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PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

The POHMS newsletter

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

INSIDE THIS ISSUE | POHMS newsletter Issue 100 | MAY '22

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REMINDER...

REVIEW THE MEMBER SECTION OF THE WEBSITE FREQUENTLY!

This is updated on a regular basis! WWW.POHMS.COM

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

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The Annual Spring Conference was a huge success!
For those who attended all presentation hand-outs are available on the POHMS website.

The Annual Fall Conference is scheduled for **November 3-4, 2022, at The Hotel Hershey**.

Registration fee for POHMS Active and Associate Members is: **$150 each.**

Registration expected to open by the end of May. Watch for this announcement.

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EDUCATIONAL GRANT REQUEST POLICY

Requirements for Educational Grant Request:

- Letter of Request
  - *Download and submit completed form: Educational Grant Request Letter 2022*
    - *Must indicate use and have practice physician signature*
    - *Due to limited funds, must be submitted a minimum of 30 days **prior** to the event*
- POHMS Executive Committee will review your request within one week upon receipt to POHMS
- Practice will then be notified of **approval or denial via email**
- POHMS will reimburse up to $1000 per practice/per year of acceptable expenses.
  - *Acceptable expenses include registration fees, hotel and travel costs, and meals*
- Proof of attendance and original receipts must be submitted for reimbursement along with a completed expense report.
  - *Download Educational Grant Expense Report 2022 to submit expenses with receipts for reimbursement*

If you have any questions and/or to send letters of request, reach out to Fran Spine at: fran@pohms.com or call 908-442-7156.

Of Note: The $250 reimbursement for each practice attending the Fall Conference is still valid and does not take away from this educational grant policy.

PLEASE

We are in need of Board Members to keep the POHMS organization viable!

OPEN POSITIONS FOR THE POHMS BOARD OF DIRECTORS

Two-year term Jan, 2022 - Dec, 2023

Become part of a great team that makes a difference for cancer patients! Sign up for a Board position! Fill out the POHMS Board of Directors Member Profile and submit to Fran Spine TODAY@ fran@pohms.com

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

There are many benefits to being a Board Member. Take a moment and review the next page...

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COMPOSITION OF POHMS BOARD

HOME

POHMS Board consists of up to 13 members

- Time involved:
  - Four board meetings per year
    - Wednesday prior to POHMS Spring and Fall Conference
    - January after Strategic Planning
    - Others as needed
  - One strategic planning meeting per year = 2 days/year (includes a Saturday)
  - Teleconference Calls
  - Committee involvement = at least one committee, most work is done by conference calls
  - Total amount of days per year, approximately 5 days
- Benefits:
  - Networking
    - Professional and personal
    - Key people from other organizations, Allied members, insurance carrier on a local level
  - Travel reimbursed
    - Mileage and tolls to attend meetings
    - Hotel
    - Meals
  - Education
    - Reimbursement
    - Human Resources
    - Practice Management
    - Best Practices
    - Learn about other practices
  - Personal and professional growth
    - Receive information on groundbreaking level
- What happens at a typical POHMS Board Meeting?
  - The POHMS Board ensures the organization stays viable;
    - Decisions made
    - Bring new issues and how to educate members
    - Organize POHMS meetings: structure, speakers, content
    - Networking: hot issues, educating staff, work with committees
    - Committee reports

The value and benefit of being a Board Member outweighs the time and commitment involved, not only for your practice but also your personal professional growth.

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CMS Releases New Guidance on Surprised Billing & Good Faith Estimates

CMS has published more guidance on the No Surprises Act, including new FAQs surrounding new surprise billing requirements and providing good faith estimates.

Since taking effect on January 1, the No Surprises Act protects patients from unexpected medical charges after scheduled items or services are completed. READ MORE

CLICK HERE to read the recently released FAQs about the No Surprises Rules

CLICK HERE to read about Good Faith Estimates for Uninsured Individuals

Medicare Advantage Debate Rekindled by Report on Coverage Denials

April 29, 2922 - Thursday's federal watchdog report accusing Medicare Advantage of denying too many services that should have been paid for under Medicare coverage rules is inflaming Washington's debate over whether the program is helping seniors or simply padding insurers' pockets. READ MORE

