pohms

PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

We at POHMS wish everyone a Happy Holiday season and a prosperous New Year!

The POHMS newsletter

CELEBRATING 25 YEARS 1994-2019

Issue 71 DECEMBER '19

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

INSIDE THIS ISSUE | POHMS newsletter Issue 71 | DECEMBER '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.

TABLE OF CONTENTS

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

This newsletter is intended for informational purposes only. Information is provided for reference only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions.

CPT codes are owned and trademarked by the American Medical Association. All right reserved.

No portion of this publication may be copied without the express written consent of POHMS. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than POHMS.

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

Step Therapy in Oncology: It's Complicated

(ACCCBuzz Blog) Nov 18, 2019 - For health plans, the impetus for step therapy—and the integration of pharmacy benefit managers (PBMs) and treatment pathways into the care process—is to lower costs, improve quality of life, and ensure that patients receive the most preferred therapy. READ ARTICLE

ASCO Resolutions on Step Therapy and QPP Adopted at AMA House of Delegates Interim Meeting

(ASCO in Action) Nov 22, 2019 - During the American Medical Association (AMA) House of Delegates (HOD) interim meeting this month, delegates approved several ASCO-backed resolutions and incorporated them into the AMA's advocacy agenda. READ ARTICLE

ASCO Launches Update to the Patient-Centered Oncology Payment Model

The American Society of Clinical Oncology (ASCO) announces that it is rolling out a major update to its Patient-Centered Oncology Payment (PCOP) model – an alternative payment model designed to support transformation in cancer care delivery and reimbursement while providing patients with high-quality, high-value cancer care. READ MORE

PBMs, Step Therapy, and QPP Changes Among ASCO's Priorities at AMA Meeting

ASCO's delegates to the American Medical Association's (AMA) House of Delegates (HOD) will propose several resolutions during the policy-making body's interim meeting, which will be held November 16-19, 2019. READ MORE

Hospitals Blast CMS' Proposed 340B Survey

Hospitals are blasting the Trump administration's move to survey them about drugs covered under the 340B discount program, saying the survey request will cost too much and is flawed. READ MORE

Hospital Price Transparency Requirements

CY 2020 Hospital Outpatient Prospective Payment System Policy Changes

On November 15, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. In response to comments, CMS is extending the effective date to January 1, 2021 to ensure hospital compliance with these regulations.

The final rule includes:

- Definitions of "hospital," "standard charges," and "items and services"
- Requirements for making public all standard charges for all items and services in a machine-readable format
- Requirements for displaying shoppable services in a consumer-friendly manner
- Monitoring and enforcement

For More Information:

- View the final rule (CMS-1717-F2): This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.
- Press Release
- Registration open for December 3 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 15).

2020 Medicare Physician Fee Schedule Payment Rates and Participation Program

The annual physician and supplier participation period begins January 1st of each year and runs through December 31st. The annual participation enrollment program for calendar year 2020 is scheduled to begin mid-November 2019.

Note: The dates listed for release of the participation enrollment / fee disclosure material are subject to publication of the annual final rule.

The 2020 Medicare Physician Fee Schedule (MPFS) payment rates will be posted to our website after publication of the MPFS final rule in the Federal Register. 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.

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

Medicare Beneficiary Identifier (MBI) Lookup Through Novitasphere

Reminder, the **MBI Lookup tool is available only in Novitasphere**, our free, secure internet portal. Use the Novitasphere **MBI Lookup Tool** to locate your patient's new Medicare MBI number when the patient is unable to provide you with their updated card. Then, update your systems and use the MBI now!

If you are not already enrolled for Novitasphere, we strongly encourage you to enroll and take advantage of all the time saving features Novitasphere has to offer! Visit our Novitasphere Center for enrollment information and forms today!

For questions about Novitasphere, please call the Novitasphere Help Desk at 1-855-880-8424.

