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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 77 JUNE '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.

COVID-19: Using the CR Modifier and DR Condition Code

CMS revised MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) to clarify when you must use modifier CR (catastrophe/disaster related) and/or condition code DR (disaster related) when submitting claims to Medicare. The update includes a chart of blanket waivers and flexibilities that require the modifier or condition code.

Leadership Panel Addresses Top Issues in Cancer Care

June 1, 2020 - Last month, at the virtual 2020 Community Oncology Alliance Annual Conference, leaders across the cancer care community gathered online for a panel discussion of current events and policy priorities in oncology care. COVID-19 and its fallout on community cancer centers dominated the discussion, which was moderated by Ted Okon, MBA, the executive director of the Community Oncology Alliance (COA). READ MORE

JCO Oncology Practice Examines Updates to ASCO's Alternative Payment Model

May 18, 2020 - A new infographic in the May 2020 print and online issues of *JCO Oncology Practice* (*JCO OP*) outlines paths to implementing the American Society of Clinical Oncology's (ASCO) Patient-Centered Oncology Payment (PCOP) model—an alternative payment model designed to support transformation in cancer care delivery and reimbursement while ensuring that patients with cancer have access to high-quality care.

HHS Extends Deadline to Attest to Provider Relief Fund Terms and Conditions by 45 Days

- HHS has extended the 45-day deadline to accept the Terms and Conditions or reject payment from the Provider Relief Fund to 90 days from the date a payment was received.
- If a provider fails to accept the Terms and Conditions within 90 days, the provider is deemed to have accepted the Terms and Conditions.
- The 45-day extension does not impact the June 3, 2020, deadline for providers to submit revenue information through the General Distribution Payment Portal in order to apply for potential additional payments.
- It is unclear at this time whether providers who have received payment by check from the Provider Relief Fund will also receive a 45-day deadline extension.

On May 22, 2020, HHS announced in a press release that providers who have received payment from the Provider Relief Fund now have 90 days from the date they received payment to accept HHS' Terms and Conditions (Terms and Conditions) or to return the funds. This is the third modification to the Terms and Conditions attestation deadline, coming after the original 30-day deadline was extended to 45 days on May 7, 2020, and after HHS' quieter May 20, 2020, clarification in its Frequently Asked Questions (FAQs). HHS' latest extension of the deadline comes in response to frontline providers' request for additional time to review and agree to the Terms and Conditions.

Although it is not explicitly stated that the new 90-day deadline applies to all payments received under the Provider Relief Fund, given that HHS references both the first and second tranches of the $50 billion General Distribution in its press release – as well as the targeted distributions for hospitals in high-impact areas, rural providers, tribal healthcare providers, and skilled nursing facilities – it seems fairly clear that a provider receiving any distribution made pursuant to the Provider Relief Fund now has 90 days from the date payment was received to attest to the Terms and Conditions applicable to that payment.

The 45-day extension also applies to HHS' guidance regarding automatic acceptance of the Terms and Conditions. HHS is now instructing that if a provider receives payment and fails to accept the Terms and Conditions within 90 days after receipt of payment, the provider is deemed to have *automatically* accepted the Terms and Conditions. READ MORE

Suspending Prior Authorization During COVID-19 Would Help Ensure Patient Access to Needed Care

In an open letter, the Regulatory Relief Coalition (RRC) called on all health plans in the United States to suspend prior authorization requirements for both COVID-19 and non-COVID-19-related services during the novel coronavirus pandemic. The Association for Clinical Oncology (ASCO) is a member of RRC, which is a group of national physician specialty organizations advocating for regulatory burden reduction in Medicare. READ LETTER

Copay Maximizers Are Displacing Accumulators—But CMS Ignores How Payers Leverage Patient Support

COVID-19 has not stopped the wheels of policy bureaucracy from grinding. Last week, the Centers for Medicare and Medicaid Services (CMS) released its final Notice of Benefit and Payment Parameters for the 2021 benefit year. You'll find the document links below. READ MORE

Excluding Drug Coupons From Beneficiary Cost Sharing Could Erode Access to Cancer Care

