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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

Issue 94 NOVEMBER '21

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

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NOW A VIRTUAL EVENT

POHMS 27TH ANNUAL FALL CONFERENCE

November 4-5, 2021

SEE PAGE 4 FOR DETAILS!!!

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

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Due to the increasing cases of COVID-19,
the POHMS organization has decided to make this a Virtual Event. All details will remain the same.

As always we are bringing you the most current information needed to help you manage your Oncology practice. This year our agenda will include: **Ted Okon** to cover **Legislative Changes**, **Michelle Weiss** covering **Coding and Billing**, and many others to cover critical topics affecting us all today. Day 2 will focus on HR and we are bringing back by popular demand: **Susan Keane Baker and Helen Richardson.** Susan will discuss customer service techniques within your practice and Helen will talk about something that has become all too familiar to us, especially throughout the pandemic: **Compassion Fatigue.**

Our Keynote Speaker for this year's Fall Conference will be:

Scott Hamilton!

Why attend?

- POHMS Fall Conference brings together over 50 oncology administrators, billing staff, and clinicians with diverse clinical knowledge and expertise
- You will increase your knowledge, learn best practices and receive the most up-to-date information affecting oncology practices
- The ability to earn AAPC CEUs
- Networking with peers and industry leaders

The target audience for the meeting is Practice Administrators/Office Managers, Oncologists, and Allied Health professionals including registered nurses, billing staff and other health care professionals involved in the care of patients with cancer. We are expecting approximately 70 POHMS attendees.

Agenda & Speakers **Registration**

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OPEN POSITIONS FOR THE POHMS BOARD OF DIRECTORS

As per POHMS By-Laws:
SECTION 5.03. NUMBER AND TERM OF OFFICE.

Number. The board of directors shall consist of such number of directors, not fewer than six (6) nor more than thirteen (13), as the Members may from time to time choose at their annual meeting.

For the two-year term Jan, 2022 - Dec, 2023, there are Nine (9) open board positions. If you are interested in a board position, please fill out the POHMS Board of Directors Member Profile and submit to Fran Spine at fran@pohms.com

This form can be found on the Members Only Section of the website. CLICK HERE

RELEASED:

Calendar Year 2022 Medicare Hospital Outpatient Prospective Payment System and ASC Payment System Final Rule

Includes finalized modifications related to the Radiation Oncology (RO) Model

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services. In addition to updating the payment rates, the Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Final Rule includes policies that align with several key goals of the Administration, including addressing the health equity gap, fighting the COVID-19 Public Health Emergency (PHE), encouraging transparency in the health system, and promoting safe, effective, and patient-centered care.

Some of the changes include;

- modifications to the hospital price transparency regulation
- 2% payment rate increase
- changes to the inpatient only list
- includes two-midnight rule medical review activities exemptions
- continue to pay ASP - 22.5% for certain separately payable drugs acquired through the 340B program
- updates to pass-through payment status on 46 drugs
- modifications to the Radiation Oncology Model's timing and design still beginning on January 1, 2022

For a fact sheet on the CY 2022 OPPS/ASC Payment System Final Rule (CMS-1753-F) CLICK HERE

The OPPS/ASC Payment System Final Rule is displayed at the Federal Register, and can be downloaded from the Federal Register CLICK HERE

RELEASED:

Calendar Year 2022 Medicare Physician Fee Schedule Final Rule

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates on policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, on or after January 1, 2022.

Update includes;

- a decrease in the conversion factor by $1.30 to $33.59
- clarifying E & M policies related to the 2021 coding changes
- refining policies for split/shared E & M visits
- changes to billing teaching physician services
- is including some of the COVID-10 PHE telehealth services through 12/31/2023
- will begin reimbursing Physician Assistant services directly to PA
- announcing a payment of $30 per dose for administration of influenza, pneumococcal and hepatitis B vaccines
- maintain payment of $40 per dose for COVID-10 vaccine
- requiring certain manufacturers to report drug pricing information for Part B
- no changes to generic multiple source drug codes
- updates to the open payment financial transparency program
- and more....