Part B Top Inquiries / Frequently Asked Questions (FAQs)

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

Check the Status of Your Claims in Novitasphere

Novitasphere, our free, secure internet portal offers Part B users the ability to quickly check the status of their claims online. Claim status information will appear on the screen, and can be printed for your records or saved to your computer!

The Claim Status feature provides a high-level overview of the Internal Control Number, date of service, billed/allowed/paid amounts, check number, finalized date, and status of the claim.

When viewing claim detail in Novitasphere, you have access to specific information such as the provider information, deductible and coinsurance amounts applied, claim diagnosis codes, procedure codes, and reason code messages.

Claim Status is one of the most utilized features by Novitasphere users! Start saving your office time today: to learn more or enroll now, visit our Novitasphere Center.

Oncology Related Medical Policy Updates

The following Local Coverage Determinations have been revised. The related Billing and Coding articles, if applicable, have been added or revised:

- Biomarkers for Oncology (L35396)
- Biomarkers Overview (L35062)
  - Billing and Coding: Biomarkers Overview (A56541)
- BRCA1 and BRCA2 Genetic Testing (L36715)Billing and Coding:
  - BRCA1 and BRCA2 Genetic Testing (A56542)
- Hemophilia Factor Products (L35111)
  - Billing and Coding: Hemophilia Factor Products (A56433)
- Implantable Infusion Pump (L35112)
  - Billing and Coding: Implantable Infusion Pump (A56778)
- In Vitro Chemosensitivity & Chemoresistance Assays (L36634)
  - Billing and Coding: In Vitro Chemosensitivity & Chemoresistance Assays (A56710)
- Intravenous Immune Globulin (IVIG) (L35093)
  - Billing and Coding: Intravenous Immune Globulin (IVIG) (A56786)
- Multiple Imaging in Oncology (L35391)
  - Billing and Coding: Multiple Imaging in Oncology (A56848)

The following Billing and Coding Articles have been revised:

- Billing and Coding: Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53049)
- Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions (A53132)
- Billing and Coding: Prolonged Drug and Biological Infusions Started Incident To a Physician's Service Using an External Pump (A55134)

NOVITAS SOLUTIONS

WEBINAR

HOME

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 December 10, 2019	11:00 a.m.	12:00 p.m.	***Novitasphere Enrollment Overview*** This course we will discuss the steps to enroll in Novitasphere, including the Enterprise Identity Management (EIDM) registration process.	1.0	Webinar
Tuesday, December 10, 2019	2:00 p.m.	3:00 p.m.	***Medicare Beneficiary Identifier (MBI) Updates*** This course introduces the new Medicare card. We will review the timelines for submitting claims using the new Medicare Beneficiary Identifier, provide updates, and assist you in locating valuable resources.	1.0	Webinar
Wednesday, December 11, 2019	10:00 a.m.	11:30 a.m.	***How to Avoid Top Claim Errors - Part B*** This course will assist you with recognizing the current top claim errors and will provide suggestions on how to avoid them. Topics will focus on an overview Top Claims Errors, Denials vs Rejections, Claim Filing Reminders and suggestions on improving the accuracy of your billing.	1.5	Webinar

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

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

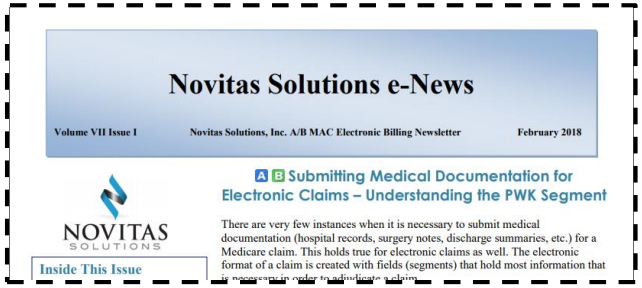
CELEBRATING 25 YEARS 1994-2019

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 *

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

CELEBRATING 25 YEARS 1994-2019

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

Price Transparency: Two Rules for the Same Issue

One rule is proposed; the other is now the final rule on price transparency. The Centers for Medicare & Medicaid Services (CMS) recently issued two rules intended to increase the transparency of pricing in the healthcare system, continuing its efforts to provide patients with more data to make informed decisions about their healthcare choices. READ MORE