May 14, 2020 - On May 7, the Centers for Medicare & Medicaid Services (CMS) released the Patient Protection and Affordable Care Act 2021 Notice of Benefit and Payment Parameters final rule, which updates the regulatory and financial standards for Affordable Care Act (ACA) Exchanges. READ ARTICLE

Manage your Medicare appeals online with Novitasphere

Did you know that you can conduct all of your Medicare appeals-related business through Novitasphere? When a mistake happens, because let's face it, we all make mistakes, we encourage you to utilize all of the Medicare appeals-related functionality offered in Novitasphere! Novitasphere users can save valuable time by conducting **claim corrections**, submitting claims or lines as **billed in error** and **appeal requests**, accessing **appeal development letters** and **appeal redetermination notices**, and checking **appeal status**.

Visit our website to learn more and enroll today!

Medical policy

The following local coverage determination posted for notice on April 9, 2020 became effective May 24, 2020. The related billing and coding article also became effective May 24, 2020.

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

The following billing and coding article has been revised:

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

April 2020 top claim submission errors

The April 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. CLICK HERE

April 2020 top inquiries FAQs

The April 2020 Part B top inquiries FAQs, received by our Provider Contact Center, have been reviewed. Please take time to review these FAQs for answers to your questions. CLICK HERE

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Listed are Novitas training events an oncology practice should consider!

WEBINAR

HOME

Novitas Self-Service Tools:

View all Self-Service Tools

Date	Starts	Ends	Event Details	CEUs	Media Type
Monday, June, 08, 2020	12:30 p.m.	02:00 p.m.	***Navigating the Basics of Medicare*** New to Medicare? Learn about the basics of Medicare, covered and non-covered services, the new Medicare Card, Preventive services, Medicare Reimbursement, Electronic billing and more.	1.5	Webinar
Tuesday, June, 09, 2020	10:00 a.m.	11:30 a.m.	***How to Avoid Top Claim Errors*** This class will assist you with recognizing the current top claim errors and will provide suggestions on how to avoid them. Topics will focus on an overview Top Claims Errors, Denials vs Rejections, Claim Filing Reminders and suggestions on improving the accuracy of your billing.	1.5	Webinar
Tuesday, June, 09, 2020	01:00 p.m.	02:30 p.m.	***Journey Through the Novitas and CMS Websites*** This class will explore the various resources on the Novitas Solutions website as well as the Centers for Medicare & Medicaid (CMS) website. We will navigate the Novitas Solutions website search function and criteria, self-service tools, specialty pages, and the calendar of events. We will review the Internet Only Manual, form list, MLN Homepage, and education resources on the CMS website.	1.5	Webinar

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

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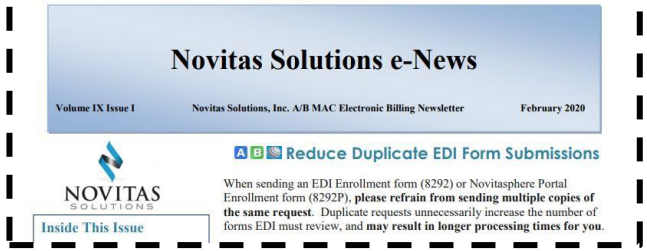
Part B Newsletter

*Current Edition Available...*CLICK HERE

Novitas Solutions e-News Electronic Billing Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



Medicare Part B HOT LINKS!

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

2020 Proposed Rules

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

2020 Final Rules

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

On-Demand *Education*

- Weekly Audio Podcasts
- Training Modules
- Acronyms & Abbreviations
- Frequently Asked Questions
- Evaluation & Management (E/M) Center
- Comprehensive Error Rate Testing (CERT) Center

CMS *Education*

- Open Payments (Physician Payments Sunshine Act) *
- Medicare Learning Network *
- National Provider Training Program *
- Internet-Only Manual *
- Provider Specialty Links
- Safeguarding Your Medical Identity *

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

Confusion Remains over Medicare Guidance on Treating Patient Homes as Hospital Departments