Public Health Emergency Extended Another 90 Days

On April 13, 2022, the Department of Health and Human Services Secretary, Xavier Becerra, announced the renewal of the COVID-19 national public health emergency (PHE) declaration. The renewal is effective April 16, 2022, and will last 90 days, until July 15, 2022. Regulatory flexibilities, including the expanded telehealth and audio-only services will continue to be available through the end of the PHE. READ MORE

2023 Medicare Hospital Inpatient Payment Proposal Addresses CAR-T Reimbursement, Quality Disparities, Social Determinants of Health

ASCO IN ACTION - April 19, 2022 - The Centers for Medicare & Medicaid Services issued the fiscal year 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed rule. In addition to updating Medicare payment rates and policies for inpatient hospitals in FY 2023, the proposed rule aims to measure health care quality disparities, improve the quality of maternity care, and obtain stakeholder feedback to advance health equity. READ MORE

2023 ACA Rule Finalizes Health Insurance Market Changes, Aims for Equitable Access to Coverage

ASCO IN ACTION - April 29, 2022 - The Centers for Medicare & Medicaid Services released the Patient Protection and Affordable Care Act 2023 Notice of Benefit and Payment Parameters final rule. The rule finalizes regulatory changes in the individual and small group health insurance markets and establishes parameters and requirements issuers need to design plans and set rates for the 2023 plan year. The rule also aims to improve enrollment policies for qualified health plans offered on the federal Marketplace to ensure consumer access to quality and affordable coverage and to advance health equity. READ MORE

CY 2023 Medicare Advantage and Part D Final Rule

April 29, 2022 - CMS is issuing a final rule that advances CMS' strategic vision of expanding access to affordable health care and improving health equity in Medicare Advantage (MA) and Part D through lower out-of-pocket prescription drug costs and improved consumer protections. READ CMS FACT SHEET AND ACCESS RULE

Attention Financial Navigators

Co-pay Assistance Program for Some Generic Medications!
Announcing KabiConnect
Designed to increase access and lower out-of-pocket costs for eligible patients with financial needs

April 13, 2022

LAKE ZURICH, Ill.--(BUSINESS WIRE)--Fresenius Kabi announced today it has introduced KabiConnect, part of the KabiCare patient support program in the United States, to offer copay assistance for the company's generic oncology medicines. Fresenius Kabi offers the most comprehensive portfolio of generic injectable oncology medicines in the U.S.

KabiConnect offers eligible patients financial support covering more than 30 different oncology medicines. The program can lower out-of-pocket costs to as little as $0 a month for eligible patients. To determine eligibility, patients should speak to their physician. Enrollment is a simple online process. Details can be found on the KabiCare website at kabicare.us

READ MORE

KabiCare U.S. Healthcare Provider Website
See Entire List of Generic Products Included in the KabiCare Patient Support Program

LIST OF COVERED DRUGS

Product Name	Strength/Concentration	NDC	Product Name	Strength/Concentration	NDC	Product Name	Strength/Concentration	NDC
Arsenic Trioxide	10mg per 10mL	63323-637-10	Fludarabine Phosphate	50mg per 2mL	63323-192-02			
		63323-637-03	Fulvestrant	250mg per 5mL	63323-715-01			
Bleomycin	15 units per vial	63323-136-10			63323-715-05			
	30 units per vial	63323-137-20	Leucovorin Calcium	100mg per 10mL	63323-631-10	Octreotide Acetate	100mcg per 1mL	63323-376-01
Bortezomib	3.5mg per vial	63323-721-10		200mg per vial	63323-710-50		500mcg per 1mL	63323-377-01
Cladribine	10mg per 10mL	63323-140-10		500mg per 50mL	63323-631-50		1mg per 5mL	63323-378-05
Clofarabine	20mg per 20mL	63323-572-70		500mg per vial	63323-711-00		5mg per 5mL	63323-379-05
Cytarabine	2g per 20mL	63323-120-20	Melphalan HCL	50mg per vial	63323-760-20	Oxaliplatin	50mg per 10mL	63323-750-10
Doxorubicin	10mg per 5mL	63323-883-05	Mesna	1g per 10mL	63323-733-11		100mg per 20mL	63323-750-20
	50mg per 25mL	63323-883-30			63323-733-10	Romidepsin	10mg per vial	63323-926-88
	200mg per 100mL	63323-101-61			63323-733-01	Temsirolimus	25mg per mL	65219-200-05
Etoposide	100mg per 5mL	63323-104-05	Methotrexate	250mg per 10mL	63323-123-10	Topotecan HCl	4mg per vial	63323-762-10
		63323-104-01		1g per vial	63323-122-50	VinBLAStine Sulfate	10mg per 10mL	63323-278-10
	500mg per 25mL	63323-104-25	Mitoxantrone Inj, USP	20mg per 10mL	63323-132-10	Zoledronic Acid	4mg per 5mL	63323-961-98
	1g per 50mL	63323-104-50		25mg per 12.5mL	63323-132-12		5mg per 100mL	63323-966-00

