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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 85 FEBRUARY '21

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

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POHMS and NJSOM Virtual Spring Conference

Friday, April 30, 2021

Mark your calendars. Our Spring Conference will be virtual and we will once again join with NJSOM to hold this event! Keep an eye on this newsletter and our website for more details coming soon!

IN-PERSON
HIPAA UPDATE TRAINING SESSION FOR POHMS MEMBERS

HIPAA Update Training Session
Hershey Lodge, Hershey, PA
September 24, 2021,
9:00 am – 1:00 pm

SPECIAL PROGRAM NOTE:
As a reminder POHMS has arranged HIPAA Update resources for all of its members through Attorneys at Oscislawski LLC AT NO COST TO YOU!

READ MORE about this exciting program and how to submit your HIPAA questions!

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URGENT MEDICARE ALERT!
Some Medicare Drug Claims Rejected in Error

Medicare systems are rejecting claims for drug HCPCS codes J0897, J3111, and J3590 in error if the drugs are for treatment of conditions other than osteoporosis in the home health setting. The claims are rejected with Fiscal Intermediary Shared System reason code 32453. Over the next several weeks, Medicare Administrative Contractors will correct the error and reprocess these claims. You don't need to take any action.

2021 Special Enrollment Period in response to the COVID-19 Emergency

In accordance with the Executive Order issued today by President Biden, the Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and will provide a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. Starting on February 15, 2021 and continuing through May 15, 2021, Marketplaces using the HealthCare.gov platform will operationalize functionality. READ MORE

ASCO UPDATE - Biden Administration, New Congress Review Recent Rules Affecting Cancer Care Delivery

In the days and weeks leading up to President Biden's inauguration, the Department of Health and Human Services (HHS)—under the prior administration—issued a number of rules and regulations that affect cancer care delivery. Many of those rules and regulations are now subject to review by the new administration and/or Congress. READ MORE

ASCO - Second Court Blocks Most Favored Nation Model Implementation

On December 28, the U.S. District Court for the Northern District of California issued a nationwide preliminary injunction blocking implementation of the Most Favored Nation (MFN) Model. The decision prevents the Centers for Medicare & Medicaid Services (CMS) from implementing the MFN Model until the agency completes the notice and comment procedures required by the Administrative Procedure Act, which requires CMS to solicit comments on a proposal and respond to those comments before finalizing any rules implementing a new payment model. READ MORE

ASH Sends Letter to Private Insurers on Telehealth

In late-December, ASH sent letters to the major private insurance carriers, including the Blue Cross Blue Shield Association and UnitedHealth Group, requesting that coverage of certain telehealth services be made permanent beyond the COVID-19 public health emergency. Specifically, the letter highlighted allowing patients to access telehealth from their homes; providing reimbursement at a rate equivalent to in-person visits; and, continuing to cover and reimburse audio-only services at a rate equivalent to in-person visits. READ LETTER

Extension of Public Health Emergency

On January 7, the Department of Health and Human Services Secretary, Alex Azar, announced the renewal of the COVID-19 national public health emergency (PHE) declaration. The renewal is effective January 21, 2021, and will last 90 days, until April 21, 2021. Regulatory flexibilities, including the expanded telehealth and audio-only services will continue to be available through the end of the PHE. READ MORE

Frequently asked questions

The December 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

December 2020 top claim submission errors

The December 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

Nurse practitioner supporting documentation

When initially enrolling a nurse practitioner, there are two supporting documents required to process the application listed below:

- Copy of the nurse practitioner's certification
- Copy of the master's degree or transcript to support the degree

These documents must be included so that we can verify the requirements to enroll the nurse practitioner in Medicare. Please review our article for more information.

CLICK HERE

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
Tuesday, February 9, 2021	10:00 a.m.	11:00 a.m.	***Novitasphere Claim Correction*** This course will examine how to determine when a claim correction can be performed in Novitasphere and how to complete a clerical reopening. We will also provide examples of claims that can and cannot be updated through the Novitasphere Claim Correction feature.	1.0	Webinar
Wednesday, February 10, 2021	10:00 a.m.	11:00 a.m.	***Overlapping Claims*** This course will provide an overview of overlapping claims. Guidance will be provided for the different facility types on what to include on their bill to prevent a claim from overlapping. There will be a review of what information the IVR will provide relating to overlaps. Answers to the most frequently asked questions relating to overlapping claims will be reviewed.	1.0	Webinar
Tuesday, February 16, 2021	10:00 a.m.	11:30 a.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.	1.5	Webinar

To sign up and register for these newly posted opportunities and to view more...CLICK HERE

