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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

We hope you enjoy this new version of the POHMS Newsletter

Issue 52 MAY '18

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

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LAST CHANCE TO REISTER FOR THE

POHMS Annual Spring Conference

See page 3 for details...

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

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POHMS UPCOMING EVENTS

POHMS Annual Spring Conference

Thursday, May 17, 2018
Sheraton Valley Forge, King of Prussia, PA

A little bit of fun tucked into a full agenda not to mention the invaluable interaction networking with our Peers and POHMS supporting vendors!

Our speakers will assist you in navigating our current challenges: from the latest government updates and the Landscape of Oncology, Disruption in Healthcare, the Medically Integrated Dispensary in Community Oncology, the Current State of Health Literacy in the US and Pennsylvania to Compliance!

Please join us in what will prove to be another successful POHMS event.

Do not hesitate, register today!

FOR ADDITIONAL DETAILS AND REGISTRATION… CLICK HERE

Continuing on Friday, don't miss the…

Human Resource Workshop

Friday, May 18, 2018
9:00 am to 1:00 pm

For POHMS Active and Associate Members

Topics include:

- **Employee Recruitment and Retention**
- **Employee Motivation**
- **Top 10 HR Concerns**

Mark Your Calendar Now!

POHMS Annual Fall Conference

October 18-19, 2018
(NOTE: Not November this year)
Hotel Hershey, Hershey, PA

Coming soon….

MACRA Updates Webinar

Watch for details to be announced soon.

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They are called 'co-pay accumulators,' and they're a way insurers make you pay more for Meds

By David Lazarus, April 27, 2018 - Many insurers are introducing so-called copay accumulators to their plans. What this means is that coupons no longer will be counted toward patients' deductibles. READ MORE

CMS to Recast 'Meaningful Use' Data Reporting Rules

(Medscape Medical News) Apr 25, 2018 - The Trump administration intends to use the annual update of the Medicare payment rule to rebrand and streamline electronic data reporting requirements, abandoning the much derided "meaningful use" name. READ ARTICLE (free registration required)

COA Practice Impact Report Details Consolidation, Shift of U.S. Cancer Care System Into More Expensive Hospital Setting

(COA) Apr 12, 2018 – The Community Oncology Alliance (COA) today released the 2018 Community Oncology Practice Impact Report which tracks data on the changing landscape of cancer care in the United States.

READ PRESS RELEASE

COA Statement On 340B Optimization Act

(COA) Apr 24, 2018 - "Years of independent studies and investigations have uncovered that the 340B program is out of control in many hospitals and is not functioning to help patients in need," Ted Okon, executive director, COA.

READ PRESS RELEASE

Frequently Asked Questions (FAQs)

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

Part B Top Claim Submission / Reason Code Errors

The Top Submission / Reason Code Errors and resolutions for March 2018 for Delaware, Washington D.C., Maryland, New Jersey, and Pennsylvania are now available. Please take time to review these errors and avoid them on future claims. CLICK HERE

Appealing New Patient Denials

Are you receiving unfavorable appeal decisions for new patient claim denials? Please read our new article for supporting documentation guidance and helpful tips. READ MORE

Learn About Novitasphere With Our New Videos

Want to learn more about Novitasphere, our FREE secure, web-based portal? Now you can watch short, educational videos, right on our website! You can find the videos on our Novitasphere Portal Center under the Quick Links. Check back often as we update these videos with new features or hot topics!

Our previously featured video, Claim Corrections in Novitasphere, can be found on the Novitasphere Reference Materials page.

Part B Top Inquiries / Frequently Asked Questions (FAQs

The Part B Top Inquiries / FAQs, received by our Customer Contact Center, have been reviewed for March 2018. New questions / answers have been added to the following categories:

- Claims
- Eligibility

Please take time to review these and other FAQs for answers to your questions. CLICK HERE

NOVITAS SOLUTIONS

WEBINAR

Listed are Novitas training events an oncology practice should consider!

