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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 76 MAY '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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Please MARK YOUR CALENDAR for these important programs.

You don't want to miss either one.

POHMS Special Program

LOCATION: Hershey Country Club
DATE: September 30, 2020
TIME: 8 am to 5 pm

Part I – Morning Session

<u>Human Resources</u>
George Hlavac, Esq.
Hoffman Hlavac & Easterly

- Sexual Harassment Training for Supervisors
- Employee retention

Times and speakers subject to change.

Part II – Afternoon Session

<u>HIPAA Update Package</u>
Helen Oscislawski
Attorneys at Oscislawski LLC

- Overview of HIPAA changes
- Enforcement Actions
- Ransomware Attacks
- Data Breach
- 21st Century Cures Act and the Information Blocking Rules
- Updated HIPAA documents (electronic)
- And so much more!!

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.

Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic

At President Trump's direction, and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, on April 30, 2020, the Centers for Medicare & Medicaid Services, issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens. These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

Full press release

CMS News Alert – Summary of COVID-19 Changes

Here is a summary of recent Centers for Medicare & Medicaid Services (CMS) actions taken in response to coronavirus disease 2019 (COVID-19), as part of the ongoing White House Task Force efforts.

READ ALERT

Updated - Telehealth Coverage Updates

Announced this week …. Parity in reimbursement for Telehealth phone calls to patients!

NEW - Telephone E/M Visits (99441 - 99443) added to CMS Telehealth Services and include payment parity to office visit coding (99212 - 99214)!

A sign-on letter from many National Societies, including ASCO and ASH, was sent to CMS explaining the need for payment parity for phone call management of our patients. Doctors have reported that they "have been able to conduct successful audio-only telephone visits with patients, in lieu of in-person or telehealth visits, obtaining about 90% of the information they would collect using audio and video capable equipment." CMS listened and, retroactively to March 1, has included the phone calls codes to the list of E/M Telehealth approved services and increased reimbursement commensurate to office visit codes. Previously, payments for audio-only telephone services for Medicare beneficiaries ranged between $14 and $41. This has been raised to a range between $46 and $110 with the higher rates retroactive to March 1, 2020.

To read the CMS press release CLICK HERE

CMS Releases 340B Drug Acquisition Cost Survey, Responses Due May 15, 2020

After receiving approval from the Office of Management and Budget (OMB) on April 23, 2020, the Centers for Medicare and Medicaid Services (CMS) released a survey on April 24, 2020, to collect information on 340B hospitals' net acquisition costs for 340B-purchased drugs. CMS announced on its Hospital Outpatient Prospective Payment System (OPPS) webpage that the survey is available through May 15, 2020, in spite of requests by hospitals and hospital groups to delay the survey's implementation because of the Coronavirus (COVID-19) emergency. READ MORE

Now Available - COA Conference Recordings & Presentations

Miss a session? Want to see it again? Couldn't attend live? The 2020 *Community Oncology Conference* is available **on-demand**! Log on to www.COAConference.com using your registered email address to access enduring content. Watch sessions, access presentations, and visit the virtual exhibit hall whenever you want.

CMS COVID-19: Dear Clinician Letter on CMS Actions including Telehealth

CMS posted a letter to clinicians that outlines a summary of actions CMS has taken to ensure clinicians have maximum flexibility to reduce unnecessary barriers to providing patient care during the unprecedented outbreak of COVID-19. The summary includes information about telehealth and virtual visits, accelerated and advanced payments, MIPS, and recent waiver information.

Letter

ASCO Update - COVID-19 Registry: Acceptable Registry for MIPS Improvement Activity

(ASCO in Action) May 1, 2020 - The Centers for Medicare & Medicaid Services (CMS) has confirmed ASCO's Survey on COVID-19 in Oncology Registry (ASCO Registry) is an acceptable clinical trial registry for the attestation of the high-weighted practice Improvement Activity (IA), "COVID-19 Clinical Trials related to the Emergency Response & Preparedness," under the Merit-based Incentive Payment System (MIPS).

