised in response to reconsideration requests and are now posted as Proposed LCDs. The Proposed LCDs are open for comments related to the current revisions only. Please refer to the Synopsis of Changes, Summary of Evidence and Analysis of Evidence sections for information pertinent to the revisions that are open for comment. The comment period will end on December 15, 2019.

- Biomarkers for Oncology (DL35396)
- Thrombolytic Agents (DL35428)

Submit Comments

The following draft Billing and Coding articles are related to the above Proposed LCDs. The articles contain the applicable CPT/HCPCS codes, ICD-10 Codes and billing and coding information.

- Billing and Coding: Biomarkers for Oncology (DA52986)
- Billing and Coding: Thrombolytic Agents (DA55237)

Self-Administered Drug Exclusion List, A53127

This article has been revised and posted for notice.
The article will become effective December 2, 2019. CLICK HERE

Modifier JB Use for Drugs/Biologicals included on the Self-Administered Drug Exclusion List
Several drugs/biologicals that are considered self-administered and included on the Novitas Self-Administered Drug (SAD) Exclusion List may be administered intravenously or subcutaneously. Effective with claims submitted for dates of service on or after December 2, 2019, Novitas will require the use of the Healthcare Common Procedure Coding System modifier when reporting subcutaneous administration of a drug/biological that is included on the Novitas SAD Exclusion List.

Further information regarding Self-Administered Drugs is found on the Medical Policy Drugs & Biologicals: Self-Administered Drug Exclusions page.

Part B Top Claim Submission/Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for September 2019 for 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. CLICK HERE

Changes to Amount in Controversy (AIC) for Appeals in 2020

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2019 is $160.This amount will increase to $170 for ALJ hearing requests filed on or after January 1, 2020. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2019 is $1,630. This amount will increase to $1,670 for appeals to Federal District Court filed on or after January 1, 2020. READ MORE

Nurse Practitioner Supporting Documentation

When initially enrolling a Nurse Practitioner, there are two supporting documents required to process the application listed below:

- Copy of the Nurse Practitioner's certification
- Master's degree

These documents must be included so that we can verify the requirements to enroll the practitioner in Medicare. If the practitioner does not have a copy of his/her Master's degree, a copy of the Master's degree transcript is acceptable. Please review our article for more information (JH) (JL).

Part B Top Inquiries / Frequently Asked Questions (FAQs)

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for September 2019. Please take time to review these FAQs for answers to your questions.

CLICK HERE

Simplify Your Appeals with Novitasphere

Save your office valuable time by submitting your Appeal Requests through Novitasphere, our free internet portal.

This feature is fast, and easy to use! Complete the Redetermination and Clerical Error Reopening Request form online, upload documentation, and submit. No need to submit your request by mail!

Users can also view Appeal Development Letters for additional information needed to process an appeal, obtain copies of the outcome of appeal decisions through the Medicare Redetermination Notice feature, or check status with the Appeal Status tool under the Self Service Tools link.

To find enrollment instructions, or copies of the User Manual, visit the Novitasphere Portal Center today!

WEBINAR

Novitas Self-Service Tools:

View all Self-Service Tools

Listed are Novitas training events an oncology practice should consider!

Date	Starts	Ends	Event Details	CEUs	Media Type
Tuesday, November 19, 2019	11:00 a.m.	12:00 p.m.	***EDI Enrollment*** This course will improve your understanding of how to locate and complete the EDI Enrollment form to become an electronic submitter	1.0	Webinar
Wednesday, November 20, 2019	10:00 a.m.	11:00 a.m.	***Novitasphere Claim Corrections*** This course will examine how to determine when a claim correction can be performed in Novitasphere and how to complete a clerical reopening. We will also provide examples of claims that can and cannot be updated through the Novitasphere Claim Correction feature.	1.0	Webinar
Thursday, November 21, 2019	11:00 a.m.	12:00 p.m.	***Novitasphere Hot Topics*** This course will discuss Novitasphere hot topics and provide answers to the most frequently asked questions. We will also provide tips and resources to assist you when using Novitasphere.	1.0	Webinar