HOME

Novitas Self-Service Tools:

View all Self-Service Tools

Date	Starts	Ends	Event Details	CEUs	Media Type
Tuesday, May 8, 2018	10:00 AM	11:00 AM	**Novitasphere Enrollment** This course we will discuss the steps to enroll in Novitasphere, including the Enterprise Identity Management (EIDM) registration process.	1.0	Webinar
Wednesday, May 16, 2018	11:00 AM	12:00 PM	**Novitasphere Claim Submission** This course will focus on how to submit claims through the Novitasphere portal. We will show you how to submit an 837 ANSI batch claim file, how to enter single claims into the Direct Data Entry feature, and how to download your electronic claim reports.	1.0	Webinar
Friday, May 18, 2018	11:00 AM	12:00 PM	**Are You Ready for the New Medicare Card** This course introduces the new Medicare card. We will discuss how to prepare for this new change, assist you in locating valuable resources, and review the timelines for submitting claims using the new Medicare Beneficiary Identifier.	1.0	Webinar
Tuesday, May 29, 2018	10:00 AM	11:30 AM	**Local Coverage Determination (LCD) Additions and Revisions** The class will discuss new Local Coverage Determinations (LCDs) and updates to existing LCDs. We will review new Local Coverage Articles and revisions. We will explore draft LCDs posted for comments and retired LCDs.	1.0	Webinar

For many more opportunities and to register…

CLICK HERE

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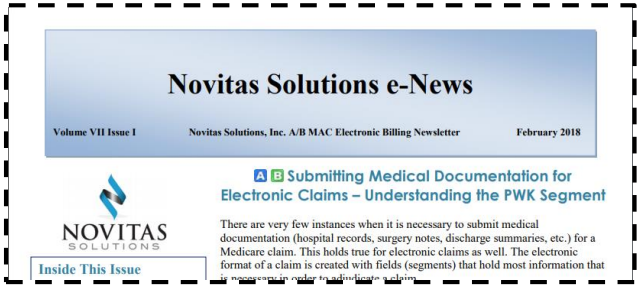
Part B Quarterly Newsletter

*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

2018 Final Rule

Physician Fee Schedule

Physician Fee Schedule Fact Sheet

HOPPS

HOPPS Fact Sheet

QPP

QPP Fact Sheet

On-Demand *Education*

- Weekly Audio Podcasts
- Training Modules
- Medicare Reference Manual
- Specialty Guides
- 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 *

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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:

Observation Evaluation & Management (E&M) codes billed same day as Inpatient Admission
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.

PROVIDER UPDATE – Provider Education

RAC Region 4 Recovery Audit Process

"New" HMS Provider Portal User Guide – Part B Providers

Auditors Going from Targeting Just Physicians to Targeting Physicians and NPPs

By Frank D. Cohen, MPA, MBB
There are now 200,000 new targets for CMS and private payers. Since the first of this year, I have engaged in several audits for which the target is not the physician, but rather a physician's assistant (PA) or a nurse practitioner (NP). While there have always been audit issues regarding…READ MORE

RAC Monitor continued on next page…

Exclusive: Medicaid: The State of the Union

By Knicole C. Emanuel Esq.

The latest and greatest in Medicaid news, state by state. While Medicare is a nationwide healthcare insurance program, Medicaid, the government-funded health insurance for the poor and developmentally disabled, is state-specific, generally speaking. The backbone of Medicaid is federal; federal regulations set forth the minimum requirements that states must follow….READ MORE

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2018 Update

Change Request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes 4 new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. READ MORE

Open Payments Review and Dispute Data by May 15

Open Payments Program Year 2017 data and any newly submitted records are available for review. Physicians and teaching hospitals: review, affirm, and, if necessary, dispute these records by May 15. Review of the data is voluntary but strongly encouraged.

Disputes must be initiated during the review and dispute period to be reflected in the June 2018 data publication. For more information, read the Review and Dispute Quick Reference Guide.

To review your data, register in the Open Payments system. Visit the Registration for Physicians & Teaching Hospitals webpage for instructions. If you are already registered, log in to review your data:

- If you have not accessed your account in 60 days or more, you will need to unlock your account in the CMS Portal
- If you have not accessed your account in 180 days or more, your account has been deactivated, and you will need to contact the Open Payments Help Desk to reinstate your account

For More Information:

- Open Payments website
- Contact the Open Payments Help Desk at openpayments@cms.hhs.gov or 855-326-8366; TTY 844-649-2766

Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16

- Wednesday, May 16 from 1:30 to 3 pm ET
- Register for Medicare Learning Network events.

CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"

CMS is overhauling and streamlining the Electronic Health Record (EHR) Incentive Programs for hospitals as well as for the Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS), which is one track of the Quality Payment Program. To better reflect this focus, CMS is renaming:

- The EHR Incentive Programs to the Promoting Interoperability Programs for eligible hospitals, critical access hospitals, and Medicaid providers
- The MIPS Advancing Care Information performance category to the Promoting Interoperability performance category for MIPS eligible clinicians

Note: this rebranding does not merge or combine the EHR Incentive Programs and MIPS.

Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

A 2017 Office of the Inspector General (OIG) report noted that, in some cases, pharmacies incorrectly billed Medicare Part B for claims using the KX modifier for immunosuppressive drugs. It is estimated that Medicare paid $4.6 million for these claims that did not comply with Medicare requirements.

In response to this report, CMS clarified manual instructions on the use of the KX modifier to help pharmacies document the medical necessity of organ transplant and eligibility for Medicare coverage. Resources for pharmacies:

- CMS and Its Claims Processing Contractors Issued Conflicting Guidance on the Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims OIG Report, August 2017
- Pharmacy Billing of Immunosuppressive Drugs MLN Matters® Article
- Clarification of the Billing of Immunosuppressive Drugs MLN Matters Article

Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New

A new MLN Matters Article on Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to Procedure (PTP) Edits, Version 24.2 Effective July 1, 2018 is available. Learn about an update to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual.

General Equivalence Mappings FAQs Booklet

The General Equivalence Mappings FAQs Booklet is available. Learn about:

- Use of external cause and unspecified codes in ICD-10-CM
- Conversion of ICD-9-CM codes to ICD-10-CM/PCS and ICD-10-CM/PCS codes back to ICD-9-CM

Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised

A revised Guidelines for Teaching Physicians, Interns, and Residents Booklet is available. Learn about:

- Payment for physician services in teaching settings
- Evaluation and Management (E/M) documentation
- Exception for E/M services furnished in certain primary care centers

ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder

The ICD-10-CM/PCS: The Next Generation of Coding Booklet is available. Learn about:

- Use of external cause and unspecified codes in ICD-10-CM
- CPT and HCPCS codes
- Similarities and differences between ICD-9-CM and ICD-10-CM
- New features and additional changes in ICD-10-CM

New Medicare Card Project – Important Updates

CMS started mailing newly-designed Medicare cards with the new Medicare Beneficiary Identifier (MBI), or Medicare Number. People enrolling in Medicare for the first time will be among the first to get the new cards, no matter where they live. Current Medicare beneficiaries will get their new cards on a rolling basis over the coming months. We will continue to accept the Health Insurance Claim Number (HICN) through the transition period.

During our planning, we continuously adjusted and improved our mailing strategy to make sure we are:

- Mailing the new cards to accurate addresses
- Protecting current Medicare beneficiaries and their personal information in every way possible

We are working on making our processes even better by using the highest levels of fraud protection when we mail new cards to current Medicare beneficiaries. Over the next few weeks, we will complete this additional work and begin mailing new cards to current Medicare beneficiaries.

We are committed to mailing new cards to all Medicare beneficiaries over the next year. For more information, visit the New Medicare Card landing and provider webpages.

Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction

For the 2017 reporting period, the Medicare Fee-For-Service (FFS) improper payment rate for oral anticancer drugs was 43.2 percent, representing a projected improper payment amount of $66.09 million. According to 2016 reporting data, improper payments resulted from:

- Insufficient documentation - 74 percent
- No documentation - 1.8 percent
- Other reasons such as duplicate payment error, non-covered or unallowable service, or ineligible Medicare beneficiary - 24.1 percent

Prevent denials by reviewing the Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs used in Conjunction Fact Sheet for coverage and documentation requirements.

Additional Resources:

- 2017 Medicare FFS Supplemental Improper Payment Data
- Supplementary Appendices for the Medicare FFS 2016 Improper Payments Report
- Local Coverage Determination: Oral Anticancer Drugs
- Local Coverage Article: Oral Anticancer Drugs

2018 MIPS Eligibility Tool

Use the updated MIPS Participation Lookup Tool to check on your 2018 eligibility for the Merit-based Incentive Payment System (MIPS). Just enter your National Provider Identifier to find out whether you need to participate during the 2018 performance year.

To reduce the burden on small practices, CMS changed the eligibility threshold for 2018. Clinicians and groups are now excluded from MIPS if they:

- Billed $90,000 or less in Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS)
- Furnished covered professional services under the PFS to 200 or fewer Medicare Part B -enrolled beneficiaries

New Waived Tests MLN Matters Article — New

A new MLN Matters Article on New Waived Tests is available. Learn about the latest tests approved by the Food and Drug Administration under Clinical Laboratory Improvement Amendments.