READ ARTICLE

CMS Provider Relief Fund
-WATCH OUT-
READ the Terms and Conditions!

CARES Act Provider Relief Fund

From the $100 billion appropriated to HHS, $30 billion is being directly disbursed to facilities and health professionals that billed Medicare FFS in 2019. Disbursements began on April 10, 2020. According to HHS, distributions from the CARES Act Provider Relief Fund are grants, not loans, and do not have to be repaid.

The funds will go to each organization's TIN which normally receives Medicare payments, not to each individual physician. These automatic payments will come to eligible organizations via Optum Bank with "HHSPAYMENT" as the payment description.

Within 30 days of receiving the funds, clinicians must sign an attestation at (covid19.linkhealth.com) confirming receipt of the funds and agreeing to the terms and conditions.

According to CMS, these funds are **grants, not loans**, and do not have to be repaid. So, It looks like **free money** you can use however you want..... **MAKE SURE YOU READ THE CONDITIONS** associated with acceptance of the funding and understand what the funds are allowed to be used for:

Some of the conditions include:
"The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus."

You must submit reports:
"Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than $150,000 total in funds under the Coronavirus Aid, Relief, and...."

Continued on next page...

This report shall contain: the total amount of funds received from HHS under one of the foregoing enumerated Acts; the amount of funds received that were expended or obligated for reach project or activity; a detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget."

You must maintain records and cost documentation:
"The Recipient shall maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions."

The following statutory provisions also apply:
"None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II" ($197,300)

CLICK HERE TO READ ALL OF THE TERMS AND CONDITIONS

Failure to abide by the terms and conditions:
Could result in False Claims Act liability for healthcare providers that do not make proper use of the funds. Thus, recipients of the funds should carefully consider their ability to comply with the terms and conditions and should ensure that proper controls are in place for proper use of the funds.

There's always FREE cheese in a mouse trap!

Invoice No Longer Required

To reduce provider burden, Novitas is implementing a new process for certain Healthcare Common Procedure Coding System codes for Part B. This process allows the provider to enter the invoice information in the narrative field (or block 19) on a claim. READ MORE

The Reopening Gateway is Available!

The Reopening Gateway is a free, web-based application that allows for automated submission of claim corrections with no enrollment process. For those offices working alternate schedules or working remotely due to COVID-19, the Reopening Gateway offers a quick and easy way to update claim data through the internet.

The application is designed to be used in conjunction with the Medicare remittance advice, since protected health information will not be retrieved and displayed from the Medicare processing systems. The Reopening Gateway offers a convenient solution to providers, billing services and clearinghouses to correct and reprocess claims. READ MORE

March 2020 Top Inquiries Frequently Asked Questions

The March 2020 Part B top inquiries FAQs, received by our Provider Contact Center, have been reviewed for March 2020. Please take time to review.

Have questions and not sure where to turn? Check out our FAQs for answers to your questions.

CLICK HERE

Medical Policy

The following Local Coverage Determination and related Billing and Coding Article have been revised:

- Services That Are Not Reasonable and Necessary (L35094)
  - Billing and Coding: Services That Are Not Reasonable and Necessary (A56967)

The following Local Coverage Determination (LCD) posted for comment on October 31, 2019 has been posted for notice. The LCD and related Billing and Coding Article will become effective May 24, 2020:

- Thrombolytic Agents (L35428)
- Billing and Coding: Thrombolytic Agents (A55237)

The following Response to Comments Article contains summaries of all comments received and Novitas' responses:

- Response to Comments: Thrombolytic Agents (A58012)

March 2020 Top Claim Submission Errors

The March 2020 Part B top claim submission errors and resolutions for Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania are now available. Please take time to review these errors and avoid them on future claims.

