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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 74 MARCH '20

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

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Save The Date!!

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 7th Annual Spring Conference

Thursday, April 2, 2020 - REGISTRATION NOW OPEN!

The Sheraton Valley Forge, King of Prussia, PA

www.sheratonvalleyforge.com

TOPICS to be covered:

- Compliance
- Insurance carriers
  - What can they do?
  - Who monitors them?
  - What can the practice do?
- Coding and Billing by Rise Cleland and Michelle Weiss

There is no fee for this event for POHMS Active and Associate Members who are up-to-date with their membership dues. However, registration is required.

Active and Associate Member Registration

Corporate Members and Exhibitors Register Here

POHMS MEMBERS STAY TUNED….

We will be having Two special programs this year which will be announced in upcoming months.

- First will be ½-day session on HIPAA (Coming the end of May or beginning of June)
- Second will be a ½-day session Sexual Harassment training for supervisors and employee retention (Coming in September)

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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.

Provisions in CMS Proposed Rule on Drug Manufacturer Coupons, Automatic Re-enrollment Could Erode Access to Cancer Care

(ASCO in Action) Mar 3, 2020 - In a letter to the Centers for Medicare & Medicaid Services (CMS), the Association for Clinical Oncology (ASCO) expressed concerns regarding two provisions in the 2021 Affordable Care Act (ACA) Notice of Benefit and Payment Parameters proposed rule. READ ARTICLE

COA Comments on Modifier 25 Audits Process Practices Should Not Have Payment for Entire Claims Held

In recent months, it has come to COA's attention that there is widespread implementation of ***Targeted Probe and Educate (TPE) audits that are investigating the use of modifier 25 codes for evaluation and management (E&M) visits*** on the same day as drug administration, particularly Part B chemotherapy and immunotherapy drugs.

While COA strongly supports appropriate checks and balances in providing cancer care to seniors and others covered under Medicare, these audits are having a very serious negative impact on community oncology practices because ***the entire claim is being held up for payment while a single line item is being audited.*** These concerns were shared with CMS Administrator Seema Verma in a letter last week.

The result of this is that a practice's cash flow may be severely impacted for up to 75 days as the practice continues to provide cancer care to their patients. Having drug claims for purchased and administered Medicare Part B drugs outstanding is an incredible financial hardship for small practices who must still make payment for the drugs given to patients. Not only can this affect a practice's financial credit, but also their long-term survival as a source of quality, high-value, and accessible cancer care for the communities they serve.

Read COA's full letter to CMS on the TPE Modifier 25 Audits.

House Panel Approves Restrictions on PBMs, Surprise Medical Billing

Those phrases were used by Georgia lawmakers Thursday to characterize the complicated practices of pharmacy benefit managers. PBMs basically are corporate middlemen between health insurers or large employers and drugmakers in handling pharmaceutical benefits. READ MORE

Access to Cancer Care Front and Center in Recent Meetings with Administration Officials and Other Stakeholders

On February 11, members of the Association for Clinical Oncology's (ASCO) Government Relations Committee met with several federal agencies and stakeholder groups to discuss top cancer policy priorities.

The meetings focused on drug pricing, access to clinical trials, Medicaid expansion and block grants, accelerated drug approval pathways, and other issues affecting people with cancer and their oncology care teams. READ MORE

Oncology Care First Is a Big Step Toward Bundled Payments in Cancer Care, Authors Say

Oncology Care First (OCF), proposed as the successor to the Oncology Care Model (OCM), will be a major step toward shifting cancer care to bundled payments, according to leaders from an emerging network of community oncology practices. READ MORE

Value-Based Care With Two-Sided Risk a Preference in Upcoming Oncology Care Model

Oncology practices that are participating in the Centers for Medicare & Medicaid Innovation's Oncology Care Model (OCM) are willing to take on two-sided risk with value-based care and shift from a fee-for-service approach, according to results of a survey conducted by the Community Oncology Alliance (COA). READ MORE

CMS Rolls Out Survey of Drug Costs for 340B Hospitals as Legal Fight Rages

The Trump administration finalized a survey of hospitals to acquire the payment rates for drugs purchased under the 340B discount program, much to the dismay of hospitals.

The Centers for Medicare & Medicaid Services on Friday published a notice on the survey in the Federal Register, calling for comments on the survey until March 9. Hospitals have been opposed to the survey, saying the survey request will cost too much and is flawed. READ MORE

New PA Law Aims to help Cancer Patients Access Advanced Cancer Treatment

HARRISBURG – Patients fighting cancer won't have to worry about their insurance companies blocking their access to the most advanced therapies under legislation signed into law by Gov. Tom Wolf last week.