To watch for newly posted opportunities and to register…CLICK HERE

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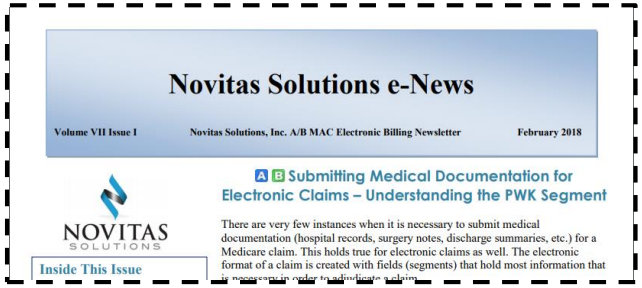
Part B Newsletter

*Current Edition Available...*CLICK HERE

Novitas Solutions e-News Electronic Billing Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



Medicare Part B HOT LINKS!

Medicare JL Part B Fee Schedule
Current Active Part B LCD Policies
Current Average Sales Price (ASP) Files
Quarterly Update to CCI Edits

2020 Proposed Rules

Physician Fee Schedule & QPP
Physician Fee Schedule Fact Sheet
HOPPS
HOPPS Fact Sheet
QPP Fact Sheet
E/M Estimated Level Impact Chart

2020 Final Rules

Physician Fee Schedule Press Release
Physician Fee Schedule and QPP Final Rule
Physician Fee Schedule Fact Sheet
Quality Payment Program Fact Sheet
HOPPS Final Rule
HOPPS Fact Sheet

On-Demand *Education*

- Weekly Audio Podcasts
- Training Modules
- 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 *

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HMS welcomes you to RAC-Info!
To visit the website CLICK HERE

MOST RECENT RAC ISSUE BEING INVESTIGATED THAT MAY BE IMPORTANT TO AN ONCOLOGY PRACTICE:

Name	Description	Number	Provider Type	Review Type	Date Approved	Posted On	Region 4 States	Region 4 MACS	Dates of Service
Therapeutic, Prophylactic & Diagnostic Infusions: Incorrect Coding and Documentation Requirements	Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.	0161	Outpatient Hospital	Complex	11/04/2019	11/05/2019	All Region 4 States	AB MACs	Claims having a "claim paid date" which is less than 3 years prior to the Demand Letter date

RACmonitor.com

Site Neutral Payment Policy and 340B in the CMS Crosshairs

Both policy issues remain on the CMS agenda, even though the agency has lost two court battles. Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma was probably well aware of what she was walking into last week at the U.S. House of Representatives Energy and Commerce committee hearing….. READ MORE

The Future of Medicare Program Integrity

Earlier this month, President Trump announced an Executive Order charging CMS to propose annual changes to combat waste, fraud, and abuse in the Medicare program. That's why I'm proud to announce our vision to modernize our program integrity methods to better protect taxpayers from fraud, waste and abuse in Medicare. Every dollar spent on Medicare comes from American taxpayers and must not be misused. READ MORE

Home Health Agencies: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit

For More Information:
Final Rule
Press Release
HH PPS website
HHA Center website
PDGM webpage
Home Infusion Therapy Services website
Home Health Quality Reporting Requirements webpage
HHVBP Model webpage

See the full text of this excerpted CMS Fact Sheet (Issued October 31).

Quality Payment Program: Participation Status Tool Includes Second Snapshot of Data

CMS updated the Quality Payment Program Participation Status Tool based on the second snapshot of data from Alternative Payment Model (APM) entities. The second snapshot includes data from Medicare Part B claims with dates of service between January 1 and June 30, 2019. The tool includes 2019 Qualifying APM Participant (QP) and Merit-based Incentive Payment System APM participation status. To learn more, see the QP Methodology Fact Sheet.