Hospitals Price Transparency Rule: Next Stop the Courthouse

Many believe this rule will never see the light of day. Among other provisions, the hospital price transparency rule pre-published by the Centers for Medicare & Medicaid Services (CMS) last Friday requires online, a publically accessible publication of "standard charges" that apply to 300 of each hospital's "shoppable" services. READ MORE

Patients Over Paperwork Newsletter

Read the latest CMS Patients Over Paperwork newsletter for updates about our work to reduce administrative burden:

- Applying a rural lens
- Second anniversary event
- Documentation simplification
- Recovery audit improvements
- New policies
- How to learn more

For More Information:

- Patients Over Paperwork website
- Past Newsletters

Physician Fee Schedule and Hospital OPPS/ASC Call: Audio Recording and Transcript

An audio recording and transcript are available for the November 6 Medicare Learning Network call on the Physician Fee Schedule and Quality Payment Program final rule and the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems final rule. Learn about provisions in these CY 2020 final rules.

Promoting Interoperability Programs: Updated list of eCQMs

CMS updated the list of electronic Clinical Quality Measures (eCQMs), which were finalized in the Medicare Physician Fee Schedule final rule. Visit the eCQI Resource Center website for an updated list and supporting documents for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System and Advanced Alternative Payment Models (Advanced APMs)
- Advanced APM: Comprehensive Primary Care Plus
- Medicaid Promoting Interoperability Program for Eligible Professionals

Remittance Advice Resources and FAQs — Revised

A revised Remittance Advice Resources and FAQs Medicare Learning Network Booklet is available. Learn about:

- How to read institutional or professional Remittance Advice (RA)
- Assigned and unassigned claims
- Balancing an RA

Drug Units in Excess of MUE: Comparative Billing Report in November

In late November, CMS will issue a Comparative Billing Report (CBR) on Drug Units in Excess of Medically Unlikely Edits (MUE), focusing on providers who submit Medicare Part B claims. These reports contain data driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.

CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com to access your report. Update your contact email address in the Provider Enrollment, Chain, and Ownership System to ensure accurate delivery. Visit the CBR website for more information.

MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the establishment and use of Patient Relationship Categories (PRCs) and codes. When tested, the PRCs will be incorporated into the claims-based cost measures, which assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during eight episodes of care. Read MLN Matters Article MM11259, and learn how to report HCPCS Level II modifiers.

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)

Quality Payment Program: 2019 APM Incentive Payment Details

The Quality Payment Program website is updated to include 2019 Alternative Payment Model (APM) incentive payment details. See the fact sheet for more information.

Medicare Telehealth Services Video

A new Medicare Telehealth Services Medicare Learning Network Video is available. Learn about:

- Who can furnish services
- Qualifications for an originating site
- Covered services
- Billing and payment

Recent LearnResource & MedLearn Matters Articles

- Claim Status Category and Claim Status Codes Update
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 — Revised
- Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators
- 2020 ASP Drug Pricing Files

BCBSA high-dollar prepayment claims review policy update

Updated December 2, 2019 - As previously communicated in a *Partners in Health Update*[SM] article, **as of January 1, 2019,** the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® plans, requires all Blue plans to obtain an itemized hospital bill up front, in order to process certain BlueCard® claims for out-of-area members. Providers need to submit an itemized bill when they receive a code on an electronic remittance report (835) and/or paper Provider Remittance as identified below. READ MORE

Professional Injectable and Vaccine Fee Schedule updates effective January 1, 2020

Effective January 1, 2020, updates will be made to our Professional Injectable and Vaccine Fee Schedule for all contracted providers. These updates are made quarterly and reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables as well as any modifications to the percentage premium. READ MORE

New medical and pharmacy product portfolios available for 2020

As previously communicated in a *Partners in Health Update*[SM] article, Independence has introduced new medical and pharmacy product portfolios that will be available to Pennsylvania large group (51+) standard plans for 2020. The new portfolio options will be offered to new and renewing customers beginning with **January 1, 2020,** effective dates.