Under Act 6 of 2020, insurance companies would be barred from forcing doctors treating metastatic cancer patients to try treatments preferred by the insurance company before allowing doctors to try advanced therapies. READ MORE

Prior Authorization Reform Would Improve Timely Access to Cancer Care

On January 30, Jerome Seid, MD, FACP testified during a hearing of the Michigan State Senate Committee on Health Policy and Human Services in support of SB 612, a bill that would make important reforms to prior authorization and step therapy protocols. Dr. Seid is a member of the Association for Clinical Oncology (ASCO) and past president of the Michigan Society of Hematology and Oncology (MSHO).

As a practicing hematologist and oncologist in Warren, Michigan, Dr. Seid provided first-hand experience to the Committee on how prior authorization impacts his patients. READ MORE

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Part B Top Inquiries / Frequently Asked Questions

The Part B top inquiries / FAQs, received by our customer contact center, have been reviewed for January 2020. Please take time to review these FAQs for answers to your questions. CLICK HERE

Claims timely filing calculator

Novitas has developed a claims timely filing calculator to assist you in determining the timely filing limit for your services. In general, Medicare claims must be filed to the Medicare claims processing contractor no later than 12 months, or 1 calendar year, from the date the services were furnished.

Institutional claims that include span dates of service (i.e., a "from" and "through" date span on the claim), the "through" date on the claim is used for determining the date of service for claims filing timeliness.

Professional claims submitted by physicians and other suppliers that include span dates of service, the line item "from" date is used for determining the date of service for claims filing timeliness. CLICK HERE

Medical policy

The following local coverage determinations (LCDs) have been revised:

- Hemophilia Factor Products (L35111)

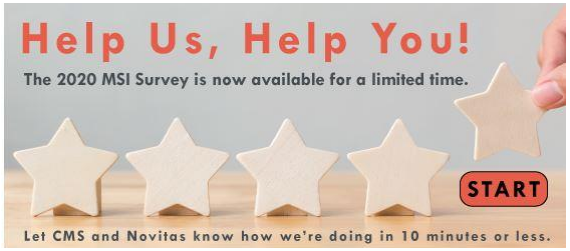
The following billing and coding articles have been revised:

- Billing and Coding: Biomarkers Overview (A56541)
- Billing and Coding: Intravenous Immune Globulin (IVIG) (A56786)

Part B Top Claim Submission / Reason Code Errors

The Top Claim Submission / Reason Code Errors and resolutions for January 2020 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

Medicare Administrative Contractor Satisfaction Indicator (MSI)



The 2020 MSI is Here: Evaluate our services!

The MSI is the best way to share your opinions directly with the Centers for Medicare & Medicaid Services about your experience with us. These survey results will help us gain valuable insights and determine process improvements. CLICK HERE

Thank you for your feedback.

Appeals
The Reopening Gateway has arrived!

Novitas Solutions is dedicated to the development of self-service tools to reduce customer burden and to improve the overall customer experience. The Reopening Gateway is a free, web-based application that allows for automated submission of claim corrections with no enrollment process. Logging into the Reopening Gateway is a quick and easy way to update claim data through the internet. CLICK HERE

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, March 10, 2020	11:00 a.m.	12:00 p.m.	***Novitasphere Enrollment Overview*** This course will cover the steps to enroll in Novitasphere, including the Enterprise Identity Management (EIDM) registration process.	1.0	Webinar
Tuesday, March 17, 2020	12:00 p.m.	1:00 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
Wednesday, March 18, 2020	3:00 p.m.	4:30 p.m.	***Novitasphere EIDM to IDM Transition Ask-the-Contractor Webinar*** The CMS Enterprise Identity Management (EIDM) system will be changing to the CMS Identity Management (IDM) system effective April 6, 2020. During our webinar, we will review the changes coming as part of the transition, what actions existing users will need to take in preparation, and what to expect on day one. After our formal presentation, we will take your questions as they relate to this transition. **Please note**: this presentation is for existing Novitasphere users.	1.5	Webinar