READ MORE

Coronavirus Disease 2019 (COVID-19): Telehealth and Telephone-only Services During The Emergency

A new article was developed to assist providers with telehealth and telephone services during the emergency. Please review the article to ensure you are keeping up to date with the most current information.

READ MORE

Novitas Self-Service Tools:

View all Self-Service Tools

Listed are Novitas training events an oncology practice should consider!

WEBINAR

HOME

Date	Starts	Ends	Event Details	CEUs	Media Type
Tuesday, May 12, 2020	11:00 a.m.	12:30 p.m.	***Novitasphere Overview*** This class is an introduction to the Novitasphere portal for Part B customers. We will present an overview on how to access Novitasphere and explore the many features this program has to offer. These features include: eligibility inquiry claim submission, electronic remittance advice, claim correction, and more!.	1.5	Webinar
Tuesday, May 12, 2020	1:00 p.m.	2:00 p.m.	***Exploring the Options for Claim Corrections*** Explore the multiple features Novitas has to offer to perform claim corrections. This class will provide answers to the most frequently asked questions as well as provide resources to assist you on determining your best option to correct a claim.	1.0	Webinar
Thursday, May 14, 2020	10:00 a.m.	11:00 a.m.	***Part B Ask the Contractor Webinar*** The Ask the Contractor webinar 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
Thursday, May 14, 2020	11:00 a.m.	12:00 p.m.	***Novitasphere Enrollment Overview*** This class will cover the steps to enroll in Novitasphere, including the Enterprise Identity Management (EIDM) registration process.	1.0	Webinar

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

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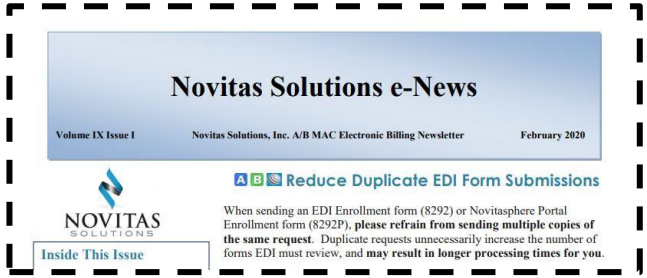
Part B Newsletter

*Current Edition Available...*CLICK HERE

Novitas Solutions e-News
Electronic Billing
Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



Medicare Part B
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

3/24/2020: COVID-19 Information:

As we all continue to navigate the rapidly evolving COVID-19 situation, HMS remains available and is here to help. HMS is committed to providing the most current and up-to-date statuses for all reviews currently in progress, under CMS' approved review guidelines. Please continue to monitor the provider portal (https://racinfo.hms.com) or contact the Provider Relations Department via email at: racinfo@hms.com or telephone at (877) 350-7992 (Part A) or (877) 350-7993 (Part B), should you have any questions regarding the status of your reviews. Above all, stay safe and healthy.

CMS Reevaluates Accelerated Payment Program, Suspends Advance Payment Program

On April 26, CMS announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. Beginning on April 26, 2020, CMS will not be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments. Funding will continue to be available to hospitals and other healthcare providers on the front lines of the coronavirus response primarily from the Provider Relief Fund. CMS has posted an updated fact sheet on the Accelerated and Advance Payment Programs with additional details and background.

COVID-19 Call: Audio Recording and Transcript

An audio recording and transcript are available for the April 7 Medicare Learning Network call on 2019 Novel Coronavirus (COVID-19) Updates. Learn about CMS waivers and COVID-19 response.

Updated Questions and Answers on COVID-19

Review CMS' updated FAQs to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Check this resource often as CMS updates it on a regular basis - we insert the date at the end of each FAQ when it is new or updated.

Coronavirus Major Policy Changes

Stay current with the fast-moving information on the Coronavirus. View the Current Emergencies on the CMS Website.