To review the announcement from CMS in its entirety; CLICK HERE

More Information:
CY 2022 Physician Fee Schedule Final Rule
CY 2022 Physician Fee Schedule Final Rule fact sheet
CY 2022 Quality Payment Program final changes fact sheet
Medicare Diabetes Prevention Program final changes fact sheet

Two New PBM Launches Aim to Bring Greater Transparency to the Market

Purchaser Business Group on Health has announced Emsana Health, with its first business arm launching as EmsanaRx, a PBM. As PBGH is a coalition of 40 large employers, the company says its PBM solution is "built by employers, for employers." READ MORE

Public Health Emergency (PHE) Extended for Another 90 Days

On Friday, October 15, 2021, HHS Secretary Xavier Becerra announced an extension of the COVID-19 Public Health Emergency (PHE). This extension will last another 90 days from October 18, 2021. The COVID-19 PHE was initially declared on January 31, 2020 (with acknowledgement that it has existed since January 27th). Any PHE declaration can only last for 90 days at a time but can be extended or renewed. It has already been renewed multiple times. There are several provisions tied to the duration of the PHE that will remain in place due to the extension of the PHE, including:

- Medicare's 25/75 blended rates for non-rural, non-CBA areas
- An increase to the federal government's matching funds for Medicaid programs (approximately 6.2% increase)
- ACO shared loss paybacks to CMS
- COVID-19 testing at no cost to the patient
- Waivers of certain telehealth restrictions and other policy changes or waivers

The next reconsideration for renewal is January 2022. For more information, CLICK HERE

Second Surprise Billing Rule Covers Dispute Resolution Processes, Good Faith Estimates for the Uninsured

ASCO in Action: The U.S. Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury ("the Departments"), along with the Office of Personnel Management (OPM), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the No Surprises Act) of the Consolidated Appropriations Act, 2021, and implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review. READ MORE

Do You Have Questions on Item 19 of the CMS-1500 Claim Form?

Box or item 19 is used to identify additional information about the patient's condition or the claim. We have noticed a high volume of invalid claim submissions with either missing data in this field or data listed in an incorrect field on the claim form.

For details on the use of item 19 or assistance completing the CMS-1500 claim form, please refer to our Completion of the CMS-1500 claim form and/or Paper to electronic claim crosswalk (5010).

Novitasphere Features and Functionality

Novitasphere is a free, secure internet portal that is available to you! It provides easy and quick access to information on patient eligibility, claim status, medical review records, and payments. Please review the Novitasphere features and functionality chart to see the full list of resources.

Not enrolled? The Novitasphere Enrollment eGuide will walk you through the steps needed to gain access.

September 2021 Top Inquiries FAQs

The September 2021 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

For quarterly FAQs CLICK HERE

Medical Policy Oncology Related

The following billing and coding articles have been revised to reflect the annual ICD-10 code updates effective for dates of service on and after October 1, 2021.

- Billing and Coding: Biomarkers for Oncology (A52986)
- Billing and Coding: BRCA1 and BRCA2 Genetic Testing (A56542)
- Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A56725)

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, November 8, 2021	10:00 a.m.	11:00 a.m.	***Novitasphere Claim Corrections*** This webinar will highlight an essential Novitasphere Portal feature for Part B providers: performing claim corrections and completing and submitting clerical error reopening requests. Novitasphere is a free, secure internet portal available for use by our JH and JL providers, facilities, billing services, clearinghouses and support staff. During this session, we will demonstrate how and when to use these features.	1.0	Webinar
Tuesday, November 9, 2021	10:00 a.m.	11:30 a.m.	***#StayConnected Workshop Series: Part B Options for Claim Corrections*** Stay connected with Novitas by attending the Post Claim Submission workshop series. During this webinar, we will explore the multiple options Novitas offers to perform Part B claim corrections. We will define the difference between a clerical error reopening (CER) and a claim correction and highlight the resources available to perform these claim updates.	1.5	Webinar
Tuesday, November 9, 2021	2:00 p.m.	3:30 p.m.	***#StayConnected Workshop Series: Journey Through the Part B Appeal Process*** Stay connected with Novitas by attending the Post Claim Submission workshop series. During this webinar, we will conduct an overview of the Medicare redetermination process, also referred to as a first level appeal. We will define the different levels of Medicare claim appeals and the associated contractors who process them. We will also review how to successfully submit an appeal using the self-service tools available to perform these transactions.	1.5	Webinar