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

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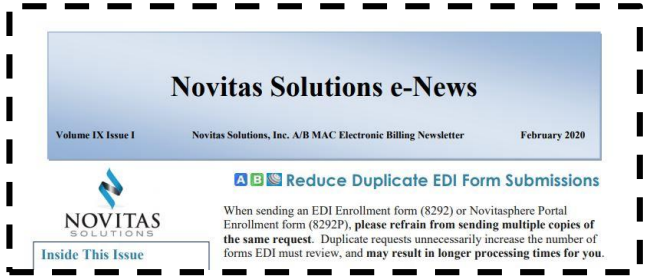
Part B Newsletter

*Current Edition Available...*CLICK HERE

Novitas Solutions e-News
Electronic Billing
Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



Medicare Part B
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

Why Auditors Can't be Unbiased

Last week on Monitor Mondays, Knicole Emanuel, Esq. reported on the case of *Commonwealth v. Pediatric Specialist,PLLC*, wherein the Recovery Audit Contractors' (RACs') experts were prohibited from testifying because they were paid on contingency. This means that the auditor (or the company for which they work) is paid some percentage of the overpayment findings it reports. READ MORE

The New World of Auditing

What's next for auditing professionals?

The first thing to note here is that I am not an auditor. So, for me to write an article on auditing tips might seem a bit unusual. But this is not an article on auditing compliance, but rather on being an auditor – and while my "tips," so to speak, are not geared toward the technical aspects of coding and auditing, they do apply to future career opportunities for auditors. READ MORE

Open Payments: Your Role in Health Care Transparency Call — March 19

Thursday, March 19 from 2 to 3 pm ET
Register for Medicare Learning Network events.

Did you know that reporting entities annually submit records to CMS of payments or transfers of value they made to physicians and teaching hospitals? Beginning in April, you have 45 days to review and dispute Program Year 2019 records. CMS will publish this data and updates to previous program years' data by June 30. Topics:

- Overview of the Open Payments national transparency program
- Program timeline
- Registration process
- Critical deadlines for physicians and teaching hospitals to review and dispute data

A question and answer session follows the presentation.

Target Audience: Physicians, teaching hospitals, and physician office staff.

Open Payments Registration

Reporting entities are currently submitting Program Year 2019 data. In order to participate in upcoming Open Payments program activities, physicians and teaching hospitals must be registered in the Open Payments system:

- If you registered last year, you do not need to register again.
- If it has been over 180 days since you logged in, your account is deactivated for security purposes. Contact the Open Payments Help Desk.

The review and dispute period is targeted to begin in April 2020.

For More Information:

- Open Payments website
- Resources webpage
- Contact the Help Desk at openpayments@cms.hhs.gov or 855-326-8366 (TTY: 844-649-2766)

Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2

A new Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2 Medicare Learning Network Educational Tool is available. Learn about:

- Comprehensive Error Rate Testing: Lumbar sacral orthosis
- Recovery Auditor Finding: Trastuzumab multi-dose vial wastage

Visit the newsletter archive for past editions.

Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31

The data submission period is open for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2019 performance period of the Quality Payment Program. Submit and update your data until 8 pm ET on March 31. Note: The data submission period for accountable care organizations and preregistered groups and virtual groups also closes on March 31.

For More Information:

- Resource Library webpage
- Access User Guide
- Introduction and Overview of 2019 Data Submission Video
- File Upload and Quality Scoring Video
- Manual Attestation of Improvement Activities Video
- Manual Attestation of Promoting Interoperability Measures Video
- Support for Small, Underserved, and Rural Practices 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)

Quality Payment Program: Updated Explore Measures Tool

CMS updated the Explore Measures Tool for the 2020 performance period. The tool now includes 2020 Meritbased Incentive Payment System (MIPS) measures and activities for the four performance categories:

- Quality
- Cost
- Improvement Activities
- Promoting Interoperability

Note: The tool is only for informational and estimation purposes. It cannot be used to submit or attest to measures and activities.

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

Measure Specifications and Lists:

- Quality Measures List
- Medicare Part B Claims Measure Specifications and Supporting Documents
- Clinical Quality Measure Specifications and Supporting Documents
- CMS Web Interface Measure Specifications and Supporting Documents
- Qualified Clinical Data Registry Measure Specifications
- Improvement Activities Inventory
- Promoting Interoperability Measure Specifications
- Cost Measure Information Forms
- Cost Measure Code Lists
- Summary of Cost Measures

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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)

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Recent LearnResource & MedLearn Matters Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0
- The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - April 2020 Update

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)

OTHER PAYER UPDATES

Independence | PROVIDER News Center

HOME

Avoid denials and processing delays by submitting necessary information for vendor-based utilization management precertification requests