Major Policy Changes:

CLICK HERE for link to CMS-1744-Interim Final Rule
CLICK HERE for link to Cares Act

Quality Payment Program: MIPS Extreme and Uncontrollable Circumstances Policy in Response to COVID-19

CMS is offering multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. In addition to extending the 2019 Merit-based Incentive Payment System (MIPS) data submission deadline to April 30 at 8 pm ET, the MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30 deadline.

If you are a MIPS eligible clinician and do not submit any MIPS data by April 30, you will not need to take any additional action to qualify for the automatic extreme and uncontrollable circumstances policy. You will be automatically identified and will receive a neutral payment adjustment for the 2021 MIPS payment year. Note: We updated the Participation Status Tool, so you can see if the policy is automatically applied.

We are also reopening the MIPS extreme and uncontrollable circumstances application for individuals, groups, and virtual groups. An application submitted by April 30, citing COVID-19 will override any previous data submission.
For More Information:

- Quality Payment Program COVID-19 Response Fact Sheet
- 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)

Dual Eligible Beneficiaries Under Medicare and Medicaid — Revised

A revised Dual Eligible Beneficiaries Under Medicare and Medicaid Medicare Learning Network Booklet is available. Learn about:

- Medicare Savings Programs, including benefits and qualifications
- Billing requirements

Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants

A revised Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Medicare Learning Network Booklet is available. Learn about:

- Qualifications
- Billing and payment guidelines

Medicare Overpayments — Revised

A revised Medicare Overpayments Medicare Learning Network Fact Sheet is available. Learn about:

- Definition of an overpayment
- Collection tools and processes
- Payment options

How to Use the Searchable Medicare Physician Fee Schedule — Revised

A revised How to Use The Searchable Medicare Physician Fee Schedule Medicare Learning Network Booklet is available. Learn to navigate and search for:

- Pricing information
- Payment policy indicators
- Relative value units and geographic practice cost index

Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course — Revised

With Continuing Education Credit

A revised Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn about:

- Identifying fraud and abuse
- Provisions and penalties
- Prevention methods
- Reporting

Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)

Section 3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act temporarily suspends the 2% payment adjustment currently applied to all Medicare Fee-For-Service (FFS) claims due to sequestration. The suspension is effective for claims with dates of service from May 1 through December 31, 2020.

CORONAVIRUS - Stay current with the fast-moving information on the Coronavirus

View the Current Emergencies on the CMS Website.

Major Policy Changes:

- CLICK HERE for link to CMS-1744-Interim Final Rule
- CLICK HERE for link to Cares Act

Medicare Advance Written Notices of Noncoverage — Revised

A revised Medicare Advance Written Notices of Noncoverage Medicare Learning Network Booklet is available. Learn how to:

- Complete the forms
- Collect payment

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

- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits — Revised
- 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 — Revised
- New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)
- New Waived Tests
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update — Revised

Telemedicine services for Independence members through June 4, 2020

This article was revised on April 3, 2020, to clarify the expansion of Independence's telemedicine services position for commercial and Medicare Advantage members.

Independence is committed to providing our members with access to the care they need. As COVID-19 has escalated into a pandemic, we are working to make sure that our members can receive appropriate testing and treatment for the virus causing COVID-19 if needed.

This article includes information on the expansion;

- Cost sharing waiver – but cost-sharing applies to specialists for services not related to COVID-19
- Expansion to include specialists
- Reimbursement will be at the same level as the current applicable contracted office fee schedule for a standard in-office visit including up to level 5 evaluation and management
- Required documentation is within the article
- Primary Care / Specialty Care Procedure Codes - 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99421, 99422, 99423, 99441, 99442, 99443
- Must include location 02 and modifier GT or 95 (Both Medicare Advantage and Commercial) –
    - Telephone only - do not report modifier GT or 95

CLICK HERE to read the reminder of the article!

Independence COVID-19 Provider Hub

Independence has launched a range of clinical and business initiatives since the start of the COVID-19 pandemic to address the key needs of the health care community on the frontlines of fighting the coronavirus. Refer to this page for important updates as we navigate this unprecedented situation together.