April 2018 MLN Catalog – Revised

A revised April 2018 MLN Catalog is available. Learn about:

- Products and services that can be downloaded for free
- Web-based training courses; some offer continuing education credits
- Helpful links, tools, and tips

2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised

With Continuing Education Credit

A revised 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training (WBT) course is available through the Learning Management System. Learn about:

- Planning and performing data validation activities
- Analyzing results and submission of findings
- Completing the post-data validation activities

CMS Transmittal 191 on OCM Bundling Edits

This transmittal formalizes the existing bundling edits on the Oncology Care Model. That is, CMS has increased the codes that may not be billed for the same beneficiary in the same month as the OCM Monthly Enhanced Services (MEOS) payment (G9678). These services include 99358 and 99359 (Prolonged non - face - to - face evaluation and management services); 99487 and 99489 (Chronic Care Management); G0506 (Assessment/care planning for patients requiring CCM services); CLICK HERE to review the remaining codes and the rest of this Transmittal

MLN Matters — Information for Medicare Fee-For-Service Health Care Professionals

Recent LearnResource & MedLearn Matters Articles

- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2018 Update (MM 10624)

Independence | PROVIDER News Center

Medical codes for services that require precertification

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

To access *Services that require precertification*, visit our Medical Policy Portal and select *Accept and Go to Medical Policy Online*. Choose the *Commercial* or *Medicare Advantage* tab from the top of the page, then select *Services Requiring Precertification* from the left-hand menu.

Reminder: Site of service changes and new coverage option for Benlysta®

As a reminder, **effective June 1, 2018,** Independence will add the infusible formulation of Benlysta to our *Most Cost-Effective Setting Program* for members enrolled in commercial products.

For More Information and to review the entire list of drugs on the "Most Cost-Effective Setting Program" CLICK HERE

Code update for home prothrombin time monitoring

The ICD-10-CM guidelines for coding home prothrombin time monitoring have recently been updated to further define the medically necessary indications. Therefore, Independence is updating our policies on home prothrombin time monitoring to reflect these coding changes.

The following policies were posted as Notifications on April 3, 2018, and will go into effect **July 2, 2018:**

- **Commercial:** #05.00.26g: Home Prothrombin Time Monitoring
- **Medicare Advantage:** #MA05.016d: Home Prothrombin Time Monitoring

See Coding Examples – CLICK HERE

Reminder: Enhanced claim edits to support correct coding principles to begin in June 2018

As a reminder, starting June 10, 2018, Independence will implement a claim editing process during prepayment review to increase compliance with current industry standards and support the automated application of correct national coding principles.* By applying these principles, we will be consistent with other payers in the region and will apply claim payment principles that are national in scope, simple to understand, and continue to comply with industry standard sources, including:

READ MORE

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OTHER PAYER UPDATES

THREE (NOT FOUR) HCPCS CODES TO REQUIRE PRIOR AUTHORIZATION EFFECTIVE MAY 1, 2018

Revised April 30, 2018
Effective with dates of service of May 1, 2018, and beyond, the three HCPCS Level II Procedure codes below will require prior authorization before providing the services to Highmark members;

J0565 – Injection, bezlotoxumab, 10 mg (Zinplava)
J9032 – Injection, belinostat, 10 mg (Beleodaq)
J9039 – Injection, blinatumomab, 1 microgram (Blincyto)

SECOND QUARTER 2018 UPDATE – CHANGES TO THE HIGHMARK DRUG FORMULARIES

This 86 page article includes information on;

- National Select Formulary – Select Commercial Plans beginning July 1, 2018
- Select Commercial and Healthcare Reform Plans July 2018
- Highmark Medicare Part D Formularies

CLICK HERE to review!

Be sure not to miss the April edition included guideline revisions for Ipilimumab (Yervoy), Bortezomib (Velcade), Ado-trastuzumab emtansine (Kadcyla)

HIGHMARK MEDICAL POLICY UPDATE
Published Monthly ...CLICK HERE

KEY FAQs ABOUT MEDICARE COMPLIANCE AND FWA TRAINING

If your practice or facility cares for Medicare-eligible patients, please read this important notice.

CLICK HERE

PROVIDER NEWS
Most Recent Issue ...
CLICK HERE

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OTHER PAYER UPDATES

A Few Articles You Won't Want to Miss:

- Changes to our National Precertification List (NPL)
- Request precerts electronically — it's fast, secure and simple
- Ordering genetic tests in the correct sequence will result in fewer denials
- Changes to commercial drug lists begin on July 1, 2018

And Much More….

MARCH
Northeast Region
Qtly Issue Available HERE

NEW!