To sign up and register for these newly posted opportunities and to view more…

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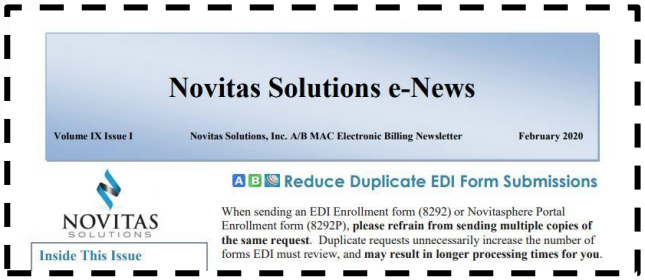
Novitas Solutions e-News
Electronic Billing
Qtly Newsletter

*Current Qtly Issue Available...*CLICK HERE



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

2022 Proposed Rules

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

On-Demand *Education*

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

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

COVTIVITI 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
Add-on Codes Paid without Primary Code and/or Denied Primary Code	CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	Automated Review	01/07/2021	05/20/2021	All Region 4 States	AB MACs	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date.

New/Modifications to the Place of Service (POS) Codes for Telehealth - Effective January 1, 2022

Learn about telehealth code updates:

- New POS code 10
- Modified description of code 02

CMS Releases 2022 Medicare Advantage and Part D Star Ratings to Help Medicare Beneficiaries Compare Plans

The Centers for Medicare & Medicaid Services (CMS) released the 2022 Star Ratings for Medicare Advantage (Medicare Part C) and Medicare Part D prescription drug plans to help people with Medicare compare plans ahead of Medicare Open Enrollment, which kicks off on October 15. READ MORE

Medicare Audits: Time is of the Essence

Today, I will be discussing the importance of timing. Timing is everything. Missing a deadline germane to any type of Medicare or Medicaid audit can be deadly. Miss an appeal deadline by one single day, and you lose your right to appeal an overpayment. READ MORE

TPE and Prepay Audits: Speak Softly, but Carry a Big Stick

Failing a TPE audit can result in onerous actions.

Healthcare audits have now resumed to 100-percent capacity – or even 150 percent. All audits that were suspended during COVID have been reinstated. READ MORE

Pneumococcal Conjugate Vaccine, 20 Valent

Medicare began covering Pneumococcal conjugate vaccine, 20 valent on October 1. CMS suggests submitting separate claims for this vaccine (HCPCS code 90677).

- Part A Medicare Administrative Contractors (MACs) will hold these claims until the April 2022 system update
- Part B MACs began processing these claims on October 4
- CMS will deny claims for vaccines provided July 1–September 30 (before it was covered by Medicare)

Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

An Office of Inspector General report found that Medicare improperly paid for non-physician outpatient services provided shortly before or during inpatient stays. Review the FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients MLN Matters Article to help you bill correctly for these services.

Additional resources:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4
- Medicare Claims Processing Manual, Chapter 12, Sections 90.7, 90.7.1
- CY 2012 Medicare Physician Fee Schedule Final Rule

January 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files & Revisions to Prior Quarterly Pricing Files

Learn about quarterly updates to the following pricing files effective for dates of service:

- January 1–March 31, 2021: January 2021 ASP and ASP Not Otherwise Classified (NOC)
- April 1–June 30, 2021: April 2021 ASP and ASP NOC
- July 1–September 30, 2021: July 2021 ASP and ASP NOC
- October 1–December 31, 2021: October 2021 ASP and ASP NOC
- January 1–March 31, 2022: January 2022 ASP and ASP NOC

Independence | PROVIDER News Center

CRNP and PA Direct Supervision Requirements

Independence's definition of "direct supervision" of a Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) has been modified to include direct supervision by a physician's virtual presence. Virtual presence includes audio/video real-time communications technology when used to reduce exposure risks for the member or health care provider.
READ MORE

CRNP and PA Credentialing and Reimbursement

Certified Registered Nurse Practitioners (CRNP) and Physician Assistants (PA) are a vital part of the Independence network of providers. All CRNPs and PAs must be credentialed to provide independent, unsupervised services to Independence members. This allows non-physician practitioners to help meet their patients' health care demands and aligns with CMS and industry standards. We shared updated contracting and credentialing scenarios on May 20, 2021.

