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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 73 FEBRUARY '20

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

TABLE OF CONTENTS

Save The Dates!!

POHMS Annual Spring Conference
Sheraton Valley Forge
King of Prussia, PA
Thursday, April 2, 2020

POHMS Annual Fall Conference
The Hotel Hershey
Hershey, PA
November 5-6, 2020

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

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POHMS Board of Directors Vacancy

Anyone interested in being a part of the POHMS Board of Directors please contact Fran at 908-442-7156 or fran@pohms.com

REMINDER:
POHMS Member Educational Reimbursement Policy

Requirements:

- Letter of Request, must indicate use and have practice physician signature
- Due to limited funds, the Letter of Request must be submitted a minimum of 30 days prior to the event
- POHMS Executive Committee will review your request within one week upon receipt to POHMS
- Practice will then be notified of approval or denial via email
- POHMS will reimburse up to $500 per practice/ per year of acceptable expenses.
  (Acceptable expenses include: registration fees, hotel and travel costs, and meals)
- Proof of attendance and original receipts must be submitted for reimbursement along with a completed expense report.

This program is available ONLY to paid POHMS Members.

CMS Expands Coverage of Next Generation Sequencing for Patients with Breast and Ovarian Cancer

The Centers for Medicare and Medicaid Services is now covering Food and Drug Administration approved or cleared laboratory diagnostic tests using Next Generation Sequencing for patients with inherited ovarian or breast cancer. Why this matters: as a result of the decision, more Medicare patients will have access to Next Generation Sequencing (NGS) in managing other types of inherited cancers to reduce mortality and improve health outcomes.

To read the press release CLICK HERE.

COA Survey Finds OCM Participants Willing to Take on Two-Sided Risk

(COA) Jan 30, 2020 - Oncology practices participating in the Centers for Medicare & Medicaid Innovation's Oncology Care Model (OCM) are willing to take on two-sided risk, according to the results of a survey conducted by the Community Oncology Alliance (COA).

Read Press Release

Patient-Centered Oncology Payment Model Submitted to HHS Alternative Payment Model Advisory Group

The American Society of Clinical Oncology (ASCO), submitted its Patient-Centered Oncology Payment (PCOP) model for consideration by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). READ ARTICLE

FDA Releases Proposed Rule and Draft Guidance on Drug Importation Into U.S.

As part of the Administration's push to lower prescription drug prices, the Food and Drug Administration (FDA) released a proposed rule and draft guidance on drug importation into the Unites States (U.S.).

READ ARTICLE

GAO Calls for More Oversight of 340B Drug Pricing Program

Weaknesses in HRSA oversight of the 340B drug pricing program may result in some hospitals receiving discounts when they are not eligible to participate, a new report from The Government Accountability Office (GAO) found.

READ MORE

Supreme Court Agrees To Hear Potentially Monumental Case Over Extent To Which States Can Regulate PBMs

Pharmacy benefits managers, the controversial middlemen in the drug pipeline, are a favorite target to blame for higher prescription drug costs. A Supreme Court decision on how much oversight states can place on PMBs could send shock waves through the debate over health care costs. In other pharmaceutical news: genetic testing and proprietary data lax oversight of the 340B drug program, a startup with the possible answer to high drug costs, and more.

READ MORE

Part B Top Inquiries / Frequently Asked Questions (FAQs)

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

CLICK HERE

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for December 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

CLICK HERE

Medical Policy

The following articles have been revised to reflect the Annual CPT/HCPCS Code updates effective for dates of service on and after January 1, 2020:

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: Services That Are Not Reasonable and Necessary (A56967)

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, February 11, 2020	11:00 a.m.	12:00 p.m.	***Novitasphere Claim Correction Overview*** 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, February 13, 2020	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
Thursday, February 20, 2020	10:00 a.m.	11:00 a.m.	***Part B Ask the Contractor Webinar*** The ACT gives providers the opportunity to ask representatives from our operational departments general questions on a variety of topics. The ACT will review topics of provider interest on: CERT errors, Electronic Data Interchange (EDI), enrollment reminders, Medicare quarterly updates, website improvements, and upcoming initiatives.	1.0	Webinar

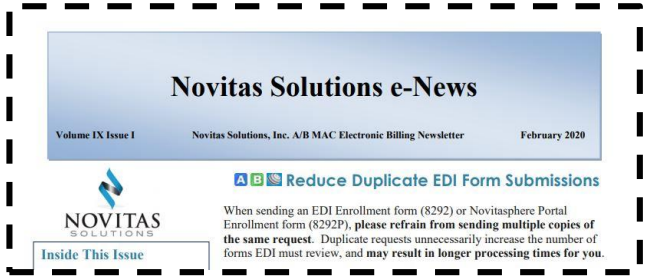
To watch for newly posted opportunities and to register…CLICK HERE

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
H O T L I N K S !