Telehealth Services — Reminder

The Telehealth Services Medicare Learning Network Booklet is available. Learn about:
Requirements
Distant site practitioners
Billing and payment for the originating site facility

Physician Self-Referral Regulations Proposed Rule

Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the "Stark Law"), which has not been significantly updated since it was enacted in 1989. The proposed rule supports the CMS "Patients over Paperwork" initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law's goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve - allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For More information:

- Proposed Rule: Public comments due by December 31
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 9).

Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

A recent Office of the Inspector General (OIG) report noted that, in some cases, pharmacies incorrectly billed Medicare Part B for claims using the KX modifier for immunosuppressive drugs. It is estimated that Medicare paid $4.6 million for these claims that did not comply with Medicare requirements.

Continued on next page...

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In response to this report, CMS clarified manual instructions on the use of the KX modifier to help pharmacies document the medical necessity of organ transplant and eligibility for Medicare coverage. Resources for pharmacies:

- Pharmacy Billing of Immunosuppressive Drugs MLN Matters Article
- Clarification of the Billing of Immunosuppressive Drugs MLN Matters Article
- CMS and Its Claims Processing Contractors Issued Conflicting Guidance on the Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims OIG Report

Quality Payment Program: MIPS Dates and Deadlines

Important Merit-based Incentive Payment (MIPS) dates and deadlines:

- December 31 – 2019 Promoting Interoperability Hardship Exception and Extreme and Uncontrollable
- Circumstances Applications deadline
- December 31 – 2020 virtual group election period closes
- January 2 – 2019 MIPS performance period data submission window opens
- March 31 – 2019 MIPS performance period data submission window closes

For More Information:

- Quality Payment Program website
- 2020 Virtual Groups Toolkit
- Improvement Activities webpage
- 2019 Improvement Activities Fact Sheet
- 2019 Improvement Activities Quick Start Guide
- Promoting Interoperability webpage
- 2019 Promoting Interoperability Fact Sheet
- 2019 Promoting Interoperability Quick Start Guide
- For questions, contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Recent LearnResource & MedLearn Matters Articles

- Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N
- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS
- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Quality Payment Program: New 2019 Resources

CMS posted new resources to the Quality Payment Program (QPP) Resource Library webpage:

- 2018 Targeted Review User Guide: How to ask CMS to review your 2020 Merit-based Incentive Payment System (MIPS) payment adjustment
- MIPS Data Validation and Audit Overview: Overview of the process that will be conducted in 2019 for the 2017 and 2018 performance years
- MIPS Data Validation File Upload Instructions Video: Walks through the process to securely upload and submit a MIPS Data Validation File to CMS
- Complex Patient Bonus Fact Sheet: Overview, eligibility requirements, and how the bonus is determined and calculated
- 2019 QPP Clinician Role Demo Video: Demonstrates the steps to add the QPP clinician role, which allows you to view your MIPS eligibility details, performance feedback, and payment adjustment

For More Information:

- 2018 Targeted Review FAQs
- 2017 MIPS Data Validation Criteria and 2018 MIPS Data Validation Criteria: Criteria used to audit and validate data submitted in each performance category
- QPP Access User Guide: Add the QPP clinician role or access the QPP portal
- QPP Resource Library webpage
- QPP website
- For questions, contact your local technical assistance organization, QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Independence | PROVIDER News Center

BriovaRx Specialty Pharmacy and Infusion Services has become Optum Specialty Pharmacy and Optum Infusion Pharmacy

As of October 1, 2019, and continuing throughout 2020, FutureScripts®, our pharmacy benefits manager, will be changing the names of their specialty pharmacy and infusion services programs from BriovaRx to **Optum® Specialty Pharmacy** and **Optum®Infusion Pharmacy**. READ MORE

Independence offers language assistance services to help members and their beneficiaries communicate

Read the article

Avoid documentation cloning

Medical record reviews conducted by Independence's Corporate and Financial Investigations Department (CFID) have shown that providers are billing higher levels of evaluation and management services based upon cloned documentation rather than the actual service provided

Read Article

Independence | PROVIDER News Center

Updates to the medical benefit specialty drug cost-sharing list for 2020

Effective January 1, 2020, Independence will update its list of specialty drugs that require member cost-sharing (e.g., copayment, deductible, and coinsurance). Cost-sharing applies to select medical benefit specialty drugs for members who are enrolled in Commercial FLEX products and other select plans. The member's cost-sharing amount is based on the terms of the member's benefit contract. In accordance with your Provider Agreement, it is the provider's responsibility to verify a member's individual benefits and cost-share requirements.