Medical Policy

The following billing and coding article has been added and will become effective June 6:

- Billing and Coding: Complex Drug Administration Coding (A59073)

The following local coverage article has been revised effective for dates of service on and after June 6:

- Self-Administered Drug Exclusion List (A53127)

MAC Chat Sessions are still Available – Ask Us Questions!

You may now sign up for one-on-one question and answer sessions with a subject matter expert to obtain assistance with Medicare-related questions.

MAC chats will be held in 15-minute sessions on the following date:

- Part B appeals and claim corrections:
  May 26, 1– 3:30 p.m. ET

We will provide additional information regarding the claim denial or the decision and/or provide next steps.

March 2022 top inquiries FAQs

The March 2022 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

Frequently Asked Questions (FAQs)

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

NOVITAS SOLUTIONS

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
Thursday, May 12, 2022	11:00 a.m.	12:00 p.m.	***#StayConnected Medicare Coverage Workshop Series: The Comprehensive Error Rate Testing (CERT) Program - Measuring Medicare's Improper Payments*** This webinar will provide an overview of the Comprehensive Error Rate Testing (CERT) program used by CMS to determine nationwide Medicare improper payments. We will outline the medical review process and provide best practices for responding to medical record requests. This session will also identify active CERT reviews topics and discuss the documentation requirements for these services.	1.0	Webinar
Thursday, May 12, 2022	2:00 p.m.	3:30 p.m.	***#StayConnected Medicare Coverage Workshop Series: Targeted Probe and Educate (TPE) - A Different Approach to Medical Review and Education*** The targeted probe and educate (TPE) program is designed to reduce provider burden by helping Medicare providers/suppliers quickly improve billing accuracy and reduce claim denials and appeals through collaborative one-on-one education. This webinar will review the TPE process, including the three round review probe strategy, error classification, and much more.	1.5	Webinar

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

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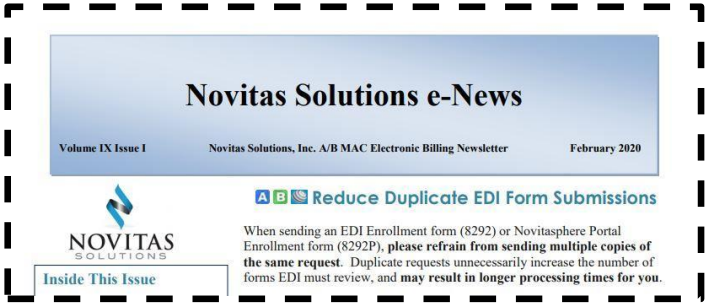
Novitas Solutions e-News
Electronic Billing Qtly Newsletter

*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**.

2022 Final Rules

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*

- 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

NEW - Cotiviti RAC 4 Provider Portal User Guide for Providers CLICK HERE

Today, you can:

- View Cotiviti RAC 4's Approved New Issues in a new window
- Get answers to your questions on the RAC Program in a new window
- View Part A - Discussion FAX Form in a new window
- View Part B - Discussion FAX Form

PHE Renewed for 90 Days – What does this mean to your clinic?

As expected, the PHE was renewed another 90-days effective April 16th, 2022.