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 *

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
Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria.	0171	Outpatient Hospital	Complex	12/12/2019	12/16/2019	All Region 4 States	AB MACs	"Claim paid date" which is less than 3 years prior to the Demand Letter date

RACmonitor.com

340B Health President Notes "Cautious Optimism" in Moving Forward in 2020

2019 was another very busy year for people involved in the 340B drug pricing program. And it marked the end of a remarkable decade of progress and challenges. READ MORE

To Sign or Not to Sign: A Provider's Responsibility

The absence of a physician's signature should not result in denial of a Medicare claim. READ MORE

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CMS Updates Open Payments Data

CMS updated the Open Payments Data Set to reflect changes to the data that took place since the last publication in June 2019. The refresh includes:

- Record updates: Changes to non-disputed records that were made on or before November 15 are published.
- Disputed records: Dispute resolutions completed on or before December 31 are displayed with the updated information. Records with active disputes that remained unresolved as of December 31 are displayed as disputed.
- Record deletions: Records deleted before December 31 were removed from the Open Payments database. Records deleted after December 31 remained in the database, but will be removed during the next data publication in June 2020.

CMS updates the Data Set at least once annually to include updates from disputes and other data corrections made since the initial publication of the data.

For More Information:
Open Payments website

- Resources webpage
- Submit questions to openpayments@cms.hhs.gov or call 855-326-8366 (TTY: 844-649-2766)

Quality Payment Program: 2019 Data Submission Videos

CMS posted new Quality Payment Program (QPP) FAQs and videos to help you submit your 2019 Merit-based Incentive Payment System (MIPS) data. The submission period closes on March 31 at 8 pm ET.

Data Submission Demonstration Videos:

- Introduction and Overview of 2019 Data Submission
- File Upload and Quality Scoring
- Manual Attestation of Improvement Activities Measures
- Manual Attestation of Promoting Interoperability Measures

Opt-In Demonstration Videos:

- Opt in as a QPP Eligible Clinician
- Opt in as a Registry

2019 Web Interface Demonstration Videos: Series of videos on Excel templates, data irregularities, planning the work, PREV-10, resolving errors, 2019 data submission, and tracking progress

For More Information:

- Resource Library webpage
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Recent LearnResource & MedLearn Matters Articles

- Outpatient Prospective Payment System (OPPS) Pricer
- January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder
- 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 — Revised
- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Quality Payment Program: 2020 Resources

CMS posted new Quality Payment Program (QPP) resources to help you understand how to participate in the 2020 performance period:

Merit-based Incentive Payment System (MIPS) Quick Start Guides:

- Overview
- Eligibility and Participation
- Part B Claims Reporting
- Quality Performance Category
- Promoting Interoperability Performance Category
- Improvement Activities Performance Category
- Cost Performance Category

Other resources:

- MIPS Data Validation Criteria
- Quality Benchmarks
- Shared Savings Program and QPP Interactions Guide
- Scores for MIPS Alternative Payment Models (APMs) Improvement Activities
- Comprehensive List of APMs
- Qualified Registries Qualified Posting
- Qualified Clinical Data Registries Qualified Posting

For More Information:

- Resource Library webpage
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Independence | PROVIDER News Center

Now in effect:
Seven drugs added to the Most Cost-Effective Setting Program

Posted February 3, 2020
Independence seeks to ensure that our members receive injectable/infusion therapy drugs in a setting that is both safe and cost-effective. Read more and see the list CLICK HERE

Independence among Blue Cross® and Blue Shield® companies partnering with Civica Rx

Posted January 23, 2020
Independence, along with the Blue Cross Blue Shield Association, and 18 other Blue Cross and Blue Shield (BCBS) companies announced a partnership with the nonprofit Civica Rx (Civica, Inc.) to form a new company that intends to lower prices of select high-cost generic drugs. READ MORE

Medical codes for services that require precertification

A list of services that require preapproval/precertification from Independence prior to being performed for our members is available for providers on our Medical Policy Portal. This list, *Services that require precertification,* includes the CPT® and HCPCS codes, where applicable, that correlate with the services and injectable drugs that are included on our Preapproval/Precertification List.