May 19, 2020 – There is continued confusion over the use of patient homes as off-campus, provider-based clinics for Medicare billing purposes. This is the provision in the Centers for Medicare & Medicaid Services' (CMS's) second recent Interim Final Rule (IFR) that allows hospitals to bill for services provided by employed hospital staff, such as therapists, dieticians, and counselors, who do not bill Medicare directly for their services (as they would in private practice). READ MORE

Now Available:
Fact Sheet for State and Local Governments – CMS Programs & Payment for Care in Hospital Alternate Care Sites

In response to the COVID-19 public health emergency, state and local governments, hospitals, and others are developing alternate care sites to expand capacity and provide needed care to patients. This newly published fact sheet provides state and local governments developing alternate care sites with information on how to seek payments through CMS programs – Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) – for acute inpatient and outpatient care furnished at the site.

Fact Sheet

New COVID-19 FAQs on Medicare Fee-for-Service Billing

CMS released additional Frequently Asked Questions (FAQs) on our recent COVID-19-related waivers to help providers, including physicians, hospitals, and rural health clinics. Find more answers to questions on:

- Outpatient therapy
- Telehealth and appropriate coding
- Federally qualified health centers

Telephone Evaluation and Management Visits

The March 30 Interim Final Rule with Comment Period added coverage during the Public Health Emergency for audio-only telephone evaluation and management visits (CPT codes 99441, 99442, and 99443) retroactive to March 1. On April 30, a new Physician Fee Schedule was implemented increasing the payment rate for these codes. Medicare Administrative Contractors (MACs) will reprocess claims for those services that they previously denied and/or paid at the lower rate.

There are also a number of add on services (CPT codes 90785, 90833, 90836, 90838, 96160, 96161, 99354, 99355, and G0506) which Medicare may have denied during this Public Health Emergency. MACs will reprocess those claims for dates of service on or after March 1. You do not need to do anything.

CMS CERT A/B MAC Outreach & Education Task Force

CMS' CERT A/B MAC Outreach & Education Task Force efforts help providers reduce errors. The information on the CMS Task Force web page will also help providers safeguard Medicare dollars. On this page, you can find education resources, presentations, event announcements and more.

Evaluation and Management Services — Revised

A revised Evaluation and Management Services Medicare Learning Network Guide is available. Learn about:

- Documentation
- Billing
- Coding

Telehealth Video: Medicare Coverage and Payment of Virtual Services

This updated video provides answers to common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Medicare FFS 2nd Level Appeals: Submission Options

Learn about communication options available to submit your 2nd level Medicare Fee-For-Service (FFS) claim appeals (i.e., requests for reconsiderations) and documentation to the Qualified Independent Contractors (QICs). Visit the Original Medicare (Fee-for-service) Appeals website to access information on QIC jurisdictions, websites, and options for submission.

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) - July 2020 Update
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy — Revised

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

Effective July 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

FutureScripts® Premium Formulary drug program updates

Effective July 1, 2020, FutureScripts, our pharmacy benefits manager, will make changes to its Premium Formulary.

READ MORE

Independence drug program formulary updates

Effective July 1, 2020, Independence will make changes to its Select Drug Program® Formulary and Value Formulary.

READ MORE

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

Independence | PROVIDER News Center

COVID-19 (Coronavirus): CRNP and PA direct supervision requirements

This article was revised on May 14, 2020, to update the effective timeline.

READ MORE

COVID-19 (Coronavirus): Telemedicine services for Independence members through June 30, 2020

This article was revised on May 12, 2020, to include additional services, billing information for facility and ancillary services, and an updated timeline.

READ MORE

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.

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HIGHMARK BLUE SHIELD

COVID-19 EXTENSIONS THROUGH SEPTEMBER 30, 2020

HIGHMARK EXTENDS COVERAGE OF COVID-19 TREATMENT AND TELEMEDICINE

To help members continue to access needed care as the pandemic continues to affect the regions we serve, Highmark has extended member cost share waivers for in-network, inpatient hospital care, as well as extending telehealth coverage, member cost share and codes through **September 30, 2020**.

READ MORE

POSSIBLE ERROR WHEN SUBMITTING TELEHEALTH CLAIMS THAT REQUIRES A SPECIFIC POS

1500 billers should continue to use Highmark's telehealth reporting guidelines using POS 02 and the GT or 95 modifier (whichever one best represents the visit). We have adjusted our system so that the reimbursement level for claims billed with the POS 02 – telehealth are no longer paying at the lower facility POS rate.