UnitedHealthcare
NetworkBulletin
An important message to health care professionals and facilities
Please route as appropriate to UnitedHealthcare contracted physicians and health care professionals in your office.

A Few Articles You Won't Want to Miss:

Front & Center
- Denosumab (HCPCS code J0897) Requires Prior Authorization Link Self-Service Updates and Enhancements
- Link Self-Service Updates
- Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs

UnitedHealthcare Commercial
- Risk Adjustment Data Validation (RADV) Audit Program

Doing Business Better
- 2017 Quality Improvement Program Overview

And Much More…
MAY Monthly Issue Available HERE

NEW!

UnitedHealthcare
Medical Policy Update
Bulletin
Medical Policy, Drug Policy & Coverage Determination Guideline (CDG) Updates

Oncology Related Articles You Won't Want to Miss:

Medical Policy Updates
Updated:
- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions – Effective Jul. 1, 2018

Medical Benefit Drug Policy Updates
New:
- Crysvita® (Burosumab-Twza) – Effective May 1, 2018

Updated:
- Benlysta® (Belimumab) – Effective May 1, 2018
- Entyvio® (Vedolizumab) – Effective May 1, 2018
- Radicava™ (Edaravone) – Effective May 1, 2018
- Vaccines – Effective May 1, 2018

MAY Monthly Issue Available HERE

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DRUG SHORTAGES –

If you are looking for a complete list of Drug Shortages from the FDA CLICK HERE.

RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- FDA granted regular approval to dabrafenib (TAFINLAR, Novartis Pharmaceuticals Corp.) and trametinib (MEKINIST, Novartis Pharmaceuticals Corp.) in combination for the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection. More Information. April 30, 2018
- FDA approved osimertinib (Tagrisso, AstraZeneca Pharmaceuticals LP) for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test. More Information. April 19, 2018
- FDA approved fostamatinib disodium hexahydrate tablets (TAVALISSE, Rigel Pharmaceuticals, Inc.) for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment. More Information. April 17, 2018
- FDA granted approvals to nivolumab and ipilimumab (Opdivo and Yervoy, Bristol-Myers Squibb Co.) in combination for the treatment of intermediate or poor risk, previously untreated advanced renal cell carcinoma. More Information. April 16, 2018
- FDA approved everolimus tablets for oral suspension (Afinitor Disperz, Novartis Pharmaceuticals Corp.) for the adjunctive treatment of adult and pediatric patients aged 2 years and older with tuberous sclerosis complex (TSC)-associated partial-onset seizures. Everolimus is also approved for two other manifestations of TSC: TSC-associated subependymal giant cell astrocytoma (SEGA) and TSC-associated renal angiomyolipoma. More Information. April 10, 2018
- FDA approved rucaparib for maintenance treatment of recurrent ovarian, fallopian tube, or primary peritoneal cancer. More Information. April 6, 2018

ICD10monitor

Auditing Issues Uncovered in Physician Documentation: Part I

One of the services I offer, aside from coding and billing education, is practice audits for evaluation and management (E&M) procedural services, and ICD-10-CM coding. Lately, as auditing season is heating up, physician practices with documentation concerns contact me daily to review their clinical documentation improvement (CDI) policies so they are secure in their practices to avoid documentation issues that can lead to negative payor audits. Read the full story →

Top 5 Developments and Concerns of Community Oncology Practices

The Community Oncology Alliance (COA) hosted its annual meeting April 12-13, 2018, in National Harbor, Maryland. The meeting, which brings together stakeholders from across oncology, delved into overcoming the challenges with patient care that community oncology practices face on a daily basis. READ MORE

Feds Boast $2.4B in Healthcare Fraud Judgments, Settlements

April 9, 2018 - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the HCFAC. The program is a collaborative effort between the attorney general and the HHS secretary, who acts through the inspector general.

National healthcare fraud has been on the upswing over the past few years. There were more than 400 defendants charged in fiscal 2017, which was an increase over 2016 (300) and 2015 (about 250). READ MORE

ASCO in Action
News, Advocacy, and Analysis on Cancer Policy

Payment Bundles That Include Drug Costs May Destabilize Cancer Care Delivery Environment

(ASCO in Action) Apr 12, 2018 - An analysis published today in the American Society of Clinical Oncology's (ASCO) Journal of Oncology Practice (JOP), suggests that including cancer drug costs in bundled payments under Medicare risks destabilizing the cancer care delivery environment. READ ARTICLE

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Reimbursement Questions & Answers

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



Question: With a physician in the suite and available, a midlevel provider sees an established patient in follow-up for chemotherapy previously ordered by the MD and addresses an issue related to the chemotherapy treatment, ie: expected side effect from the chemotherapy. We want to confirm that the visit would qualify for "incident to".