READ THE REIMBURSEMENT GUIDELINES AND MORE

What's New for 2022 Medicare Advantage plans

As it has for the past 80 years, Independence continues to offer a wide range of benefits to members enrolled in its Medicare Advantage and Medicare Supplement plans. Read ahead for a summary of what's available in 2022. CLICK HERE

Independence | PROVIDER News Center

It's Important to Refer Members to In-network Labs for Services

Independence network providers should refer members only to participating providers for covered services. This includes, but is not limited to, ancillary services such as laboratory and radiology, unless the provider has obtained preapproval from Independence for the use of a non-participating laboratory.

READ MORE

Updates to the Medical Benefit Specialty Drug Cost-share List Effective January 1, 2022

Effective January 1, 2022, Independence will update its list of specialty drugs that require member cost-sharing (i.e., copayment, deductible, and coinsurance). Cost-sharing applies to select medical benefit specialty drugs for members who are enrolled in Commercial FLEX products and other select plans. The member's cost-sharing amount is based on the terms of the member's benefit contract. In accordance with your Provider Agreement, it is the provider's responsibility to verify a member's individual benefits and cost-share requirements.

The 2022 cost-share list includes 207 drugs, with the following additions: CLICK HERE

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No Surprises Act – Upcoming Changes

In December 2020, Congress passed the No Surprises Act as part of the Consolidated Appropriations Act (CAA) which will take effect on **January 1, 2022**. The No Surprises Act is intended to provide greater consumer protections to patients by addressing surprise medical bills at the federal level.

The No Surprises Act requires health plans to implement changes that will impact both members and providers. The following changes will affect what is required of providers in Highmark's network. This includes: READ THE REST OF THIS ARTICLE

Providers Must Respond to Highmark's Availability Survey

Highmark and various federal and state regulatory bodies have specific requirements that someone from your office must be available 24/7. To ensure providers comply with these requirements, Highmark conducts regular surveys of network providers.

Over the next several months, you may receive a telephone call from a vendor working on behalf of Highmark asking questions related to appointment availability. You must answer the survey questions to ensure compliance with all requirements is maintained. READ MORE

Claim Status Inquiry Attachments Now Available in Navinet

Providers are now able to submit supporting documentation for a Claim Status Inquiry directly through NaviNet.

This feature may be used when Highmark requests additional information regarding a claim. Uploading and attaching documents through NaviNet will reduce the need for you to mail or fax supporting documents separately, which helps: READ LIST

Highmark Provider Manual Update

The *Highmark Provider Manual* is designed to be an online resource for all providers - professionals, facilities, and ancillary providers - participating in Highmark's networks in Pennsylvania, Delaware, New York and West Virginia. It is available to you as an online resource in order to provide you with the most up-to-date information.

We continually review and update the manual to better meet your needs. Recent updates have been made to Chapter 2, Unit 5 (Telemedicine Services). The entire manual was also updated to include New York.

As always, we value your feedback. Please let us know how we're doing in providing you with the important information you need to know - just click on the editor contact link below and drop us a line. *We're waiting to hear from you!*

Please click on Highmark Provider Manual to access the site directly; however, the *Highmark Provider Manual* is always available under **EDUCATION/MANUALS** on the Provider Resource Center. For even faster access, click on **MANUALS** on the Quicklinks Bar at the top of the Provider Resource Center's homepage.

If you have recommendations for future enhancements to the *Highmark Provider Manual*, please contact us at HPMeditor@highmark.com.

HIGHMARK BLUE SHIELD

Claim Payments and Remittances to be Provided by PNC Healthcare Beginning November 2021

Beginning **November 8, 2021**, claim payments will be generated from PNC-ECHO Health Trust rather than Highmark Inc. Electronic Remittance Advices (ERAs) will be distributed using the ECHO Payer ID 58379. Read more about this change CLICK HERE!

Highmark's ECCM Program to Replace Aspire Health by end Of 2021

Effective **December 31, 2021**, Highmark will end its contract with Aspire Health. Aspire Health has been providing Highmark with additional support for Highmark Medicare members with complex health conditions or facing a serious illness since 2015.