READ MORE INCLUDING COST EFFECTIVE SITE-OF-SERVICE BENEFIT DIFFERENTIALS

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

REMINDER: 2020 FORMULARY CHANGES ARE COMING

DO ANY OF YOUR MEDICARE PATIENTS NEED NEW PRESCRIPTIONS?

Effective **January 1, 2020**, Highmark will be making specific changes to the medications covered on the formularies that may affect your Medicare patients. We're making these changes to ensure the safe and effective use of prescription medications, as well as to keep prescription medications affordable for our members. READ MORE

CERTAIN DRUGS/PROCEDURE CODES TO BE REVIEWED BY HIGHMARK

Currently, certain procedure codes/drugs below are currently submitted to AllianceRx Walgreens Prime for prior authorization review. **Effective January 1, 2020,** these drugs/procedure codes will be reviewed by Highmark instead of AllianceRx Walgreens Prime. After that date, any prior authorization requests for the codes listed below must be submitted to Highmark for review. READ MORE

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

READ MORE

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

READ MORE

PROVIDER NEWS

Most Recent Issue …

CLICK HERE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

- Coverage Guidelines Revised for Natalizumab (Tysabri)
- Coverage Guidelines Revised for Irinotecan (Camptosar)
- Coverage Guidelines Developed for Levoleucovorin (Khapzory)
- Coverage Guidelines Revised for Eribulin Mesylate (Halaven)
- Coverage Guidelines Revised for Programmed Death Receptor (PD-1)/ Programmed Death-Ligand (PD-L1) Blocking Antibodies
- Coverage Guidelines Revised for Trabectedin (Yondelis)
- Coverage Guidelines Revised for Ocrelizumab (Ocrevus)
- And more non-Hematology/Oncology related updates…

OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

NEW!

UnitedHealthcare NetworkBulletin
An important message to health care professionals and facilities

A Few Articles You Won't Want to Miss:

Front & Center
- Enhancements to the 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
- Changes to Advance Notification and Prior Authorization Requirements
- Dual Special Needs Plan Policy Changes for 2020
- Genetic and Molecular Testing Prior Authorization/Notification Updates
- Outpatient Injectable Chemotherapy and Related Cancer Therapies Prior Authorization/Notification Updates and Reminders for Specialty Medical Injectable Drug Processes

UnitedHealthcare Commercial
- UnitedHealthcare Will Reward Care Providers through the Cancer Therapy Pathways Program

UnitedHealthcare Community Plan
- Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement

UnitedHealthcare Medicare Advantage
- National Drug Code Requirement Policy, Professional and Facility Update

And Much More...
DECEMBER Monthly Issue Available HERE

NEW!

UnitedHealthcare Medical Policy Update Bulletin
Medical Policy, Drug Policy & Coverage Determination Guideline (CDG) Updates

Oncology Related Articles You Won't Want to Miss:

Take Note
ANNUAL CPT® AND HCPCS CODE UPDATES

Medical Policy Updates
Revised:
- Omnibus Codes
- Prolotherapy and Platelet Rich Plasma Therapies

Replaced:
- Therapeutic Radiopharmaceuticals

Medical Benefit Drug Policy Updates
Revised:
- Oncology Medication Clinical Coverage

Utilization Review Guideline
Updated:
- Office Based Procedures – Site of Service