READ MORE

CHANGES TO THE HIGHMARK DRUG FORMULARIES

Following is the update to the Highmark Drug Formularies and pharmaceutical management procedures for May/June 2020.

READ MORE

REIMBURSEMENT POLICY RP-053 GENE & CAR-T/CELLULAR THERAPY UPDATED

Effective May 1, 2020, Highmark Reimbursement Policy Bulletin RP-053, Gene and Cellular Therapy (Car-T), has been updated to reflect changes for procedure codes Q2042 and Q2041 that are billed as inpatient.

READ MORE

PROVIDER NEWS

Most Recent Issue …

CLICK HERE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

- Reminder: Radiation Therapy Coverage Guidelines Effective Aug. 1
- Coverage Criteria Revised for Chimeric Antigen Receptor T-Cell Therapy
- Coverage Guidelines Established for Isatuximab-irfc (Sarclisa)

UnitedHealthcare

UnitedHealthcare COVID-19 End Date and Billing Guidance

Stay informed about COVID-19

Although the national public health emergency period currently has an end date of July 24, 2020, we know your work is far from over. The following resources will help you quickly reference the effective dates for UnitedHealthcare's temporary benefit, program and procedure changes related to COVID-19, as well as billing guidelines for services such as COVID-19 testing, treatment and telehealth.

Program Date Summary

Our Summary of COVID-19 Dates by Program outlines the beginning and end dates of program, process or procedure changes that UnitedHealthcare implemented as a result of COVID-19. Full details of these changes, including applicable benefit plans and service information, can be found online. Please be aware of the following key dates:

- June 1 – All currently effective prior authorization requirements and site of service reviews resume.
- June 30 – Claims with a date of service on or after Jan. 1, 2020 will not be denied for timely filing if submitted by June 30, 2020.
- July 24 – COVID-19 telehealth service coverage and related cost-share waivers for Individual and fully insured Group Market health plan members are extended through July 24, 2020. We'll adhere to state regulations for Medicaid plans.
- Sept. 30 – Cost share is waived for Medicare Advantage members for both primary and specialty office care visits, including telehealth, through Sept. 30, 2020.

Billing Guidance

To help you understand how UnitedHealthcare will reimburse services during the national public health emergency period, please download the COVID-19 Provider Billing Guidance. It outlines billing codes and modifiers. Because guidance may change, please check regularly for updates.

Continued on next page...

UnitedHealthcare

Other Key Reminders

- Mental Health Resources for Health Care Professionals: Resources and support are available to help you focus on, manage and understand your mental and physical well-being during this challenging time.
- HouseCalls and Optum at Home Visits: These visits resumed in some markets on May 22, 2020. We are continuing virtual visits in other markets and will continue to evaluate and resume in-person visits where possible.
- Antibody Test Registration: We're asking all laboratories and health care professionals who perform COVID-19 antibody tests to register the tests they use. The registration takes only a few minutes to complete.

We're Here to Help

As we have throughout the national public health emergency, we're working to update the information that you need as quickly as possible. We continue to update UHCprovider.com/covid19, so please check back frequently for the latest information for health care professionals. Thank you.

Cancer Therapy Pathways Program Opportunities

Your practice may **earn rewards** for eligible commercial plans through the Cancer Therapy Pathways Program. You must confirm your participation in the program by July 30, 2020, to be eligible for the first reward period, January through June 2020. See Terms and Conditions document and UnitedHealthcare Cancer Pathways website for more details related to rewards.

The Pathways provider dashboard contains information about your practice's participation and adherence. This dashboard is available for viewing through Optum's Cancer Guidance Program.

Cancer Therapy Pathways are available to UnitedHealthcare Community Plan, Medicare Advantage and commercial plans (excluding UnitedHealthcare Oxford commercial plans).

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OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

HOME

NEW!

A Few Articles You Won't Want to Miss:

Front & Center

- Policy, Protocol and Program Delays
- New EDI Claim Edits
- Cancer Therapy Pathways Program Opportunities

UnitedHealthcare Commercial 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.