Part of Highmark's Living Health initiative is to build new internal capabilities and solutions and expand the existing ones to meet the needs of our members. One of these capabilities is Highmark's Enhanced Community Care Management (ECCM) system which was built in 2016 as a supportive palliative care solution. READ MORE

Attention Providers Who Received Letters From Aspire Health

Some providers may have received letters from Aspire Health stating that your patient recently experienced a financial or insurance change and decided to opt out of Aspire Health's services. As such, the patient was discharged from Aspire Health's services. Those letters are incorrect. **There have been no financial or insurance changes or gaps in care for your patient.** READ MORE

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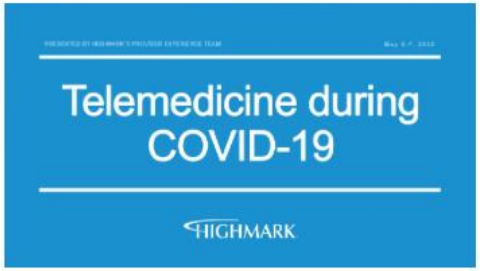
OTHER PAYER UPDATES



View the Webinar: Telemedicine during Covid-19

CLICK HERE TO VIEW

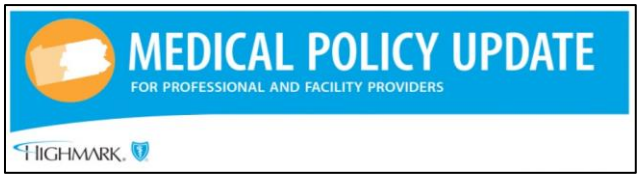
PROVIDER NEWS
Most Recent Issue …
CLICK HERE

HIGHMARK BLUE SHIELD

NEW! Reimbursement Policy 072: Injection and Infusion Services

Reimbursement Policy 072: Injection and Infusion Services (RP-072) will take effect on **January 1, 2022**. RP-072 will provide direction on how to properly bill for injection and infusion services to help you avoid common billing mistakes that lead to adjustments and audit recoveries.

READ MORE



HIGHMARK MEDICAL POLICY UPDATE

Published Monthly … CLICK HERE

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

- Policy Established for Amivantamab-vmjw (Rybrevant)

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OTHER PAYER UPDATES

aetna

Current Issue Available... CLICK HERE

NEW!

United Healthcare

Network Bulletin
Oncology Related Featured Topics

- Appendix Bulletins
  - Medical policy updates: November 2021
  - Pharmacy Updates
  - Prior authorization and notification requirement updates
    - 2021 Summary of Changes
  - Reimbursement policy updates: November 2021

And Much More...NOVEMBER Updates Available HERE

United Healthcare

NEW!

Medical Policy Update Bulletins: NOVEMBER 2021

- UnitedHealthcare Commercial & Affiliates
- UnitedHealthcare Exchange Plans
- UnitedHealthcare Community Plan
- UnitedHealthcare Medicare Advantage

Monthly Issue Available HERE

United Healthcare

NEW!

Reimbursement Policy Update Bulletins: NOVEMBER 2021

- UnitedHealthcare Commercial Plan
- UnitedHealthcare Community Plan
- UnitedHealthcare Individual Exchange
- UnitedHealthcare Medicare Advantage

Monthly Issue Available HERE

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RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- FDA approves asciminib for Philadelphia chromosome-positive chronic myeloid leukemia
- FDA approves atezolizumab as adjuvant treatment for non-small cell lung cancer
- FDA approves pembrolizumab combination for the first-line treatment of cervical cancer
- FDA approves abemaciclib with endocrine therapy for early breast cancer
- FDA recognizes Memorial Sloan-Kettering database of molecular tumor marker information

New Report Finds Biosimilars Could Save States Billions of Dollars Annually

Interactive Tool Shows State-by-State Cost-Saving Potential of Biosimilars

The Biosimilars Forum, in partnership with the Pacific Research Institute (PRI), released a report and interactive tool highlighting the billions of dollars that biosimilars can save states. READ MORE

Need Help Talking to Patients and Clinic Staff About COVID-19 Vaccines? New Infographic Can Help

A new infographic from Cancer.Net, answers common questions and addresses concerns people with cancer have about COVID-19 vaccines available in the United States. Designed to be printed and shared with patients and caregivers, the infographic highlights the increased risk people with cancer face from COVID-19, the protection provided by vaccines, and the importance of vaccination for patients with cancer and the people who care for them. READ MORE