Revised:
- Outpatient Surgical Procedures – Site of Service

DECEMBER Monthly Issue Available HERE

CELEBRATING 25 YEARS 1994-2019

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

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 atezolizumab (Tecentriq, Roche) for adults whose non-squamous non-small cell lung cancer (NSCLC) is metazoic. The regulatory decision covers the treatment in combination with the chemotherapy regimen paclitaxel and carboplatin. More Information. December 4, 2019
- FDA approved acalabrutinib (CALQUENCE, AstraZeneca) for adults with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). More Information. November 21, 2019
- FDA approved givosiran (GIVLAARI, Alnylam Pharmaceuticals, Inc.) for adults with acute hepatic porphyria (AHP). More Information. November 20, 2019
- FDA approved crizanlizumab-tmca (ADAKVEO, Novartis) to reduce the frequency of vaso-occlusive crises (VOCs) in adults and pediatric patients aged 16 years and older with sickle cell disease. More Information. November 15, 2019
- FDA granted accelerated approval to zanubrutinib (BRUKINSA, BeiGene, Ltd.) for adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. More Information. November 14, 2019
- FDA approved luspatercept-aamt (REBLOZYL, Celgene Corp.) for treatment of anemia in adult patients with beta thalassemia who require regular red blood cell transfusions. More Information. November 8, 2019

CMS Administrator Seema Verma Criticizes High Drug Launch Prices

At the recent Milken Institute's Future of Health Summit in Washington, DC, Centers for Medicare and Medicaid Services ("CMS") Administrator Seema Verma spoke about new drug launch prices and posed the question "What is too high?" READ MORE

Mounting Drug Shortages Delay Treatments For Patients With Bladder Cancer

(CNBC) Nov 27, 2019 - BCG is one of more than a 100 drugs listed by the Food and Drug Administration as in shortage this year. READ ARTICLE

ONS-ASCO Webinar on Offering Clinical Trials to Patients

The Oncology Nursing Society (ONS) and ASCO will co-host a free webinar, Offering Clinical Trials Can Make a Difference: Patient and Care Team Perspectives, on December 11 from 3:00 – 4:00 PM (EST).

A cancer survivor, community oncologist, and research nurse will share their perspectives on the benefits and challenges of being involved in clinical trials, especially in the community setting. They will offer practical strategies and resources to increase clinical trial access and participation, including how to effectively discuss clinical trials with patients and colleagues.

REGISTER NOW

Featured speakers:

- Daniel B. Flora, MD, PharmD
  Medical Oncology Research Director
  St. Elizabeth Cancer Center
- Leila Hamroun-Yazid, AIA, NCARB, LEED AP
  Founding Member of the Oncology Patient Advocates for Clinical Trials (OPACT) Group
  Helen F. Graham Cancer Center & Research Institute in the Christiana Care Health System
- Michele Lacy, RN, BSN, OCN
  Administrative Director
  Metro Minnesota Community Oncology Research Consortium

ASCO News for Patient Advocates

ASH Releases New Clinical Practice Guidelines on Immune Thrombocytopenia

(ASH) Dec 3, 2019 - Evidence-based guidelines to drive improved care for patients with ITP.

READ PRESS RELEASE

CHECK OUT
OUR LATEST ISSUE....
CLICK HERE

Reimbursement Questions & Answers

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

Question: For outpatient hospital supervision, what are the definitions of Direct and General Supervision?

Answer: Direct Supervision – Physician must be "immediately available" and "interruptible" to provide assistance and direction, but does not need to be present in the room.
General Supervision – (from the 2020 Final Rule) - The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.
OF NOTE: In the 2020 Final Rule, CMS further stated: "providers have the flexibility to establish what they believe is the appropriate level of physician supervision for these procedures, which may well be higher than the requirements for general supervision."

****

Question: What are the list of services covered at a Skilled Nursing Facility under the bundled payment for Medicare A?

Answer: This answer is complex because while a certain drug may be excluded, the supportive care might not be. Below is a link to an MLN article that explains what is included and excluded. *Pay particular attention to page 4 of this MLN Document.* CLICK HERE

Here is also an older, but good article on this subject as well. CLICK HERE

And a newer ASCO article. CLICK HERE

****

Continued on next page...