CLICK HERE

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Independence | PROVIDER News Center

HOME

Policies & Guidelines

Access medical and pharmacy policies as well as clinical practice guidelines and information about services that require preapproval.

CLICK HERE

Updates to the list of medical benefit specialty drugs that will require precertification and/or cost-share effective July 1, 2020

Specialty drugs that will require precertification

Effective July 1, 2020, the following specialty drugs, which have been approved by the U.S. Food and Drug Administration (FDA) and are eligible for coverage under the medical benefit for Independence members, will require precertification: CLICK HERE to view list.

Medicare Advantage incentives for telehealth annual wellness visits during COVID-19 crisis

READ MORE

Enhanced claim edits to support correct coding principles and important information about ICD-10-CM Excludes Notes

READ MORE

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PLACE OF SERVICE CHANGES FOR AUTHORIZED SERVICES

To address the evolving nature of the Covid-19 health crisis, providers may need to adjust the place of service for authorized services more than usual. Highmark is committed to assisting you in this important effort to ensure that our members have continued access to quality health care despite the challenging circumstances. Please review the following guidelines to ensure a seamless transition for your patients.

READ MORE

HIGHMARK TELEMEDICINE POLICY

Please be advised that any temporary modifications or provisions in our telemedicine policies and procedures are **for dates of service from March 13 through June 13, 2020** unless otherwise noted. Should this change at any time, we will update this information accordingly. READ MORE including FAQ including….

May I provide virtual visits by phone or audio only?

Yes. Per the OCR's guidelines, during the Public Health Emergency (PHE), a provider may use video **OR audio** to provide virtual visits to patients using any non-public facing remote communication product that is available. Claims billed for these services will be processed the same as a virtual visit that utilizes both audio and video as normally recommended.*

**Medicare Advantage NOTE: Highmark Medicare Advantage plans continues to follow CMS's guidelines for telemedicine visit coverage and reimbursement. Accordingly, only telephonic appointments are appropriate for a Medicare patient's Virtual Check In.*

- Access
- Coding / Billing / Reimbursement
- Member Coverage

OTHER PAYER UPDATES

PEER-TO-PEER REVIEW TIME FRAME INCREASED TO 180 DAYS

In order to continue to support you and our members through the COVID-19 situation, Highmark is increasing our peer-to-peer review time frame from 60 days to 180 days for any denials. We want to ensure all our members receive a full and fair review despite the constraints we are all facing. All other denial guidelines remain the same at this time for Commercial members.

READ MORE

HIGHMARK TEMPORARILY INCREASING PAYMENTS RELATED TO MEDICARE SEQUESTRATION

CARES ACT MAKES AVAILABLE EMERGENCY FUNDING TO PROVIDERS

READ UPDATE

REIMBURSEMENT POLICY 043: CARE MANAGEMENT

Just as you do everything in your power to deliver the best care for patients; at Highmark, we do everything in ours to ensure our providers are accurately reimbursed for that care.

READ MORE

CLAIM PAYMENTS DURING THE PUBLIC HEALTH EMERGENCY

READ UPDATE

CHANGES TO SERVICES THAT ARE NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT

READ LIST

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

PROVIDER NEWS

Most Recent Issue …

CLICK HERE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

- Coverage Guidelines Established for Luspatercept (Reblozyl)
- Coverage Guidelines Revised for Sebelipase alfa (Kanuma)
- Coverage Guidelines Established for Givosiran (Givlaari)

OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

NEW!

A Few Articles You Won't Want to Miss:

Front & Center
- Policy, Protocol and Program Delays
- COVID-19 Treatment Update
- Prior Authorization and Notification Requirement Updates

UnitedHealthcare Community Plan
- Genetic and Molecular Prior Authorization Update

Pharmacy Update
- This pharmacy bulletin outlines upcoming new or revised clinical programs and implementation dates. It is available at UHCprovider.com/pharmacy for UnitedHealthcare commercial and UnitedHealth Oxford commercial plans.