ASCO in Action

Urge Congress to Support Legislation to Address Social Determinants of Health

Use the ASCO ACT Network to tell your representatives in Congress to co-sponsor he Social Determinants of Health Accelerator Act, ASCO-backed legislation to address social determinants of health and improve outcomes for all patients. READ MORE

Trends in Total and Out-of-Pocket Cost Among Privately Insured Patients With Cancer

The rise in cancer treatment costs in combination with the increase of cost-sharing have financially burdened privately insured, nonelderly patients with cancer with increasing out-of-pocket (OOP) costs. READ MORE

Compliance with Price Transparency Rules at US National Cancer Institute–Designated Cancer Centers

In an effort to contain health care costs, the Centers for Medicare & Medicaid Services (CMS) began requiring hospitals to disclose prices negotiated with insurers on January 1, 2021. Existing analysis of transparency efforts via chargemaster lists has shown substantial variation in prices and limited utility when comparing prices for oncological services. READ MORE

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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: Are there any Medicare guidelines for using an electronic signature when ordering medications?

Answer: In a MLN fact sheet (ICN 905364, March 2021), the Centers for Medicare & Medicaid Services (CMS) provide the following medical review guidelines for using an electronic signature:

- Systems and software products must include protections against modification, and you should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.
- Order Part B medications, other than controlled substances, through a qualified e-prescribing system.
- Order medications incident to DME, other than controlled substances, through a qualified e-prescribing system. Reviewers shouldn't require the provider produce hardcopy pen and ink signatures as evidence of a medication order.

Check with your attorneys and malpractice insurers before using alternative signature methods.

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Continued on next page...

FAQ'S

Question: I haven't received my AMA CPT book yet and was wondering if you know if there are any changes in the administration section this year?

Answer: The AMA CPT has been released and you can order it from many sites, including the AMA site, AAPC site and even Amazon. Reviewing my copy I do not see any changes within the Infusion section (96360 - 96549). You do what to be sure to review the E & M section, especially the chronic care and principal care management code and nomenclature changes.

****

Question: How does CMS interpret the requirement that step therapy only be applied to new prescriptions or administrations of Part B drugs for enrollees that are not actively receiving the affected medication?

Answer: Medicare Advantage Organizations may only apply step therapy policies to new prescriptions or new administrations of Part B drugs. This means that enrollees currently receiving a particular drug under Part B cannot be required under a step therapy policy to change their medication. For example, a new plan enrollee currently undergoing a particular drug therapy cannot be forced to switch to the preferred drug therapy of the plan upon enrollment. Similarly, an existing enrollee already undergoing a particular drug therapy must not be required to change therapies should a plan establish or update a step therapy program. Consistent with Part D rules, CMS expects plans will follow a look- back period of at least 108 days to determine whether the enrollee is eligible for a new start prescription. CLICK HERE for a reference.

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CORPORATE ALLIES

DIAMOND LEVEL

BeiGene

Bristol Myers Squibb

CHOC Community Hematology Oncology Consortium

Daiichi-Sankyo

flatiron HC

G1 THERAPEUTICS

Genentech
A Member of the Roche Group

Incyte

McKESSON

MERCK

oncopeptides

Takeda ONCOLOGY

GOLD LEVEL

abbvie

astellas

janssen
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Lilly

NOVARTIS

pharmacyclics

TAIHO ONCOLOGY

SILVER LEVEL

ALEXION

AMGEN Oncology

IPSEN
Innovation for patient care

Oncology Supply
AmerisourceBergen Specialty Group

SANOFI

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POHMS Committees

By-Laws
CHAIR: Diane Carter

Finance Committee
CHAIR: Diane Carter

Marketing/Membership Development
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.

POHMS Board of Directors

Executive Committee

Diane Carter, MSN, RN
President

Ellen Bauer, BSN, RN
Secretary

Lisa Smith
Treasurer

Board of Directors

AJ Cordero
Cancer Care Associates of York

Clark Betyn
Roswell Park Cancer Center

Cheryl Downs
Penn Hematology Oncology
Langhorne

Janice Leon
Paoli Hematology Oncology
Associates, Pc

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