Question: When can a pre-existing condition be applied to a Medicare-gap insurance product?

Answer: GENERALLY, when purchasing a Medigap policy, the insurance company is allowed to engage a pre-existing waiting period of up to, but not longer than, 6 months.

However, if the Medigap plan is purchased during a patients "guaranteed issue right" (which is within 63 days of when they lose or end certain kinds of health coverage) or during "open enrollment" then the insurance cannot impose a pre-existing waiting period.

Here is a link to a good article with more information on this subject. CLICK HERE

****

Question: Were there any big changes the Administration codes in the 2020 CPT?

Answer: There were NO changes in the Administration section of the AMA CPT in 2020.

****

Question: What are the 2020 codes for Chronic Care Management where we only have to be monitoring ONE chronic condition? Can a specialist (like oncology) use these codes?

Answer: You will want to review G2064 - for at least 30 minutes per month of services provided by a physician or other qualified health care professional & G2065 - for at least 30 minutes per month for services performed by clinical staff under the direction of a physician or other qualified health care professional, and also the additional time code G2058.

****

Continued on next page...

Question: We have a Medicare Advantage plan that is implementing a step edit on a patient who has been on the same medication for a long time. Are they allowed to make a patient change a medication that is working for them?

Answer: No, under the provision, a step-edit can only be implemented if it is a new prescription. You will want to refer to the CMS Memorandum for the information to report this Advantage plan:

CLICK HERE for link to Memorandum. CLICK HERE for FAQ.

****

Question: Can you provide the Oncology Specific HCPCS Code Changes for 2020?

Answer:

NEW Oncology Related HCPCS Codes for 2020 (*list not all inclusive*)	
J9030	Bcg live intravesical 1mg
J9036	Inj. belrapzo/bendamustine
J9118	Inj. calaspargase pegol-mknl
J9119	Inj., cemiplimab-rwlc, 1 mg
J9199	Injection, infugem, 200 mg
J9204	Inj mogamulizumab-kpkc, 1 mg
J9210	Inj., emapalumab-lzsg, 1 mg
J9269	Inj. tagraxofusp-erzs 10 mcg
J9309	Inj, polatuzumab vedotin 1mg
J9313	Inj., lumoxiti, 0.01 mg
J9356	Inj. herceptin hylecta, 10mg
Q5112	Inj ontruzant 10 mg
Q5113	Inj herzuma 10 mg
Q5114	Inj ogivri 10 mg
Q5115	Inj truxima 10 mg
Q5116	Inj., trazimera, 10 mg
Q5117	Inj., kanjinti, 10 mg
Q5118	Inj., zirabev, 10 mg

CORPORATE ALLIES

HOME

DIAMOND LEVEL

AMGEN
AstraZeneca
Bristol-Myers Squibb
Celgene
CHOC Community Hematology Oncology Consortium
Daiichi-Sankyo
Genentech A Member of the Roche Group
McKESSON Empowering Healthcare
Takeda ONCOLOGY

GOLD LEVEL

ARRAY BIOPHARMA
astellas
Incyte
Lilly
MERCK
NOVARTIS
pharmacyclics

SILVER LEVEL

ALEXION
janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson
Oncology Supply AmerisourceBergen Specialty Group
SANDOZ Biopharmaceuticals
SANOFI
TAIHO ONCOLOGY Making the human connection

pohms PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

CELEBRATING 25 YEARS 1994-2019

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.

POHMS Committees

By-Laws
CHAIR: Diane Carter

Finance Committee
CHAIR: Roxanne Alessandroni

Marketing/Membership Development
CHAIR: Ellen Bauer

Programs Committee
CHAIR: TBD

POHMS Board of Directors

Executive Committee
Diane Carter, MSN, RN
President

Roxanne Alessandroni
Treasurer

Ellen Bauer, BSN, RN
Secretary

Board of Directors
Alice Hopkins
Diane Minter

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

CELEBRATING 25 YEARS 1994-2019