And Much More...MAY Monthly Issue Available HERE

NEW!

Oncology Related Articles You Won't Want to Miss:

Medical Benefit Drug Policy Updates

Revised:
- Actemra® (Tocilizumab) Injection for Intravenous Infusion
- Benlysta® (Belimumab)
- Crysvita® (Burosumab-Twza)
- Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)
- Maximum Dosage and Frequency
- Off-Label/Unproven Specialty Drug Treatment
- Reblozyl® (Luspatercept-Aamt)

Utilization Review Guideline (URG)

Revised:
- Provider Administered Drugs – Site of Care

MAY Monthly Issue Available HERE

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RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- Food and Drug Administration granted accelerated approval to capmatinib (TABRECTA, Novartis) for adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test. More Information. May 6, 2020

- Food and Drug Administration approved daratumumab and hyaluronidase-fihj (DARZALEX FASPRO, Janssen Biotech, Inc.) for adult patients with newly diagnosed or relapsed/refractory multiple myeloma. This new product allows for subcutaneous dosing of daratumumab. More Information. May 1, 2020

- Food and Drug Administration approved niraparib (ZEJULA, GlaxoSmithKline) for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy. More Information. April 29, 2020

- Food and Drug Administration granted accelerated approval to a new dosing regimen of 400 mg every six weeks for pembrolizumab (KEYTRUDA, Merck) across all currently approved adult indications, in addition to the current 200 mg every three weeks dosing regimen. More Information. April 28, 2020

- Food and Drug Administration granted accelerated approval to sacituzumab govitecan-hziy (TRODELVY, Immunomedics, Inc.) for adult patients with metastatic triple-negative breast cancer who received at least two prior therapies for metastatic disease. More Information. April 22, 2020

- Food and Drug Administration expanded the indication of ibrutinib (IMBRUVICA, Pharmacyclics LLC) to include its combination with rituximab for the initial treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). More Information. April 21, 2020

Continued on next page...

RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- Food and Drug Administration granted accelerated approval to pemigatinib (PEMAZYRE, Incyte Corporation) for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test. More Information. April 20, 2020

- Food and Drug Administration approved tucatinib (TUKYSA, Seattle Genetics, Inc.) in combination with trastuzumab and capecitabine, for adult patients with advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting. More Information. April 17, 2020

- Food and Drug Administration approved mitomycin (JELMYTO™, UroGen Pharma) for adult patients with low-grade upper tract urothelial cancer (LG-UTUC). More Information. April 15, 2020
- Food and Drug Administration approved selumetinib (KOSELUGO, AstraZeneca) for pediatric patients, 2 years of age and older, with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN). More Information. April 10, 2020

- Food and Drug Administration approved encorafenib (BRAFTOVI, Array BioPharma Inc.) in combination with cetuximab for the treatment of adult patients with metastatic colorectal cancer (CRC) with a BRAF V600E mutation, detected by an FDA-approved test, after prior therapy. More Information. April 8, 2020

- Food and Drug Administration approved luspatercept-aamt (REBLOZYL, Celgene Corporation) for the treatment of anemia failing an erythropoiesis stimulating agent and requiring 2 or more red blood cell (RBC) units over 8 weeks in adult patients with very low- to intermediate-risk myelodysplastic syndromes with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T). More Information. April 3, 2020

FDA Grants Accelerated Approval to a New Dosing Regimen of 400 mg Every Six Weeks for Merck's KEYTRUDA® (pembrolizumab)

On April 28, 2020, the Food and Drug Administration granted accelerated approval to a new dosing regimen of 400 mg every six weeks for pembrolizumab (KEYTRUDA®, Merck) across all currently approved adult indications, in addition to the current 200 mg every three weeks dosing regimen.