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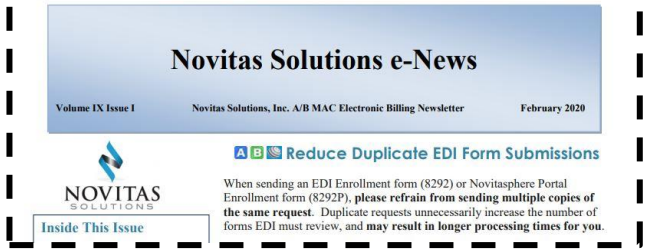
Part B Newsletter

*Current Edition Available...*CLICK HERE

Novitas Solutions e-News
Electronic Billing
Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE


Novitas Solutions e-News

Volume IX Issue I | Novitas Solutions, Inc. A/B MAC Electronic Billing Newsletter | February 2020

NOVITAS SOLUTIONS

Inside This Issue

Reduce Duplicate EDI Form Submissions

When sending an EDI Enrollment form (8292) or Novitasphere Portal Enrollment form (8292P), **please refrain from sending multiple copies of the same request**. Duplicate requests unnecessarily increase the number of forms EDI must review, and **may result in longer processing times for you**.

2021 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

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

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:

No new Oncology related issues since December 2019

A Study of Contractor Consistency in Reviewing Extrapolated Overpayments

The use of extrapolation in Medicare and private payer audits has been around for quite some time now. And lest you be of the opinion that extrapolation is not appropriate for claims-based audits, there are many, many court cases that have supported its use, both specifically and in general. Arguing that extrapolation should not have been used in a given audit, unless that argument is supported by specific statistical challenges, is mostly a waste of time. READ MORE

Think in Ink

Documentation should be concise information, justifying the acuity of an inpatient level of care when appropriate. Statements that physician documentation needs improvement are always being made. These thoughts come from many levels: executives, nurses, utilization review, quality, clinical documentation integrity specialists (CDISs), physician advisors, and so many others. READ MORE

Transparency Rules and the No Surprises Act

First, the Hospital Transparency rule took effect recently. The rule requires hospitals to disclose the prices it charges for 300 shoppable items and services, including the negotiated rates it charges specific payers for those services. READ MORE

HCPCS Code G2211 is a Bundled Service and Not Separately Paid

Medicare Administrative Contractors are denying separate payment for HCPCS code G2211. Under Section 113 of the Consolidated Appropriations Act, HHS is not paying for this code under the Physician Fee Schedule until January 1, 2024. HCPCS code G2211 is a bundled service. Medicare Administrative Contractors will automatically reprocess claims that were paid. You don't need to do anything.

Care Compare: 2019 Preview Period Open through March 25

The Doctors and Clinicians Preview Period is open through March 25 at 8 pm ET. Preview your 2019 Quality Payment Program (QPP) performance information before it appears on the Medicare Care Compare website and in the Provider Data Catalog.

Access the preview through the QPP website. Accountable Care Organizations (ACOs) can preview performance information through their 2019 Merit-based Incentive Payment System Performance Feedback Reports.

For More Information:

- Care Compare: Doctors and Clinicians Initiative webpage
- Preview Period: Performance Information for Doctors and Clinicians presentation
- Doctors and Clinicians Preview Period user guide
- ACO Performance Information on Care Compare fact sheet
- Contact QPP@cms.hhs.gov

Open Payments Data

CMS updated the Open Payments dataset to reflect changes to the data that took place since the last publication in June 2020. We refresh this data at least once annually to include updates from disputes and other data corrections made since the initial publication of the data.

Visit the Open Payments webpage for more information.

Importance of Proper Documentation: Provider Minute Video

Why is proper documentation important to you and your patients? Find out how it affects items and services, claim payment, and medical review in the Provider Minute: The Importance of Proper Documentation video.

Learn about:

- Top five documentation errors
- How to submit documentation for a Comprehensive Error Rate Testing review
- How your Medicare Administrative Contractor can help

Recent LearnResource & MedLearn Matters Articles

- Calendar Year (CY) 2021 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Independence | PROVIDER News Center

HOME

Reminder: eviCore Lab Management Program expanded to Medicare Advantage members

Independence expanded its utilization management program for genetic/genomic tests, certain molecular analyses, and cytogenetic tests for all Independence Medicare Advantage members **as of January 1, 2021.** We are working with eviCore healthcare (eviCore), an independent specialty benefit management company, to manage precertification and/or prepayment coverage reviews for these tests.

To learn more about the program, please read our announcement article.

Independence Administrators to delegate some precertification to eviCore

This article was revised on January 28, 2021, to update the program's policy information.

Beginning April 1, 2021, Independence Administrators will delegate precertification for certain services to eviCore healthcare (eviCore), an independent specialty benefit management company.