Specialty Medical Injectable Drug Program Updates

- You can access The Specialty Medical Injectable Drug Program Bulletin for the latest updates on drugs added to review at launch, program requirements and policies. Click through for complete details or visit UHCprovider.com.

And Much More...JUNE 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
- Immune Globulin (IVIG and SCIG)
- Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)
- Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)
- Orencia® (Abatacept) Injection for Intravenous Infusion

Updated:

- Clotting Factors, Coagulant Blood Products & Other Hemostatics

Utilization Review Guideline (URG)

Updated:

- Immune Globulin - Site of Care

Revised:

- Outpatient Surgical Procedures – Site of Service

JUNE Monthly Issue Available HERE

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RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- Food and Drug Administration approved ramucirumab (CYRAMZA, Eli Lilly and Company) in combination with erlotinib for first-line treatment of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations. More Information. May 29, 2020

- Food and Drug Administration approved atezolizumab in combination with bevacizumab (TECENTRIQ and AVASTIN, Genentech Inc.) for patients with unresectable or metastatic hepatocellular carcinoma who have not received prior systemic therapy. More Information. May 29, 2020

- Food and Drug Administration approved the combination of nivolumab (OPDIVO, Bristol-Myers Squibb Co.) plus ipilimumab (YERVOY, Bristol-Myers Squibb Co.) and 2 cycles of platinum-doublet chemotherapy as first-line treatment for patients with metastatic or recurrent non-small cell lung cancer (NSCLC), with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations. More Information. May 26, 2020

- Food and Drug Administration approved brigatinib (ALUNBRIG, ARIAD Pharmaceuticals Inc.) for adult patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. More Information. May 22, 2020

- Food and Drug Administration approved olaparib (LYNPARZA, AstraZeneca Pharmaceuticals, LP) for adult patients with deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC), who have progressed following prior treatment with enzalutamide or abiraterone. More Information. May 19, 2020

- Food and Drug Administration approved atezolizumab (TECENTRIQ®, Genentech Inc.) for the first-line treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have high PD-L1 expression (PD-L1 stained ≥ 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 10% of the tumor area [IC ≥ 10%]), with no EGFR or ALK genomic tumor aberrations. More information. May 18, 2020

Continued on next page...

RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- Food and Drug Administration approved ripretinib (QINLOCK, Deciphera Pharmaceuticals, LLC.), for adult patients with advanced gastrointestinal stromal tumor (GIST) who have received prior treatment with 3 or more kinase inhibitors, including imatinib. More Information. May 15, 2020
- Food and Drug Administration granted accelerated approval to rucaparib (RUBRACA, Clovis Oncology, Inc.) for patients with deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy. More Information. May 15, 2020
- Food and Drug Administration approved the combination of nivolumab (OPDIVO, Bristol-Myers Squibb Co.) plus ipilimumab (YERVOY, Bristol-Myers Squibb Co.) as first-line treatment for patients with metastatic non-small cell lung cancer whose tumors express PD-L1(≥1%), as determined by an FDA-approved test, with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations. More Information. May 15, 2020
- Food and Drug Administration expanded the indication of pomalidomide (POMALYST, Celgene Corporation) to include treating adult patients with AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy and Kaposi sarcoma in adult patients who are HIV-negative. More Information. May 14, 2020
- Food and Drug Administration expanded the indication of olaparib (LYNPARZA®, AstraZeneca Pharmaceuticals, LP) to include its combination with bevacizumab for first-line maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, and/or genomic instability. More Information. May 8, 2020
- Food and Drug Administration granted accelerated approval to selpercatinib (RETEVMO, Eli Lilly and Company) for the following indications:
    - Adult patients with metastatic RET fusion-positive non-small cell lung cancer (NSCLC);
    - Adult and pediatric patients ≥12 years of age with advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy;
    - Adult and pediatric patients ≥12 years of age with advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). More Information. May 8, 2020

US Needs Drug Negotiating Power, ASCO Study Concludes

(The Center for Biosimilars) May 31, 2020 - Cancer drug prices are rising in the United States and Europe, but European regulators negotiate drug prices, and the results are seen in pricing trends, say investigators in a presentation at the American Society of Clinical Oncology. READ ARTICLE

Oncology Care Model Reduces Costs but Savings are Modest

Do oncologists in practices that have embraced the Oncology Care Model (OCM) make different care choice from those in practices that are not participating in this Medicare payment program? Yes, it appears that they do.