"As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective April 16, 2022, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, July 19, 2021, October 15, 2021, and January 14, 2022, that a public health emergency exists and has existed since January 27, 2020, nationwide." READ MORE

2021 MIPS Cost Performance Category Reweighted to 0% for Groups and Individuals

The Centers for Medicare & Medicaid Services (CMS) recognizes the impact that the COVID-19 pandemic public health emergency (PHE) continued to have on clinicians and the services they provided during the Quality Payment Program's 2021 performance period. As such, CMS is reweighting Merit-based Incentive Payment System (MIPS) cost performance category from 20% to 0% for the 2021 performance period for both groups and individuals. READ MORE

Patient Eligibility Information for Additional Services — Now Available

You can now check eligibility (PDF) for these Medicare-covered services:

- Flu shots provided in the last 18 months
- Pneumococcal shots (HCPCS codes 90671 and 90677; eligibility information is already available for 90670 and 90732)
- Cognitive Assessment & Care Plan Services (CPT 99483)
- Colorectal cancer screening — blood-based biomarker (HCPCS G0327)

For these services, we return CPT or HCPCS codes and dates of service (DOS) or next eligible dates. When we return DOS, we also return NPIs so you can coordinate care.

If you need help, contact your eligibility service provider.

What's the Comprehensive Error Rate Testing Program?

CMS created the Comprehensive Error Rate Testing (CERT) program to measure the rate of improper Fee-for-Service payments. The error rate measures payments that didn't meet Medicare requirements; it doesn't indicate fraud.

How does the CERT program work?

The CERT contractor reviews a sample of processed claims. If a claim doesn't meet Medicare's coverage, coding, and billing rules or the provider fails to submit medical records, it's counted as a total or partial improper payment. Medicare Administrative Contractors analyze CERT error rates to reduce improper payments by updating their internal processes and educating providers.

HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals

CMS published the first quarter 2022 HCPCS Level II Application Summary and Coding Decisions for Drugs and Biologicals (PDF). For more information, visit the HCPCS Level II Coding Decisions webpage.

ICD-10 Diagnosis Codes: Comment by May 9

May 9 is the deadline for comments on proposed ICD-10 diagnosis codes and revisions for the October 1, 2022, implementation date. Send your comments to nchsicd10cm@cdc.gov.

Review information from the March ICD-10 Coordination and Maintenance Committee Meeting, including recording, agenda, materials, and presentations.

Launch of the Cross-Cutting Initiatives

CMS announced a series of Cross-Cutting Initiatives (CCIs) that will drive the Centers' and Offices' strategic vision to advance health equity, expand coverage, and improve health outcomes. In addition to advancing the 6 strategic pillars that we announced last year, the CCIs aim to improve behavioral and maternal health coverage, drug price affordability, and rural health care delivery, along with strengthening quality improvement strategies and ensuring coverage for eligible individuals post-pandemic. The CCIs will also identify opportunities to streamline the consumer experience of our coverage programs and expand coverage, while leveraging data to drive innovation and person-centered care. We're committed to track, monitor, and refine success measures for these initiatives in partnership with stakeholders and to report on progress.

More Information:

- CMS Strategic Plan webpage
- CCI fact sheet
- National Quality Strategy fact sheet
- Behavioral Health Strategy fact sheet
- Addressing & Improving Behavioral Health webpage

Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants — Revised

Learn about recent policy changes affecting non-physician practitioners (PDF), including:

- Nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs) can certify Medicare patient home health benefit eligibility and oversee patient care plans.
- NPs, CNSs, certified nurse-midwives (CNMs), and PAs may provide services on assignment, but they can't charge a patient more than amounts permitted under 42 CFR 424.55. If a patient pays more than these limits, the practitioner must refund the patient amount over the allowed charge.
- PAs meet statutory physician supervision requirements by collaborating with physicians and forming partnerships according to their state's scope of practice laws.
- PAs bill the Medicare Program directly for their services and get paid like NPs and CNSs.
- PAs may reassign their services' payment rights and incorporate as a group of only practitioners in their specialty and bill the Medicare Program like NPs and CNSs.
- PAs must bill under their national provider identifier.
- We pay PAs for their professional services, including services and supplies provided incident to their services.
- We pay professional PA services provided in all rural and non-rural settings and areas; we make payment to them only if no facility or other provider bills or we didn't pay for any other services they provided.

Recent LearnResource & MedLearn Matters Articles

- MM12688 - Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation
- MM12606 - International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--July 2022 (PDF)

Independence | PROVIDER News Center

NOW IN EFFECT:
Updated Preferred Products for Select Oncology and Oncology Adjunct Therapies

Independence added new preferred products for pegfilgrastim and rituximab. READ MORE

Telemedicine Reimbursement Rate Update

Effective June 1, 2022, Independence will update its reimbursement rate for Telemedicine Services.