Providers should seek precertification from eviCore for:

- Certain genetic/genomic tests (i.e., nucleic acid testing) and certain molecular analyses;
- radiation therapy.

READ MORE

Billing guidelines for leuprolide acetate (Fensolvi®)

Effective March 8, 2021, Fensolvi will only be covered for non-oncologic diagnoses based on the medical necessity criteria outlined in our medical policies.

READ MORE

Introducing Blue Medicare Advantage

Independence is pleased to announce a new joint venture with Anthem, Inc., under the name of Blue Medicare Advantage (Blue MA). Blue MA is the trade name of Group Retiree Health Solutions, Inc., an independent licensee of the Blue Cross Blue Shield Association. READ MORE

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HIGHMARK EXTENDS TEMPORARY PAYMENT INCREASE RELATED TO MEDICARE SEQUESTRATION

Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) in part to assist providers with any operational and business challenges by providing emergency funding. Included in the CARES Act is the temporary suspension of Medicare sequestration reductions. Recently, **Congress approved extending the suspension of Medicare sequestration reductions through March 31, 2021.**

READ MORE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

Nothing Oncology Specific in this month's issue.

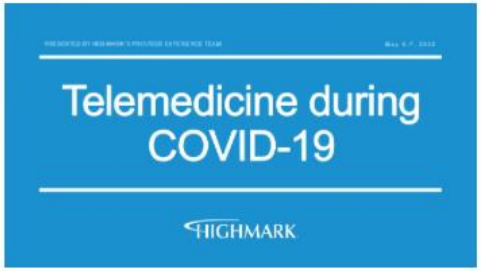
Watch for Updates to Highmark's List of Procedures Requiring Authorization

During the year, Highmark adjusts the List of Procedures/DME Requiring Authorization, which includes outpatient procedures, services, durable medical equipment (DME), and drugs that require authorization for our members.

READ MORE

For More Information CLICK HERE

OTHER PAYER UPDATES



View the Webinar: Telemedicine during Covid-19

CLICK HERE TO VIEW

PROVIDER NEWS
Most Recent Issue …
CLICK HERE

CORRECTION: MEDICARE ADVANTAGE POLICY N-32: SERUM IRON STUDIES – NCD 190.18

On March 16, 2020, Medicare Advantage Medical Policy N-32 Serum Iron Studies – NCD 190.18 was published with incorrect diagnosis codes in the Non-Covered Diagnosis Codes section.

As of **January 4, 2021**, the Non-Covered Diagnosis Codes section has been updated. You can review the revised version of Medicare Advantage Medical Policy N-32 on the **Provider Resource Center** under **Medicare Advantage Policy Search.**

Highmark List of Procedure Codes Requiring NDC

Effective 01/01/2021

CLICK HERE

Enhanced claim edits to support correct coding principles – New coding validation program

Starting February 1, 2021.

READ MORE

OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

NEW!

United Healthcare

Network Bulletin Featured Topics

- Medical policy update bulletins: February 2021
- Reimbursement policy updates: February 2021
- Specialty Medical Injectable Drug program updates: February 2021
- UnitedHealthcare is transitioning to InterQual criteria

And Much More...
FEBRUARY Updates Available HERE

United Healthcare

NEW!

Oncology Related Medical Policy Updates You Won't Want to Miss:

Commercial Medical Benefit Drug Policy Updates
Updated:

- Clotting Factors, Coagulant Blood Products & Other Hemostatics
- Erythropoiesis-Stimulating Agents
- Immune Globulin (IVIG and SCIG)
- Rituximab (Rituxan®, Ruxience® , & Truxima®)
- White Blood Cell Colony Stimulating Factors

Commercial Utilization Review Guideline Updates
Revised:

- Chemotherapy Observation or Inpatient Hospitalization

FEBRUARY Monthly Issue Available HERE

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RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- Food and Drug Administration granted accelerated approval to tepotinib (Tepmetko, EMD Serono Inc.) for adult patients with metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations. More Information. February 3, 2021

- Food and Drug Administration approved the combination of nivolumab (Opdivo, Bristol-Myers Squibb Co.) and cabozantinib (Cabometyx, Exelixis) as first-line treatment for patients with advanced renal cell carcinoma (RCC). More Information. January 22, 2021

- Food and Drug Administration granted accelerated approval to daratumumab plus hyaluronidase (Darzalex Faspro, Janssen Biotech Inc.) in combination with bortezomib, cyclophosphamide and dexamethasone for newly diagnosed light chain (AL) amyloidosis. More Information. January 15, 2021

- Food and Drug Administration approved fam-trastuzumab deruxtecan-nxki (Enhertu, Daiichi Sankyo) for adult patients with locally advanced or metastatic HER2-positive gastric or gastroesophageal (GEJ) adenocarcinoma who have received a prior trastuzumab-based regimen. More Information. January 15, 2021

- Food and Drug Administration approved crizotinib (Xalkori, Pfizer Inc.) for pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive. The safety and efficacy of crizotinib have not been established in older adults with relapsed or refractory, systemic ALK-positive ALCL. More Information. January 14, 2021

Reimbursement Questions & Answers

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

Question: I see the Medicare announcement that the specialist E & M codes is bundled. Does this mean we have to have it on our claim? Why?