READ MORE

Billing for Office Visit and Chemotherapy on the Same Day

If you provide an office visit and chemotherapy on the same day, you can bill for both. Where the problems begin is when the provider appends "Modifier 25" to that office visit service. Modifier 25 tells the insurance company that the visit is "significant, separately identifiable evaluation and management (E/M) service" above and beyond the procedure performed that day. Now, we all feel that the visit IS separate from the administration, we certainly are not billing for an examination that takes place while the patient is in the chemo chair during the administration! So many ask, "Why is Medicare making us bring the patient back on a different day for the office visit?" "That is bad medicine and unfair for our patients!"

What is often not understood is that the E/M visit on the same day as chemotherapy IS a paid benefit however, the payment is "bundled" into the payment for the "initial" administration code.

Continued on next page...

When the administration codes were first released, ASCO fought for extra RVUs (value) to be included in the administration codes because they explained, an oncologist would never just put a patient in a chair and start chemo without some evaluation, at least a minimal exam, and checking their count. When the codes released, the "initial" administration codes included physician work RVUs that reimburses for a minimum level office visit to evaluate the patient and affirm they are able to receive treatment. To be clear, a physician is paid for a minimal visit with every initial administration and, unbundling or making the patient come twice would be considered fraud, "double-dipping," and obtaining reimbursement for something they are already being paid for.

With that said, Medicare allows a provider to separately bill for a visit on the same day as the treatment when the visit is above the minimal visit AND medically necessary. In these cases, they would append a modifier 25, which indicates the service is a "significant, separately identifiable evaluation and management (E/M) service" above and beyond the procedure that was also performed that day.

So, for example, a patient that presents and is examined by the provider who also checks their count and affirms they are able to receive the treatment previously ordered. In this case, the visit was already paid for within the RVUs for the initial administration code and the modifier 25 cannot be appended. However, if a provider sees a patient and they complain of a new problem unrelated to the chemotherapy or treatment plan already ordered, or they are being seen to evaluate the disease progression,etc., then a modifier 25 would be appropriate. Remember medical necessity and clear documentation is the key and certainly necessary anytime modifier 25 is appended. There have been multiple audits, payment takebacks, and penalties for misuse of modifier 25. Also, as a reminder, Advanced Practice Providers should be careful to be billing under their own National Provider Number when billing for a new problem or new treatment plan is determined.

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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: I have a question for you. Code Q3014 – telehealth originating site facility fee. Can this code be billed with each telehealth service? EX: 99213 – telehealth and Q3014? I have some carriers that are requesting us to use this code. I thought it was for hospitals.

Answer: You would only bill this code if you are the originating site (the site where the patient is). A telemedicine facility fee, Q3014, is paid to the originating site. Q3014 is the fee for the originating site and is billed only by the facility where the patient is located, and the E&M or other CPT/HCPCS code is billed by the provider in the remote location based on the service that was provided. If the patient were at your office and a physician calls into the office, then that would mean you could bill the originating site fee. (not likely). It is more commonly billed by a nursing home, facility, etc. The same provider should not bill both Q3014 and the E&M service.

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Question: Our physicians were asking about continuing telehealth calls after the end date of the stay at home order. Do you think it is best to have patients start coming back into the office after this date? We are nervous about coverage after this order ends. Any advice on this would be great.

Answer: It is a great idea to establish a plan for what you will do after the Public Health Emergency (PHE) has expired. The PHE which allows the use of the 1135 Waiver, is what is allowing the expansion of telehealth and us to bill Medicare for telehealth services when the patient is at home.

Answer continued on next page...

Answer continued from previous page...