To access *Services that require precertification,* visit our Medical Policy Portal. Links to *Services that require precertification* have also been added to the Quick Links section on the right-hand side of this page.

Independence | PROVIDER News Center

Changes to reimbursement of consultation codes for commercial members

Effective April 15, 2020, Independence will update its reimbursement position on the Current Procedural Terminology (CPT®) codes used to report consultation services provided to Independence's commercial members. READ MORE

Enhanced claim edits to support correct coding principles and important information about professional reporting of observation care

Posted January 8, 2020
Observation care is a well-defined set of specific, clinically appropriate services that include short-term treatment, assessment, and reassessment, which are furnished to a patient while a decision is being made to determine if the patient will require admission as an inpatient or can be discharged. READ MORE

Improved method to contact our Provider Network Services team

Posted January 14, 2020
The Independence Provider Network Services (PNS) team, is committed to making it easier for our providers to do business with us. Despite the constant challenges within our industry, we are working hard every day to meet the rising needs of our provider network. READ MORE

Clinical documentation improvements and general coding tips for Medicare Advantage members

Posted January 14, 2020
We used existing guidelines and best practices of diagnosis coding to develop a dedicated Medicare Risk Adjustment webpage to assist our providers in accurately coding and documenting diagnoses for our Medicare Advantage members. READ MORE

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REMINDER: AUTHORIZATIONS REQUIRED FOR OUT-OF-NETWORK OUTPATIENT SERVICES EFFECTIVE JANUARY 1, 2020

Posted January 13, 2020
Beginning January 1, 2020, Highmark requires authorization for outpatient services on the List of Procedures/DME Requiring Authorization when obtained from an out-of-network provider. This requirement applies to Highmark commercial products. READ MORE

HIGHMARK TEAMS WITH CIVICA RX, BLUE CROSS BLUE SHIELD ASSOCIATION TO LOWER OUTPATIENT GENERIC DRUG COSTS

Posted January 23, 2020
Highmark announced that it is a founding member of a new subsidiary designed to ensure that Highmark insurance members continue to have access to affordable generic prescription drugs in outpatient settings. Read their PRESS RELEASE

JANUARY/FEBRUARY 2020 UPDATE CHANGES TO THE HIGHMARK DRUG FORMULARIES

As of January 2020, the formularies and pharmaceutical management procedures will be updated on a bimonthly basis, rather than quarterly, and the following changes reflect the decisions made in November 2019 by our Pharmacy and Therapeutics Committee. CLICK HERE to review!

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HIGHMARK INC.'S ANTI-FRAUD DEPARTMENT USING ARTIFICIAL INTELLIGENCE TO REDUCE FRAUD, WASTE AND ABUSE IMPACT

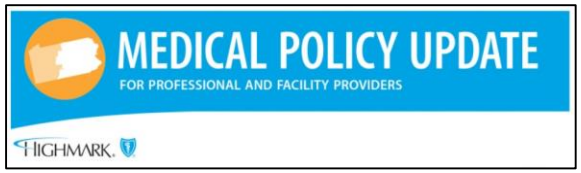
Posted February 3, 2020

Highmark Inc.'s Financial Investigations and Provider Review (FIPR) department made a financial impact of over $260 million in savings related to fraud, waste and abuse in 2019 and has saved more than $850 million over the past five years. In 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 January edition that includes information on:

- Nothing new for oncology this month – there are some 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
- Prior Authorization Submission Enhancements
- Changes to Advance Notification and Prior Authorization Requirements
- Updates to Requirements for Specialty Medical Injectable Drugs - Includes important information on Colony Stimulating Factors

UnitedHealthcare Commercial
- Reimbursement Policy Updates

And Much More…
FEBRUARY Monthly Issue
Available HERE

NEW!

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates

Revised:
- Proton Beam Radiation

Medical Benefit Drug Policy Updates

New:
- Adakveo® (Crizanlizumab-Tmca)
- Givlaari™ (Givosiran)

Revised:
- Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)
- Rituximab (Rituxan®, Ruxience™, & Truxima®)
- White Blood Cell Colony Stimulating Factors

Utilization Review Guideline (URG)

Revised:
- Outpatient Surgical Procedures – Site of Service
- Provider Administered Drugs – Site of Care

FEBRUARY 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

- Food and Drug Administration granted accelerated approval to tazemetostat (TAZVERIK, Epizyme, Inc.) for adults and pediatric patients aged 16 years and older with metastatic or locally advanced epithelioid sarcoma not eligible for complete resection. More Information. January 23, 2020

- Food and Drug Administration approved avapritinib (AYVAKIT, Blueprint Medicines Corporation) for adults with unresectable or metastatic gastrointestinal stromal tumor (GIST) harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including D842V mutations. More Information. January 9, 2020

- Food and Drug Administration approved pembrolizumab (KEYTRUDA, Merck & Co. Inc.) for the treatment of patients with Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors who are ineligible for or have elected not to undergo cystectomy. More Information. January 8, 2020

OTHER NEWS

Rare diseases top another strong year for novel drug approvals

A clutch of swift FDA decisions boosted average US drug approval times in 2019, helping biopharma to deliver another bumper crop of new medicines.