The approval was based on pharmacokinetic modeling and exposure-response analyses that compared the predicted exposure of pembrolizumab 400 mg every six weeks to observed exposures of pembrolizumab in patients who received pembrolizumab at 2 mg/kg every three weeks, 200 mg every three weeks, and 10 mg/kg administered every two weeks. The pharmacokinetic modeling were supported by additional exposure-response analyses across the pembrolizumab development program and an interim analysis of pharmacokinetics and overall response rate (ORR) in a cohort of patients (Cohort B) enrolled in Study KEYNOTE-555 (NCT03665597). Cohort B of Study KEYNOTE-555 was an international, single-arm, multi-center study that enrolled 101 patients with advanced or metastatic melanoma who had not received prior PD-1, PD-L1, or CTLA-4 inhibitors (other than CTLA-4 inhibitors in the adjuvant setting). The ORR was 39% (95% CI: 24, 55) in the first 44 patients enrolled in KEYNOTE-555.

For additional safety and efficacy information, and recommended dosing regimens, view the full prescribing information for KEYTRUDA.

This new dosing regimen is approved under accelerated approval based on pharmacokinetic data, the relationship of exposure to efficacy, and the relationship of exposure to safety. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Merck's Biosimilar ONTRUZANT® (trastuzumab-dttb) is Available through Specialty Distributors and Wholesalers

Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., is pleased to announce that ONTRUZANT® (trastuzumab-dttb) for injection, for intravenous use 21 mg/mL, a biosimilar* to Herceptin® (trastuzumab), is available through specialty distributors and wholesalers. Please contact your specialty distributor or wholesaler to confirm product availability.

**Biosimilar means that the biological product is approved based on data demonstrating that it is highly similar to an FDA-approved biological product, known as a reference product, and that there are no clinically meaningful differences between the biosimilar product and the reference product. Biosimilarity of ONTRUZANT has been demonstrated for the condition(s) of use (eg, indication(s), dosing regimen(s), strength(s), dosage form(s), and route(s) of administration described in its Full Prescribing Information).*

ONTRUZANT is available as follows:

PRODUCT	HCPCS CODE1	DESCRIPTOR[1]	HOW SUPPLIED	NDC	CATALOG PRICE[a]
ONTRUZANT	Q5112	Injection, trastuzumab-dttb, biosimilar (ONTRUZANT), 10 mg	Carton with one 150-mg vial, single-dose	0006-5033-02	$1,324.66
			Carton with one 420-mg vial, multi-dose	0006-5034-02	$3,709.04

Indications and Usage: CLICK HERE

Selected Safety Information: CLICK HERE

As Shift Toward Telemedicine Continues, In-Home Infusions Remain a No-Go

The coronavirus disease 2019 (COVID-19) pandemic is drastically changing how cancer is being treated, with an emphasis on triaging patients for in-clinic visits, as well as using home care and telemedicine when possible. While keeping patients at home decreases their risk of contracting the virus, it can also create challenges and safety issues when it comes to procedures like infusions.

READ MORE

Financial Assistance from the Federal Government for Physicians and Practices Impacted by the COVID-19 Pandemic

(Updated as of 4/27/2020)

On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) into law. The law, which established new stimulus and aid programs, will provide more than $2 trillion in emergency economic relief to individuals and businesses affected by the coronavirus crisis . ASCO is providing this resource guide to assist members in accessing critical support needed to sustain the care of patients with cancer.

READ MORE

Program Offers Patients Free Transportation to Cancer Appointments During Pandemic

A new program offers complimentary, door-to-door transportation for patients with cancer needing help getting to and from medical appointments with their community oncology practice during the COVID-19 pandemic.

The Community Oncology Alliance (COA) and CancerCare launched the COA/CancerCare Patient Assistance Transportation Program to ensure patients continue to receive vital cancer treatments from licensed community oncology professionals they know and trust. The program is open to patients receiving cancer care at a registered practice who do not have the ability to travel due to COVID-19. Community oncology practices can register for the program on the COA website CLICK HERE.