The Public Health Emergency Declaration website states - "Duration and Notification: The declaration lasts for the duration of the emergency or 90 days, but may be extended by the Secretary." To view the PHE website, CLICK HERE. At this point, we do not know IF they will pass any type of telehealth coverage that will allow us to care for our patients at home. At this time, it is presumed we will go back to what was before the PHE and that means that telehealth is only payable in rural settings and from specific locations (not a patient's home).

Remember, private payers can do what they want. I have already seen extensions through the end of the year for some private payers.

So, long story short, yes, I would begin to prepare to transition your patients back to the office and in the meantime, keep an eye out for updates that may extend the ability to utilize telehealth. Additionally, you should review codes that were payable before the pandemic that allows providers to be reimbursed for remote services like virtual care, principle care management.

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Question: Our Hem/Onc physician was asked to consult on a cardiac patient who is being treated for a blood disorder. The progress notes, radiology, and lab studies were sent electronically to our physician for review. The patient is established to the consulting physician's practice, but has not been seen in the last 14 days. The consulting physician reviewed the notes and documented time as follows:

- Five minutes - chart notes and data review (date)
- 15 minutes on (date) - phone consult with cardiologist and three additional minutes writing up the discussion

No face to face with the patient. Can and/or how should this be billed?

Answer: I recommend reviewing CPT code 99448 and the guidelines within CPT. If you meet the criteria, report based on the total time spent. In total, the consultant spent 20 minutes, and more than 50% was spent on the consultative discussion. Because the criteria for reporting code 99448 or 99451 are met, the consulting physician should report code 99448.

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Question: What is the difference between a copay accumulator and a copay maximizer?

Answer: Under an accumulator program, the manufacturer's copay support does not count toward the patient's deductible or out-of-pocket maximum obligations. This reduces the plan's cost by shifting more drug costs to patients and manufacturers.

Under a copay maximizer, the full value of the manufacturer's copayment program is applied evenly throughout the benefit year. A maximizer has an advantage over an accumulator because it reduces or eliminates the patient's out-of-pocket obligations. The patient's actual out-of-pocket costs can be low enough that they never reach their annual deductible and out-of-pocket maximum.

- The patient's out-of-pocket costs are set equal to the maximum annual value of a manufacturer's copayment program. Thus, the copayment is not based on the list or net price of the drug. It is instead determined solely based upon the amount of manufacturer-funded copay assistance.

In the maximizer example above, a manufacturer's program with a total value of $15,000 would equate to a patient's monthly copayment of $1,250.

Here is a link to an article that clearly shows that Maximizers sound good but, "ultimately, the patient will lose." CLICK HERE

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Question: Recently, we received refund request from a recovery company on behalf of Blue Cross for a patient treated (chemotherapy in 2018 and 2019). When we treated the patient, there was only Blue Cross but it seems like the patient applied for Medicare due to chronic kidney disease according to Blue Cross. At this time, Medicare shows primary for the period we treated the patient, but patient did not have Medicare at the time he was treated. Medicare is denying the claims as untimely. And isn't Medicare the payer of last resort? I don't want to refund Blue Cross?

Answer: The first thing you have to do is to verify with the patient (or patient's family) whether the patient was indeed disabled and received Medicare benefits during that time period.

Here is the rule about CKD and Medicare:

- If someone has health insurance through their employer or their spouse's employer, that insurance plan will be primary (pays first) for 30 months starting the day his or her dialysis begins. After that, Medicare pays first, and their employer health plan will pay second.

So, understanding the timing is essential. Once you have clearly established the coverage and responsibility, I assume you will have to reach back to BC and get them the proof they need to resolve this. If and when possible, I would do a 3 way call with the patient on the line too so BC can't say – the patient has to fix this. The patient needs our help to resolve issues like this, especially when they are stuck in the middle.

Here is some additional information on Medicare and CKD that might help.

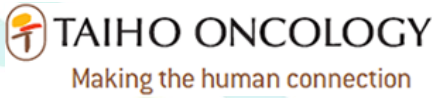
Kidney Failure and Medicare: What you should know – Medicare Rights Center

CORPORATE ALLIES

DIAMOND LEVEL

GOLD LEVEL

SILVER LEVEL



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CHAIR: TBD

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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