READ ARTICLE

U.S. Officials Will Let Novartis Pay Expenses for Some Kymriah Patients Who Must Travel for Treatment

In an unexpected move, the U.S. Department of Health and Human Services will allow Novartis (NVS) to pay for travel, lodging, and meal expenses for Medicare and Medicaid beneficiaries who must leave home to be administered the Kymriah gene therapy.

READ MORE

Pfizer Brings Three New Biosimilars to U.S. Patients at Substantial Discounts

(Pfizer) Jan 23, 2020 - Pfizer will become the first company to bring three oncology monoclonal antibody (mAb) biosimilar treatments to the U.S. market.

Read Corporate Press Release

PracticeNET Hits the Ground Running in 2020

January 31, 2020 - In January, PracticeNET added three new practices, increasing its total participation to 57 practices. PracticeNET is a free business benchmarking network developed by ASCO to help oncology practices get a handle on their productivity, staffing, revenue, and other measures.

READ MORE

Now Available: January PracticeNET Call Slides

ASCO hosted the January 2020 PracticeNET call on January 16. Access to the agenda and slides are now available. Please visit the ASCO Practice Engagement Program page for more information about ASCO's wide selection of practice-focused programs, or email our Practice Engagement Director Chris LoBiondo.

CLICK HERE

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Understanding the Interplay Between State Medicaid Programs and 340B

The 340B program was established in 1992 by Section 340B of the federal Public Health Service Act (PHSA). The 340B program requires pharmaceutical manufacturers that participate in Medicaid—essentially all pharmaceutical manufacturers—to sell outpatient drugs at discounted prices to the healthcare providers and healthcare programs set forth in the statute, which are known as covered entities. READ MORE

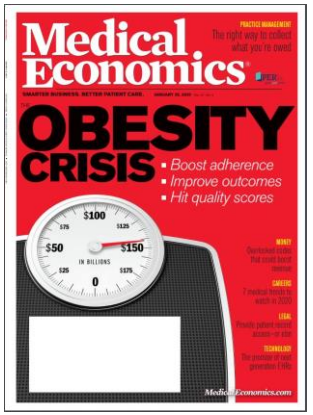
Best Practices for Avoiding 340B Duplicate Discounts in Medicaid

Today, January 8, 2020, the Centers for Medicare & Medicaid Services (CMS) issued an Informational Bulletin to state Medicaid programs on best practices to avoid billing manufacturers for rebates on 340B drugs, also known as duplicate discounts. The incidence of duplicate discounts has increased significantly, specifically with the growth of Medicaid managed care, and the growing number of 340B eligible entities, including contract pharmacies. States should exclude claims filled with 340B drugs from the quarterly rebate requests sent to manufacturers.

With respect to this Information Bulletin, it notes that CMS managed care regulations require that states include a provision in their managed care plan contracts that the managed care plans have a mechanism in place to exclude 340B managed care organization (MCO) utilization from the Medicaid rebate pool data submitted to the state.

Other approaches described in the Informational Bulletin include: carving out 340B entities and contract pharmacies from Medicaid; using specific identifiers on 340B MCO claims, such as National Council for Prescription Drug Programs (NCPDP) or Medicare Part B 340B drug modifiers so they are not included in the Medicaid rebate pool; and using specific Bank Identification Numbers (BIN) and Processor Control Numbers (PCN) on patient identification cards so that the claim can be excluded from the Medicaid rebate pool if 340B claims are carved-out from Medicaid.

Best Practices for Avoiding 340B Duplicate Discounts in Medicaid



CHECK OUT OUR LATEST ISSUE....
CLICK HERE

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Reimbursement Questions & Answers

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

Question: If a patient is discharged from the hospital, can they come to the outpatient department or a private practice and receive chemotherapy on the same DOS per Medicare? If not, how long do they have to wait?