When the medical services listed in Medical Policy #00.10.41j: Telemedicine Services are performed through telemedicine by an Independence participating professional provider, reimbursement for the medical service will be at 85 percent of the provider allowance, subject to the specific terms and conditions of the participation agreement.

The reimbursement change does not apply to telemedicine for Medicare Advantage members or behavioral health services.

We view telemedicine as a complement to, not a replacement for, in-office services. It is not designed for all care. We hope that you will continue to work with your patients on treatment plans, using telemedicine when it is appropriate. We strive to develop policies that get patients the right care at the right time and place.

To learn more about the policy, including the eligible services, communication modes, capitation, and billing codes, please read Medical Policy #00.10.41j: Telemedicine Services. If you have questions about this change, please email telemedicine@ibx.com.

OTHER PAYER UPDATES

Independence | PROVIDER News Center

Please Attest Your Provider Data to Avoid Suppression from our Directory

April 27, 2022 - As a participating provider, the Consolidated Appropriations Act (CAA) requires you to keep us informed of changes to your provider directory information. The CAA also requires health plans to verify and update their provider directory information every 90 days. To meet this verification requirement, providers need to review their provider data every 90 days and attest that the information listed is correct. *Note: Third-party organizations are exempt from this requirement.* READ MORE

Updates to the List of Specialty Drugs that will Require Precertification

Effective July 1, 2022, the list of specialty drugs that are eligible for coverage under the medical benefit for Independence Administrators members and Independence Blue Cross commercial and Medicare Advantage HMO and PPO members will change.

READ LIST

Updates to the Medical Benefit Specialty Drug Cost-Share List Effective July 1, 2022

Effective July 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.

READ THE LIST OF 213 DRUGS

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Highmark Commercial Standard Professional Fee Schedule & Pricing Methodology Update

Effective **July 1, 2022**, Highmark will be making an annual update to our standard professional fee schedule and pricing methodology1 in our service areas in Pennsylvania, Delaware, and West Virginia for the commercial lines of business. READ MORE

ATTENTION: MEDICARE ADVANTAGE PROVIDERS ONLY

Issue Identified: Provider Appeal Timelines for Medical Review Determinations

After Highmark reviews the medical necessity of a procedure, a determination letter is sent to Medicare Advantage members stating that they have 60 days to appeal the determination. However, **providers have 180 days from receipt of the denial notification** to appeal medical review determinations on behalf of the member regardless of the member's timeline.

Authorizations will soon be Required for Out- Of-area and Out-of-network Musculoskeletal, Genetic Testing, and Radiation Oncology Services

Effective August 1, 2022, Highmark is expanding its prior authorization requirements for Musculoskeletal, Genetic Testing, and Radiation Oncology services managed by eviCore to now include out-of-area (OOA)1 and out-of-network (OON)2 providers serving Highmark members enrolled in its fully insured Commercial, Medicare Advantage, Affordable Care Act (ACA) plans, and members of select self-insured (Administrative Services Only) groups. READ MORE

OTHER PAYER UPDATES

Highmark Seeking Members for the Medical Review Committee 2023-2024 Term

Highmark is seeking members to serve on its Medical Review Committee for the **2023-2024 two-year term**. The Medical Review Committee generally meets four times a year via a Zoom video conference call. Members are expected to attend all meetings and be prepared to participate in each case discussion. If you are selected for the committee, you will receive an honorarium from Highmark for meeting participation.

Applications to become a committee member are due by **August 1, 2022**. Directions on how to apply are below. READ MORE

PROVIDER NEWS

Most Recent Issue ... CLICK HERE

HIGHMARK MEDICAL POLICY UPDATE

Published Monthly ... CLICK HERE

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

- Coverage Guidelines Revised for Tildrakizumab-asmn (Ilumya)
- Criteria Revised for Treatment of Hereditary Amyloidosis
- AND MORE!!!!

OTHER PAYER UPDATES

NEW!

United Healthcare

Network News

- Policy and Protocol
- Reimbursement policy
- Medical policy
- Prior authorization

And Much More...Latest Updates Available... CLICK HERE

aetna®

Current Issue Available... CLICK HERE

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RECENT FDA ONCOLOGY RELATED APPROVALS/CHANGES

- FDA approves alpelisib for PIK3CA-related overgrowth spectrum - April 6, 2022
- FDA approves axicabtagene ciloleucel for second-line treatment of large B-cell lymphoma - April 1, 2022

Stop Failing Patients - Step Therapy

Just released April 25, 2022 -

"First, do no harm" is the vow all health care professionals abide by, yet the same oath is not required by other health system participants.