Answer: No, it is not required to bill the specialist code. As you know, in a legislation related to COVID relief, there is a provision that disallows Medicare from reimbursing the G2211 for 3 years. You should not bill the G2211 with your outpatient visit codes until January 1, 2024.

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Question: It is my understanding that the Oncology Care Model was to end this year, June, 2021, is this still true? When does the Oncology Care First model begin?

Answer: While the CMMI website still says the OCM is to end in June, 2021, in a COVID-19 Relief announcement from Medicare last June, CMS stated that the OCM will be extended one year, until June 2022. They did not mention OCF in that announcement or in the Final Rules that were released in December, however, ASCO and COA have stated they "assume" it has been extended as well. It was supposed to begin January of this year. Of note; COA mentioned they are keeping an eye on the new Administration and HHS and expect some changes to OCF and the models overall. We will have to wait to see what happens.

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Continued on next page...

Question: I've heard that MFN was put on hold. Thank goodness! Is this gone for good and we will stay at ASP +6%?

Answer: I've received this question numerous times, I've confirmed again today that, because of the California lawsuit, Judge Chhabria's order vacates the MFN Rule until CMS completes the notice and comment process under the Administrative Procedure Act. This will also allow some time for the new Biden administration to respond to the MFN Model and the pending litigation. Here is a link to a recent ACCC article on this topic, CLICK HERE

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Question: Wow, I see that the Transitional Care Management Services reimbursement went up substantially this year! To be honest, we forget to bill this most of the time and just bill the office visit. My goal for 2021 is to capture this revenue! Can you tell me where to find more information on billing these services?

Answer: I do see that the CMS MLN fact sheet on Transitional Care Management Services is "under revision" so, I need to refer you to the FAQ, CLICK HERE. I also see that a different Medicare contractor, Noridian, has a great website on this topic CLICK HERE. Lastly, there was a recent article in Medical Economics I would also recommend CLICK HERE

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Continued on next page...

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FAQ'S

Question: Hoping you can point me in the right direction, I have a Medicaid takeback on claims 4 and 5 years old stating Medicare primary. Of course, Medicare will not pay over file limit and when we checked the patient's insurance at time of service it did not show Medicare at all. Any suggestions?

HOME

Answer: There are exceptions to the Timely Filing Rule with Medicare and retroactive Medicare entitlement is one of them. Below is an excerpt from the Medicare Claims Processing Manual, Chapter 1 which should help you; see below and CLICK HERE FOR REFERENCE

70.7.3 – Retroactive Medicare Entitlement Involving State Medicaid Agencies
(Rev. 2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

The time for filing a claim will be extended if CMS or one of its contractors determines that failure to meet the filing deadline is caused by all of the following conditions:
(a) At the time the service was furnished the beneficiary was not entitled to Medicare.
(b) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.
(c) A State Medicaid Agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the date of the furnished service.

In these situations, at the time services were furnished the beneficiary was entitled to Medicaid but not to Medicare. After the date of the furnished services, the beneficiary is then notified that he or she is entitled to Medicare. Finally, sometime after the date of the furnished service, the State Medicaid Agency recoups the money it paid the provider or supplier. If the State Medicaid Agency recoups the money it paid the provider or supplier 6 months or more after the date the service was furnished, the provider or supplier may be given an extension to have those claims filed to Medicare.

In order to qualify for this exception, the provider or supplier will need to provide the claims processing contractor with the following information:

- *documentation verifying the date that the State Medicaid Agency recouped money from the provider/supplier;*
- *documentation verifying that the beneficiary was retroactively entitled to Medicare to or before the date of the furnished service (e.g., an official SSA letter to the beneficiary, or if an official SSA letter is not available, the contractor shall check the CWF database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement; see the example in section 70.7.2 above concerning the CWF for additional details regarding this contractor verification process); and,*
- *documentation verifying the service/s furnished to the beneficiary and the date of the furnished service/s.*

If the contractor determines that all of the conditions described above for meeting this exception are met, the contractor will notify the provider or supplier in writing that a filing extension will be allowed from the end of the 6th calendar month from the month in which the State Medicaid Agency recovered its money.

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CHAIR: Ellen Bauer

Programs Committee
CHAIR: Fran Spine

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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