Answer: If the patient has been discharged, it is my understanding that they would be eligible for any outpatient services medically necessary, even if it is the same day. I searched the Medicare manual and cannot find anything that negates this.

There are a couple of Rules that we think might cause a problem with same day services, however they do not apply because they are related to the days *prior* to a hospitalization.

"The 3-day Rule", sometimes referred to as the 72-hour rule, requires all diagnostic or outpatient services rendered during the DRG payment window (the day of and three calendar days prior to the inpatient admission) to be bundled with the inpatient services for Medicare billing.

Observation Stays and the "*Two-Midnight Rule*" which states that inpatient admission and payment are appropriate when the treating physician expects the patient to require a stay that crosses two midnights and admits the patient based on that expectation.

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Continued on next page...

Question: What is a Medicare IMM? I heard it is an "Important Message from Medicare" that we are required to give to our patients! Is this something that we have to do? I don't know anything about this! Help!

Answer: IMPORTANT MESSAGE FROM MEDICARE (IM or IMM): A hospital inpatient admission notice given to all beneficiaries with Medicare, Medicare and Medicaid (dual-eligible), Medicare and another insurance program, Medicare as a secondary payer. Therefore, this is a requirement for the hospital admitting a patient.

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Question: When I bill for drawing blood from a port, we usually use the port flush code, 96523 (*because the port must be flushed that day too*), along with the CBC w/diff code 85025. We use the flush code because several insurances deny the port draw code 36591. Now we are getting the "exclusivity" denial Remark N19! WHY?

Answer: Checking the CMS NCCI edits, it appears there was an update in April 2019, and now you cannot bill the port flush, 96523 with a CBC, 85025. However, there is no edit for 36591 with a lab procedure. When billing the 96523, the AMA CPT does specifically state, "*Do not report 96523 in conjunction with other services. To report collection of blood specimen, use 36591.*"

Additionally, CPT codes 36591 and 36592 are eligible for separate reimbursement only under very limited and specific circumstances.

The AMA CPT book includes parenthetical guidelines below these codes which state: "*Do not report 36591 [or 36592] in conjunction with other services except a laboratory service.*"

Under CMS guidelines, CPT 36591 and 36592 are designated as status T codes on the Physician Fee Schedule RBRVU file. Status T is defined as "*There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.*"

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Continued on next page...

Question: When an MD goes on vacation, can we bill his patients who are getting treatments with a Q5 modifier on the administration and/or medication codes? I know we can use Q5 on EM when Dr. A provides coverage for Dr. B while Dr. B is out of the office for whatever reason (illness, vacation, etc.). The covering physician, Dr. A, must be a permanent part of the existing practice and Tax Identification number. He may not be hired from the outside, or operate under a different tax ID number. I am just not sure if treatment administration (96413/96365/96372, etc) would be appropriate to use the Q5 and bill under the MD NOT in the office at the time of the service.

Answer: "Reciprocal Billing" (which used to be called Locum Tenens)

Definition: Services furnished by a substitute physician under a reciprocal billing arrangement.

Appropriate Usage:

- When a physician agrees to see patients of another physician under arrangements of the original physician
- The regular physician is not available to see patients
- The patient arranges or seeks service of their regular physician
- Short term coverage provided, under 60 days
- When a group member acts on behalf of a hospice attending physician

Inappropriate Usage:

- When the physician is covering for an absence of a long term
- When the physician is in the same group and same specialty

Answer continued on next page...

CMS Resources

CMS Internet-Only Manual, Publication 100-04 Chapter 1 , Section 30.2.10

Note: The regular physician maintains the records, and who saw the patient that day by name and National Provider Identifier (NPI).

Reciprocal billing includes "services"... (from Novitas MAC website):

Covered Visit Service Defined

With respect to physicians, the term "covered visit service" includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as "incident to" the physician's services. You would use the Q5 Modifier.

NOTE: If you are billing for services within the same group (Tax I.D.), then you would bill everything under the provider seeing the patient and put the referring/ordering physician on the claim in the appropriate spot.

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Question: Can a patient on Medicare have a different services paid for on the same day (e.g. chemotherapy, CT scan)?

Answer: Yes. There are rules about how they are billed if it is the outpatient hospital that provides both services. In this case they must be billed on separate claims. I've included the link to the CMS MLN about this: CLICK HERE (Be sure to scroll down to the example.)

CORPORATE ALLIES

HOME

DIAMOND LEVEL

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

GOLD LEVEL

abbvie
ARRAY BIOPHARMA
astellas
Incyte
Lilly
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

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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

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
Lisa Smith

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