The most often implemented utilization management strategy by insurance companies to reduce drug spending is step therapy, colloquially known to patients as "fail first." This practice results from negotiations between a drug manufacturer and an insurer or pharmacy benefit manager, leading to coverage of certain biopharmaceuticals. Unfortunately, the fail-first protocols mandate that a patient ought to fail on one or more drugs that their provider did not select for them, effectively de-prioritizing the disease management decisions made by providers and their patients. READ MORE

New CMS Report Delves into Hospital Consolidation Trends

April 22, 2022 - The Centers for Medicare & Medicaid Services on Wednesday released data about mergers, acquisitions, consolidations and changes of ownership from 2016 to 2022 for hospitals and nursing homes enrolled in Medicare. The U.S. Department of Health and Human Services also is issuing a related report using this data to examine trends in changes of ownership over the past six years. READ MORE

Reimbursement Questions & Answers

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

Question: We received a "take back" for our drug and the infusion after an audit because "the nurse did not follow the physician's order." The drug we gave can be given by push or by infusion and while the physician order did say, administer IV over 20 minutes, instead our nurse pushed it. is there anything we can do? Can they do this?

Answer: Yes. The reason is, legally, the nurse has no authority to change a physician order on their own. From the payer perspective, they only have to reimburse what was ordered by the physician.

****

Question: Our physician ordered hydration to be given before the pre-meds and the cisplatin treatment. Hydration ran from 8:30 to 9:01. Can we bill for the hydration with 96361?

Answer: If your physician ordered the hydration to be given over 30 minutes and the actual hydration was given over 31 minutes because that is when the nurse dc'd the infusion, then no. AMA CPT states that 96361 can only be billed for infusions over 30 minutes and since the additional minute was not medically necessary, you should not bill.

****

Continued on next page...

FAQ'S

Question: Our office has continued to use the 95/97 guidelines for billing our office visits, even after the changes. They feel it is built into their system and accurate. Can we do this?

Answer: Any office visits billed on or after January 1, 2021 be billed using the CPT E/M code and guideline changes. All payers are utilizing the new guidelines and certainly using the 95/97 guidelines will likely have a different level. Hospital coding still follows the 95/97 guidelines however, this is expected to change next year.

****

Question: I'm newer to infusion coding but, I don't understand concurrent. Our office gives two drugs, Oxaliplatin and Leucovorin, and they are infused over the same time, 2 hours. To me that is concurrent and we should be able to use the concurrent code x 2, correct? How do you bill for the 2nd hour of the concurrent drug?

Answer: In this case, as long as they are in two separate bags, you would code the Oxaliplatin as 96413 (initial first hour) and 96415 (second hour) and then the Leucovorin with concurrent code 96368. Concurrent infusion code 96368 can only be billed once per session and is not a time based code so you are not able to bill anything additional for the 2nd hour.

CORPORATE ALLIES

DIAMOND LEVEL

BeiGene

Bristol Myers Squibb

CardinalHealth
Essential to care

CHOC
Community Hematology Oncology Consortium

Daiichi-Sankyo

Genentech
A Member of the Roche Group

Incyte

McKESSON

MERCK

Takeda
ONCOLOGY

GOLD LEVEL

GILEAD
Creating Possible

janssen
Pharmaceutical Companies of Johnson & Johnson

Jazz Pharmaceuticals

Lilly

morphosys

NOVARTIS

pharmacyclics

TAIHO
ONCOLOGY

SILVER LEVEL

abbvie

ALEXION

AmerisourceBergen
Oncology Supply

astellas
Leading Light for Life

EMD SERONO

sanofi

pohms
PREMIER ONCOLOGY HEMATOLOGY MANAGEMENT SOCIETY

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 Committees

By-Laws
CHAIR: TBD

Finance Committee
CHAIR: Lisa Smith

Marketing/Membership Development
CHAIR: TBD

Programs Committee
CHAIR: Fran Spine

POHMS Board of Directors

Executive Committee

Lisa Smith
President/Treasurer

Cheryl Downs
Secretary

Board of Directors

AJ Cordero
Cancer Care Associates of York

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