Recently we have seen an increase in precertification denials for services requested through our delegated vendors who complete reviews for our utilization management programs: READ MORE

View up-to-date policy activity on our Medical Policy Portal

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefit Programs occur in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal to stay up to date with changes to our policies. READ MORE

Review your provider profile

Provider offices are encouraged to review their demographic information published in the provider directory on a quarterly basis. READ MORE

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

Effective April 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

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

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HIGHMARK BLUE SHIELD

Drugs Added to Site of Care

Highmark Blue Shield has added the following injectable drugs to site of care criteria: Panzyga®, Onpattro®, and Ultomiris. Additionally, all subsequent new to market immune globulin products will be managed through Site of Care.

The Medical Policy will apply to both professional provider and facility claims. The effective date will be May 1, 2020.

Please refer to Medical Policies I-151 Site of Care, I-14 Immune Globulin Therapy, I-130 Eculizumab (Soliris) and Ravulizumab (Ultomiris), and I-202 Treatment of Hereditary Amyloidosis for additional information.

READ MORE

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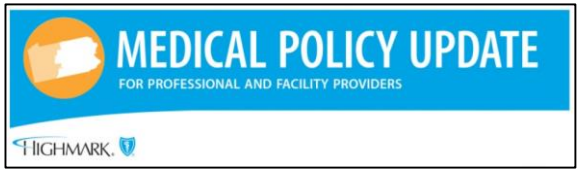
Highmark Blue Shield Frequently Used Contact Information

To view this document CLICK HERE

PROVIDER NEWS
Most Recent Issue …
CLICK HERE



HIGHMARK
MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

- Injectable Drugs Added to Site of Care
- Coverage Guidelines Established for Crizanlizumab-tmca (Adakveo)
- Inpatient place of service added to Clinical Trials

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:

A Few Articles You Won't Want to Miss:
Front & Center
- Additions to Cancer Therapy Pathways
- Prior Authorization and Notification Requirement Updates
- Pharmacy Update
- Specialty Medical Injectable Drug Program Updates

UnitedHealthcare Commercial
- Appeal Overturn to Be Notified by PRA

UnitedHealthcare Community Plan
- Genetic and Molecular Prior Authorization Update
- Specialty Pharmacy Requirements
- Reimbursement Policy

UnitedHealthcare Affiliates
- Prior Authorization and Site of Service Reviews

And Much More…MARCH 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:

<u>Medical Benefit Drug Policy Updates</u>

New:
- Intravenous Iron Replacement Therapy (Feraheme® & Injectafer®)
- Vyondys 53™ (Golodirsen)

Revised:
- Botulinum Toxins A and B
- Exondys 51® (Eteplirsen)
- Ketalar® (Ketamine) and Spravato™ (Esketamine)
- Oncology Medication Clinical Coverage
- Rituximab (Rituxan®, Ruxience™, & Truxima®)

Updated:
- Denosumab (Prolia® & Xgeva®)

<u>Utilization Review Guideline (URG)</u>

Revised:
- Chemotherapy Observation or Inpatient Hospitalization
- Provider Administered Drugs – Site of Care

MARCH 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 approved isatuximab-irfc (SARCLISA, sanofi-aventis U.S. LLC) in combination with pomalidomide and dexamethasone for adult patients with multiple myeloma who have received at least two prior therapies including lenalidomide and a proteasome inhibitor. More Information. March 2, 2020
- Food and Drug Administration approved neratinib (NERLYNX, Puma Biotechnology, Inc.) in combination with capecitabine for adult patients with advanced or metastatic HER2-positive breast cancer who have received two or more prior anti-HER2 based regimens in the metastatic setting. More Information. February 25, 2020

Drug Repository Programs Address High Costs, Access and Waste Issues When Appropriately Implemented

The American Society of Clinical Oncology (ASCO) today released a position statement on state drug repository programs, outlining ASCO's support for drug repository programs solely for oral medications provided they are maintained within a closed system. The Society also makes recommendations to help ensure that these programs are implemented appropriately, with sufficient patient protections in place. READ MORE

FDA Gets Ready for Changes to Biologics Regulation

(Bloomberg Law) Feb 20, 2020 - Drug companies will have more clarity over how the FDA regulates their products following an agency rule revising the definition of certain complex and expensive drugs. READ ARTICLE

FTC and Commonwealth of Pennsylvania Challenge Proposed Merger of Two Major Philadelphia-area Hospital Systems