Future COVID-19 Legislation Must Protect Patient Access to Cancer Care

(ASCO in Action) Apr 28, 2020 - The Association for Clinical Oncology (ASCO) joined hundreds of other health organizations in signing onto four separate letters to Congress regarding future COVID-19 legislation as part of an effort to ensure patient access to high-quality, high-value cancer care during the pandemic. READ ARTICLE

CHECK OUT OUR LATEST ISSUE....
CLICK HERE

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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

Reimbursement Questions & Answers

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

Question: There is a lot of information about Medicare and telehealth, do these changes apply to Medicare Advantage plans?
Answer: Medicare Advantage plans are encouraged to adopt the CMS telehealth changes, but they are not required to. Additionally, CMS announced that they will permit MA plans to waive cost-sharing for telehealth services.

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Question: What are the timing rules to switch from Medicare Advantage back to Medicare?
Answer: A patient can disenroll from Medicare Advantage (during the annual open enrollment, from October 15 to December 7, or during the annual Medicare Advantage open enrollment period, from January 1 to March 31) and switch back to Original Medicare.

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Question: What will happen to their pharmacy plan when they switch from Medicare Advantage to regular Medicare, does that transfer too?
Answer: A patient also can't switch prescription drug plans or join, switch, or drop a Medicare Medical Savings Account Plan during this period. If they switch to original Medicare during this period, they will have until March 31 to also join a Medicare prescription drug plan to add drug coverage. Coverage will begin the first day of the month after the plan gets their enrollment form.

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Question: Our providers want us to bill Medicare for Advanced Care Planning (99497 - 99498) with telehealth. Is this ok and can we do phone one (no video) with these calls?
Answer: Yes, CMS has included the ACP codes on the telehealth list and they also note that audio only is acceptable.

Continued on next page...

Question: If a physician sees a patient (consulting physician) that is considered to be in "Observation Status", the CPT codes to bill for the consulting physician are E/M codes with POS 22, correct? And the observation CPT codes are only used by the admitting physician, correct? If an Oncologist sees the patient while the patient is in observation status, they use the regular E/M codes.

Answer: Yes, you are correct. E & M, and the position would be 22 because the patient is not admitted to the hospital yet and therefore an outpatient hospital status.

I have also confirmed you will choose the E & M visit codes for the non-admitting provider. Below is an excerpt from a CGS Medicare Fact Sheet:

Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes. - For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

For information regarding hospital billing of observation services, see CMS Pub 100-04, Chapter 4, §290.

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Question: We are a private practice and have been billing our telehealth services with a place of service "02". We recently learned that we can bill with the place of service "11" (office) and a modifier "95." Does it make any difference which one we use really?

Answer: It does. Claims with position "11" will be processed at the Non-Facility (higher) rate.

Continued on next page...

Question: Medicare just announced that they will be reimbursing the same amount for the phone calls as they do for the office visits retroactive to March 1st. Good news, but we were wondering if we have to resubmit our claims for the additional payments, or will Medicare just reprocess for the additional amounts?
Answer: Great question! With the recent announcement, Medicare did not mention anything about claims that were already processed with the lower rate. It is likely they will auto-reprocess the claims, so at this time, I would recommend sitting tight and keeping an eye out for an announcement from Medicare.

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Question: Our Physicians have asked me to reach out to you to clarify the following: CMS Document 1744, released March 30th, on Page 136 - Our question: For telehealth visits, if the visit is only MDM, does time spent need to be documented in the note?
Answer: No. If you are basing your level on MDM, then time does not need to be documented. You will use your CPT book and the E & M guidelines we have been using..... these rules are not new.

What did change during this PHE for telemedicine/office visits with audio and video is the fact that we are allowed to use time rules similar to what till be in effect in 2021. The reference for the time coding is from CMS-1744-IFC - page 136.

"On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, **with time defined as all of the time associated with the E/M on the day of the encounter**; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule."

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Our Mission

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

Vision Statement

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

Values Statement

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

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

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