The cost-share list will be expanded to include 186 drugs, including the following additions: READ MORE

Medicare Advantage plans: What's new for 2020

Starting January 1, 2020, Independence will offer several new and innovative benefits to our Keystone 65 Basic HMO, Keystone 65 Focus HMO-POS, Keystone 65 Preferred HMO, Keystone 65 Select HMO, and Personal Choice 65SM PPO members. With no copayment or premium increases, these new benefits are centered around improving affordability for members. Below is a summary of new offerings and changes.

READ MORE

Updates to the list of specialty drugs that will require precertification

Effective January 1, 2020, the following specialty drugs, which are eligible for coverage under the medical benefit for Independence commercial and Medicare Advantage HMO and PPO members, will require precertification:

READ THE LIST OF DRUGS – CLICK HERE

HIGHMARK BLUE SHIELD

CHANGES IN AUTHORIZATION REQUIREMENTS FOR OUT-OF-NETWORK OUTPATIENT SERVICES EFFECTIVE JANUARY 1, 2020

READ MORE

PRIOR AUTHORIZATION LIST TO BE UPDATED ON DECEMBER 1, 2019

*** POHMS MEMBERS – Be sure to read this article as a number of drugs are being removed from the Prior Authorization List Effective December 1!

READ MORE

IN CASE YOU MISSED IT... A RECAP OF IMPORTANT NEWS FOR PROVIDERS

READ MORE

CHANGES TO UNPLANNED INPATIENT HOSPITALIZATION REQUESTS SUBMITTED THROUGH NAVINET EFFECTIVE 12/1/2019

READ MORE

OTHER PAYER UPDATES

PROVIDER NEWS

Most Recent Issue …

CLICK HERE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

Be sure to review the recently released October edition that includes information on:

- Clinical Guidelines Revised for Denosumab (Prolia, Xgeva)
- Preferred Products Established for Bone Resorption Agents for the Treatment of Osteoporosis
- And more non-Hematology/Oncology related updates…

OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

NEW!

A Few Articles You Won't Want to Miss:

Front & Center

- Enhanced Features for Prior Authorization and Notification Tool on Link
- Pharmacy Update: Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and UnitedHealthcare Oxford Plans
- OptumRx Retiring Fax Numbers Used for Pharmacy Prior Authorizations

UnitedHealthcare Commercial

- Site of Service Medical Necessity Reviews for MR/CT Imaging Procedures for UnitedHealthcare Oxford Commercial Benefit Plans – Effective Feb 1, 2020

UnitedHealthcare Medicare Advantage

- Update on Change to National Drug Code Reimbursement Policy for Outpatient Facilities

Doing Business Better

- Medical Records Standards

And Much More...

NOVEMBER Monthly Issue Available HERE

NEW!

Oncology Related Articles You Won't Want to Miss:

Take Note

Implementation Delayed For Medical Benefit Drug Policy Updates

Medical Policy Updates

Revised:

- Genetic Testing for Hereditary Cancer

Medical Benefit Drug Policy Updates

Revised:

- Botulinum Toxins A and B
- Clotting Factors, Coagulant Blood Products & Other Hemostatics
- Erythropoiesis-Stimulating Agents

Utilization Review Guideline

Updated:

- Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service

Revised:

- Outpatient Surgical Procedures – Site of Service

NOVEMBER Monthly Issue Available HERE

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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 biosimlar pegfilgrastim-bmez (Ziextenzo, Sandoz, a Novartis division) indicated to decrease the incidence of infection, as manifested by febrile neutropenia (low white blood cell count with a fever), in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. More Information. November 5, 2019

- FDA approved niraparib (ZEJULA, Tesaro, Inc.) for patients with advanced ovarian, fallopian tube, or primary peritoneal cancer treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD)-positive status. HDR is defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability in patients with disease progression greater than six months after response to the last platinum-based chemotherapy. More Information. October 23, 2019

A severe shortage hits a drug used for cancer, immune disorders, epilepsy, causing canceled treatments and rationing

A severe shortage of immune globulin — a popular medicine used to treat epilepsy, cancer and immune disorders — is forcing doctors nationwide to cancel patients' lifesaving infusions, even as hospitals and treatment centers are resorting to rationing and dose-cutting. READ MORE

Product Specific J-code for ELZONRIS' (tagraxofusp-erzs)

The Centers for Medicare & Medicaid Services (CMS) has announced the assignment of a product-specific J-code for ELZONRIS' (tagraxofusp-erzs). The new code, J9269, is defined as Injection, tagraxofusp-erzs, 10 micrograms, and is effective as of October 1, 2019.

ASCO in Action

New Policy Brief Explains How Co-pay Accumulators, Maximizers Increase Cost of Cancer Care for Patients

(ASCO in Action) Oct 30, 2019 - Health insurers, employers, and pharmacy benefit managers (PBMs) have shifted a growing share of the costs for specialty prescription medicines to their patients and beneficiaries.

READ ARTICLE

Patients Need Protection from Surprise Medical Bills, Organizations Tell Congress

(ASCO in Action) Oct 30, 2019 - In a letter to leaders of the U.S. Senate and House of Representatives, ASCO, along with more than 100 other medical groups, urged Congress to protect patients from unanticipated, or "surprise," medical bills that can occur when gaps in health insurance coverage lead them to receive care from out-of-network providers.

READ ARTICLE

CHECK OUT OUR LATEST ISSUE....
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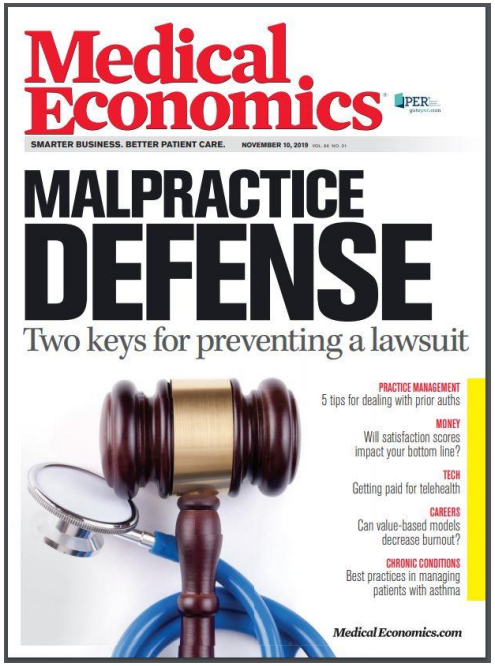

HHS Proposal to Reform of Stark Law and Anti-Kickback Statute is Good First Step, But More Changes Needed

October 10, 2019 - The Community Oncology Alliance (COA) applauds the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) for today's announcement proposing changes to modernize the Physician Self-Referral Law (the Stark Law) and the Federal Anti-Kickback Statute.

READ MORE

Reimbursement Questions & Answers

If you have reimbursement questions you need answers to, please submit them to the Editor at Michelle@WeissConsulting.org

Question: Are there clinics that bill the interprofessional telephone/internet/electronic health record consultations? (99446 – 99451) If so, do they have issues with reimbursement? What can you share with me on this service?