The Federal Trade Commission has authorized an action to block the proposed merger of Jefferson Health and Albert Einstein Healthcare Network, two leading providers of inpatient general acute care hospital services and inpatient acute rehabilitation services in both Philadelphia County and Montgomery County, Pennsylvania. READ MORE

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

As Patents Expire, Oncology Biosimilars Poised to Expand, Authors Say

(The Center For Biosimilars) Feb 11, 2020 – By 2023, patents on nearly 20 oncology biologics will expire, which could lead to more biosimilars in cancer care and therefore reduced costs, according to a review article. READ ARTICLE

New wait list process for closed disease funds

PAN | Helping for 15 Years

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I'm excited to let you know that in mid-April, PAN will launch a Disease Fund Waist List, which will replace our current Fund Reopen Notification System.

Patients, caregivers, providers and pharmacists will all be able to add a patient's name to the Disease Fund Wait List whenever a fund is closed. *The wait list will give individuals the opportunity to apply for assistance in the order their names were added to the wait list. It will also ensure that all eligible patients are served on a first-come, first-served basis.*

For more information, please read our full list of FAQs or contact us at 1-866-316-7263.

American Medical Association President Warns Against 'One-Size-Fits-All' Single-Payer System

(The Hill) Feb 12, 2020 - The president of the American Medical Association (AMA) criticized "Medicare for All" as a "one-size-fits-all solution" on Wednesday, but acknowledged that some doctors, particularly younger ones, support the idea. READ ARTICLE

CHECK OUT OUR LATEST ISSUE....
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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: Can we treat a patient who is covered under VA benefit, in a practice? How does this work?

Answer: Non-VA Care is medical care provided to eligible Veterans when VA facilities are not locally available or accessible to the patient, or when the required specialty, technology, or physicians are not available. Care is provided utilizing facilities outside of the VA.

All VA medical centers and eligible patients can use the Non-VA Medical Care Program when needed. A pre-authorization for treatment outside of VA facilities is required to receive Non-VA Care, unless the medical event is an emergency.

Non-VA Care should not be considered an entitlement program or a permanent routine treatment option in lieu of the VA healthcare system. Non-VA Care is utilized when receiving specialty care at a VA facility is not "feasibly available."

The VA may consider authorizing Non-VA Care when the VA cannot provide adequate medical care for an eligible veteran due to:

- A lack of available VA-employed specialists to treat the patient's illness
- Long wait times at the regional or local VA facility where specialty care is offered
- The VA facility capable of delivering the specialty care is located far enough from the Veteran's home that receiving treatment requires additional transportation that may compromise scheduled treatments
- The VA facility not providing the same, usual and customary community standard of care* to the Veteran that would equal treatment provided to civilians

Here is a Fact Sheet you may find helpful! CLICK HERE

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Continued on next page...

Question: Where do I find the letter from CMS that sets the rules for the Medicare Advantage Plan's Step Edit authority? We have a plan that is making us change treatment due to a step edit. Isn't it true the are not supposed to do that?

Answer: No, they are not allowed to require a change of the drug due to the step edit. Within the rules it says, *"Finally, MA plans should ensure that new step therapy requirements do not disrupt ongoing Part B drug therapies for enrollees. Step therapy may only be applied to new prescriptions or administrations of Part B drugs for enrollees that are not actively receiving the affected medication."*

Here is the link to this reference; CLICK HERE

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Question: What are the new single Chronic Care Management codes?

Answer: Beginning in 2020, CMS introduced Principal Care Management (PCM) services to provide comprehensive care management for beneficiaries with a single, high-risk condition;

G2064 (Physician/NPP) – G2065 (Nurse)
Comprehensive care management services for a single high-risk disease, at least 30 minutes of physician or other qualified health care professional me per calendar month (for G2064) or of clinical staff time directed by a physician or other qualified health care professional per calendar month (for G2065) with the following elements:

- One complex chronic condition lasting at least 3 months, which is the focus of the care plan
- The condition is of sufficient severity to place patients at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

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Continued on next page...

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
janssen
PHARMACEUTICAL COMPANIES OF Johnson & Johnson
Lilly
NOVARTIS
pharmacyclics

SILVER LEVEL

ALEXION
Oncology Supply
AmerisourceBergen Specialty Group
SANDOZ
Biopharmaceuticals
SANOFI
TAIHO ONCOLOGY
Making the human connection

pohms
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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