Answer: If the service that the midlevel provider performs is an integral part of the plan of care that was initially established by the billing/supervision MD, the service would qualify for "incident to" as long as all incident to criteria is met. The plan of care/treatment plan set by the physician must be followed by the midlevel practitioner. When the midlevel makes a change to that plan, the midlevel services are no longer incident to. This is also the case for the "oh, by the way" situations for which the midlevel is now addressing treatment that is not already under the billing/supervision physician's plan of care. In such a case, incident to no longer applies.

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Question: If a midlevel sees an established patient "incident to" but during the visit the patient has a new problem. The Midlevel discusses the problem with the MD who is in the suite and available and documents the MDs decision-making. (example: provide the patient with a prescription for an antibiotic – addressing their cold/flu symptoms). Is it appropriate to bill this visit as "incident to" or would it be necessary to bill this visit under the NPI of the midlevel since she has addressed a "new" problem outside the side effects of the patient's chemo.

Continued on next page...

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Answer: For the situation described, it is not appropriate to bill the visit as an "incident to" service. The service is no longer incidental to the physician because a "new" problem was addressed during the Mid-level visit. The Mid-level must bill the service under his/her own NPI/PTAN. The Mid-level should choose the CPT code based on the medically necessary services documented in the patient's medical record.

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Question: If the provider office meets the "incident to" requirements - is it necessary to put the NPI of the midlevel provider anywhere on the claim?

Answer: Currently, it is not necessary to put the NPI of the rendering midlevel provider anywhere on the claim when the billing/supervising physician is submitting the service under Medicare's incident to concept.

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Question: Just wondering if you had any tips or suggestions for discharging a patient while undergoing treatment. I would be sending her a certified letter stating the reason we can no longer care for her along with the names and phone numbers of other oncologists in town (not sure if this needs to be done or not due to the circumstances of discharge). Without saying too much, she is regularly under the influence of narcotics and Dr. feels he cannot properly treat her as she tends not to show up on a regular basis, and when she does, she is no condition for chemotherapy. We have never discharged a patient during treatment and just want to make sure we are covering our basis. Thanks.

Answer: I recommend that you review this article, I believe you will find answers to your questions about discharging the patient; CLICK HERE.

Continued on next page...

Question: Would you mind clarifying the proper use of 96368 for billing in chemotherapy. Can we bill for the 96368 if they are a therapeutic drug and a chemotherapy drug going to the same access site??? Can we only bill the 96368 when they are concurrent and going to different access sites? I have gotten so many different answers and feel that you could answer this question once and for all.

Answer: I used to call it "Concurrent Confusion" - because it is challenging to understand. If you have a therapeutic drug, in a SEPARATE BAG, hanging at the same time as another drug - (concurrently) - then you can use the code.

The AMA defines a concurrent infusion as one in which two drugs are simultaneously infused or multiple infusions are provided through the same intravenous line. Note: Multiple substances mixed in one bag are considered to be one infusion, not a concurrent infusion, and you should not use the 96368 in this situation.

The concurrent CPT/Charge is limited to unit of one regardless of the duration of the concurrent infusion.

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CORPORATE ALLIES

DIAMOND LEVEL

AMGEN

Bristol-Myers Squibb

Celgene

CHOC Community Hematology Oncology Consortium

Genentech
A Member of the Roche Group

Lilly

McKESSON
Empowering Healthcare

Oncology Supply
AmerisourceBergen Specialty Group

Takeda
ONCOLOGY

GOLD LEVEL

astellas

Bayer HealthCare
Pharmaceuticals

Incyte

janssen
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

MERCK

NOVARTIS

pharmacyclics

SILVER LEVEL

Daiichi-Sankyo

SANDOZ
a Novartis company

TAIHO ONCOLOGY
Making the human connection

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POHMS Committees

By-Laws
CHAIR: Maryann Wingate

Finance Committee
CHAIR: Diane Carter

Marketing/Membership Development
CHAIR: Ellen Bauer

Programs Committee
CHAIR: Azlynn Swartz

Our Mission

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

Vision Statement

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

Values Statement

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

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

POHMS Board of Directors

Executive Committee
Maryann Wingate
President

Kim DiStasio
Vice President

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Treasurer

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