Answer: These services were updated and new codes added in the Physician Fee Schedule Final Rule in 2019. Below is some information that should help:

The code descriptors for Interprofessional Internet Consultations are as follows:
CPT 99446: *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review (National Medicare Fee schedule is $18.38)*
CPT 99447: *Same as 99446, but 11-20 minutes of medical consultative discussion and review (Fee schedule is $36.48)*
CPT 99448: *Same as 99446, but 21-30 minutes of medical consultative discussion and review (Fee schedule is $54.78)*
CPT 99449: *Same as 99446, but 31 minutes or more of medical consultative discussion and review (Fee schedule is $72.80)*
CPT 99451: *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time (Fee schedule is $37.48)*
CPT 99452: *Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes (Fee schedule is $37.48)*

Beginning January 1, 2019, physicians and other Qualified Healthcare Providers ("QHCPs") eligible to independently bill for E/M services can obtain standalone reimbursement for Interprofessional Internet Consultations according to the following parameters:

Billing Practitioner - Billing for interprofessional services is limited to those practitioners that can independently bill Medicare for E/M services. Though the descriptors for codes 99446-99449 and 99451 only include "assessment and management service provided by a consultative physician," the text in the Rule includes consultative QHCPs, so long as the consulting QHCP is eligible to independently bill Medicare for E/M services. CPT Code 99452 applies to the treating/referring physician or QHCP and the consultant of the codes apply to the consultative physician or QHCP.

Answer continued on next page...

Answer continued from previous page...

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Consent -Verbal patient consent must be documented in the patient's medical record for each consultation. The patient's consent must include assurance that the patient is aware of applicable cost-sharing.

Cost Sharing - Providers must collect the requisite copayment from the patient for each service billed, as with all Medicare Part B services.

Benefit of the Patient - The consultation must be undertaken for the benefit of the patient. Because the patient is going to be responsible for cost-sharing, CMS is concerned about distinguishing these Interprofessional Internet Consultations from those undertaken for the edification of the practitioner, such as information shared as a professional courtesy or as continuing education.

****

Question: I heard the E & M documentation requirements are changing (for the better) but, we were wondering if this change is for 2020? Did they adopt the one payment for all model? Have you heard anything?

Answer: The Physician Fee Schedule Final Rule for 2020 was released recently and did finalize the Evaluation and management (E/M) changes, however the changes are effective in 2021, not 2020. Below is a summary of the changes:

CMS finalized its proposal to pay separately for nine different levels of E/M visits in calendar year 2021 — levels one through four for new patients (current procedural terminology [CPT] codes 99202–99205) and levels one through five for established patients (CPT codes 99211–99215). This is a reversal from the blended payment rates CMS proposed in the 2019 Final Rule, which would have consolidated the payment rate for levels two through four for new and established patients beginning in CY 2021.

The overall goal was to reduce the documentation burden. CMS has adopted revised E/M code definitions developed by the AMA CPT Editorial Panel starting Jan. 1, 2021. Below is a summary of this revisions:

- Eliminate history and physical as elements for code section: While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level. The workgroup revised the code descriptors to state providers should perform a "medically appropriate history and/or examination"

Answer continued on next page...

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Answer continued from previous page...

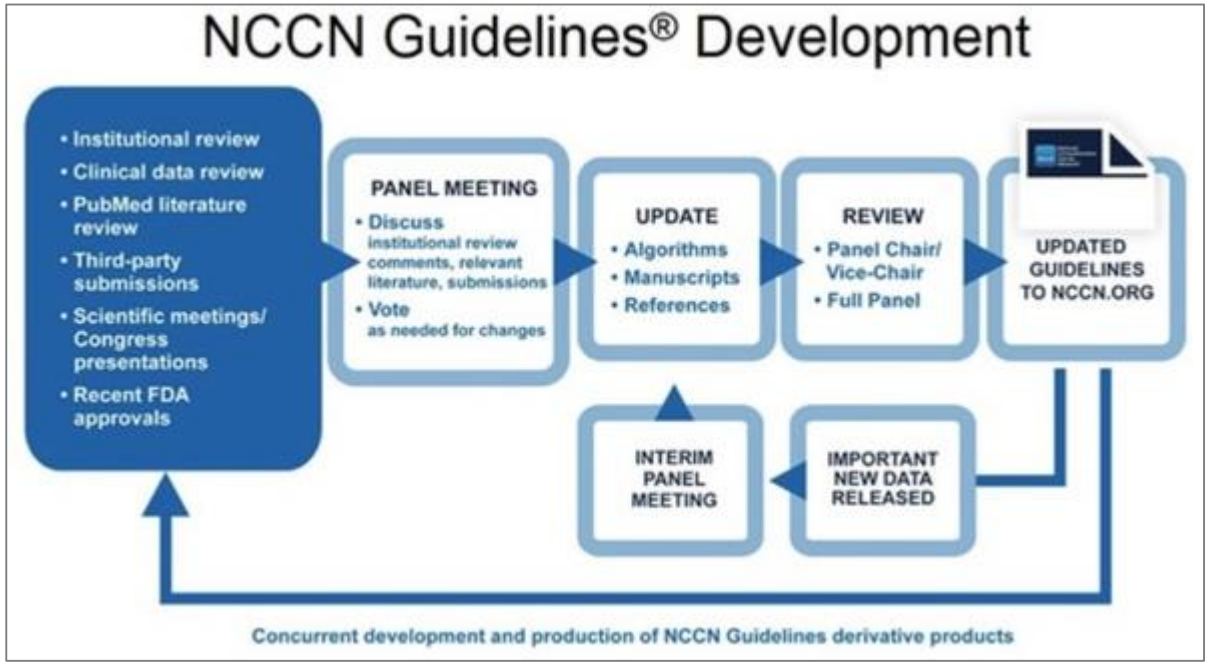
- Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time: MDM: The Workgroup did not materially change the three current MDM sub-components, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines. (See below for additional discussion.)
- Time: The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and not MDM.
- Modifications to the criteria for MDM: The Panel used the current CMS Table of Risk as a foundation for designing the revised required elements for MDM. Current CMS Contractor audit tools were also consulted to minimize disruption in MDM level criteria. Removed ambiguous terms (e.g. "mild") and defined previously ambiguous concepts (e.g. "acute or chronic illness with systemic symptoms"). Also defined important terms, such as "Independent historian."
- Re-defined the data element to move away from simply adding up tasks to focusing on tasks that affect the management of the patient (e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP).
- Deletion of CPT code 99201: The Panel agreed to eliminate 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.
- Creation of a shorter prolonged services code: The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

To review the specific details about these changes, refer to the 2020 Final Rule and/or review the CPT Editorial Panel summary CLICK HERE

Continued on next page...

Question: Our physician is treating a patient for a diagnosis that is not listed in NCCN for the drug he is using. We are afraid we will not be reimbursed since it is a Medicare patient. What do we need to do to get NCCN to add this diagnosis? Our physician says there is a ton of clinical evidence to support this indication.

Answer: **Answer**: NCCN Guidelines have a "Development Process"



To request an indication to be reviewed, you will submit your request directly to NCCN. The guidelines and information related to the information required with your submission is found on the NCCN website. CLICK HERE to review their detailed instructions.

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Our Mission

POHMS provides education and operational best practices to Hematology Oncology members through professional development and networking. The organization empowers members by creating an environment of support, collaboration and continuous learning.

Vision Statement

Active leadership and unity for all POHMS members to thrive in the evolving Hematology Oncology community.

Values Statement

At POHMS, we are committed to the highest standards of ethics and integrity and strongly believe that we are responsible to our members, stakeholders, and to the communities we serve. As a part of our responsibility, we strive to create an environment of continuous learning and improvement in the oncology hematology industry.

We are passionate about the success of our members. Our driving innovation and commitment to personal and professional development makes an invaluable resource. Educational programs and professional meetings help foster a network of growth, support, and collaboration. The sharing of ideas and trends enable POHMS to continue to build upon our tradition of innovation.

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