Connection

Important information for Fallon Health physicians and providers January 2020

What's new

Fallon offers new infusion therapy program for members

Beginning April 1, 2020, Fallon Health will begin offering its members a new option for infusion therapy. Through "Site of Service," administered by Magellan Rx, this program offers in-home therapy as a lower-cost alternative. The program is intended for members currently receiving infusion therapy in an outpatient hospital setting. The in-home option adds more convenience for members. Plus, infusions at home and at provider offices reduce potential exposure to hospital-based infections. While members in need of infusion therapy have open access to receive infusions at hospitals, in provider offices or in their home, most members aren't fully aware that in-home infusion might be appropriate and available to them.

For all eligible members, the convenience of in-home infusion eliminates both the time needed to travel to an infusion site and the time a member has to take off from work for infusions. Home infusion should appeal especially to members who live in rural areas.

Magellan identifies members receiving hospital-based infusion therapy from a set list of drugs that are safe to be administered at an alternate site or in the home. Magellan will reach out to

fallonhealth

eligible members to see if they're interested. Magellan's care team will work with members and their providers to offer options for clinically appropriate and convenient sites for the infusions. While it may make sense for infusions to take place in some members' homes, a clinical setting might make sense for others.

Magellan's registered nurse care managers will talk with members to help them better understand their disease, drug therapy, the availability of different infusion sites, infusion benefits and support services. If a member decides to change the site of infusion, the nurse would reach out to the provider to help make it happen.

If you have questions about this program, please call Magellan Rx at 1-800-424-1762. ■

New program for medical benefit drug management

Effective January 1, 2020, Fallon Health transitioned to Magellan Rx Management for medical pharmacy benefit prior authorizations and post-service pre-payment claims edits. These include edits concerning eligible diagnoses, maximum dosage/units, duration and frequency.

Prior authorization requests can be submitted through Magellan's electronic portal and—in many cases—will get an immediate response. Verbal and facsimile requests will also be accepted. Medical necessity coverage criteria, approved by both the Fallon Health Pharmacy and Therapeutics Committee and Magellan Rx's National Pharmacy and Therapeutics Committee, are available online.

Educational materials are available on Fallon's website, including the formulary indicating which drugs require prior authorization. We also posted a recorded webinar for you to watch at your convenience. Please contact your Provider Relations representative with any questions. ■

It Fits! benefit expands

Effective January 1, 2020, Fallon Health is expanding the It Fits! benefit. The It Fits! program rewards members for being healthy. This year our program will allow for the reimbursement of streaming fitness programs and Peloton subscriptions. ■

Dexcom G6

Dexcom G6 is now available as a pharmacy benefit with an approved prior authorization. If approved, members are able to obtain Dexcom G6 at the pharmacy under their pharmacy benefit. Dexcom G6 will continue to be available through the member's DME benefit as well. Note: For the Fallon Medicare Plus HMO and Fallon Medicare Plus Central HMO populations, Dexcom 6 obtained at a pharmacy will fall under the Part B benefit. ■

Product spotlight

Fallon Medicare Plus crosswalk

With the launch of our new Fallon Medicare Plus™ and Fallon Medicare Plus Central HMO products, we thought you could benefit from the crosswalk chart below, in case your patients have any questions.

2019 Plan Options	2020 Plan Options
Fallon Senior Plan Flex Enhanced Rx HMO	Fallon Medicare Plus Orange HMO
Fallon Senior Plan Saver Enhanced Rx HMO Fallon Senior Plan Saver Enhanced Rx HMO-POS	Fallon Medicare Plus Green HMO
Fallon Senior Plan Standard Enhanced Rx HMO Fallon Senior Plan Plus Enhanced Rx HMO Fallon Senior Plan Plus Enhanced Rx HMO-POS	Fallon Medicare Plus Blue HMO
New plan for 2020	Fallon Medicare Plus Central Orange HMO
New plan for 2020	Fallon Medicare Plus Central Green HMO
New plan for 2020	Fallon Medicare Plus Central Blue HMO
Fallon Senior Plan Super Saver Rx HMO	Fallon Medicare Plus Super Saver HMO
Fallon Senior Plan Saver HMO	Fallon Medicare Plus Saver No Rx HMO

In addition, Fallon Senior Plan Premier HMO is now Fallon Medicare Plus Premier HMO. The new plan option is Fallon Medicare Plus Central Premier HMO. Fallon Companion Care is Fallon Medicare Plus Freedom.

Please contact your Provider Relations representative if you have any questions. ■

Community Care

Fallon Health's Community Care product is offered as a ConnectorCare plan for the subsidized individual market in Massachusetts and is sold on the Massachusetts Health Connector. The Community Care limited network includes central Massachusetts, parts of Middlesex and Norfolk counties, and Mansfield. **For those who qualify for a subsidy, premiums are as low as $0 in the Central and MetroWest regions.**

The Community Care network consists of Reliant Medical Group, Harrington HealthCare System, Saint Vincent Medical Group and select PCPs and specialists affiliated with MetroWest HealthCare Alliance. Hospitals include Saint Vincent Hospital, Harrington Hospital, HealthAlliance Hospital(s), Clinton Hospital, Marlborough Hospital, MetroWest Medical Center(s) and Milford Regional Medical Center. Tertiary hospital services are provided by UMass Memorial Hospitals. Lowell General PHO and physicians at Lowell Community Health Center are also included in the Community Care network as of January 1, 2020.

For questions or additional information, please call our Provider Relations Department at 1-866-275-3247, prompt 4. ■

Smoking cessation

Do you have patients who would like to quit using tobacco products? The Quit to Win (QTW) program at Fallon can help by providing support in conjunction with smoking cessation medications that you might prescribe.

The QTW program utilizes the teaching model based on the tobacco cessation program at the Center for Tobacco Treatment Research & Training Center, UMass Medical School. During these sessions, motivational interviewing techniques, along with an individualized quit plan, are used to guide your patient through the quitting process.

The program consists of approximately eight weekly telephonic coaching sessions, facilitated by a certified quit coach. Text message support is also available.

Please refer Fallon members by calling 1-888-807-2908, email *QuitToWin@fallonhealth.org* or fax 1-508-798-8394. ■

NaviCare® – Model of Care training

The main objective behind our NaviCare product is to assist our members in functioning at the safest level in the most appropriate setting, utilizing both Medicare and Medicaid covered benefits and services. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. NaviCare services every county in Massachusetts, with the exception of Nantucket and Dukes.

Every member has a customized plan of care developed by their Care Team. Benefits include, but are not limited to, in-home supportive services such as homemakers, the Personal Care Attendant (PCA) Program, Adult Day Health Care, Group Adult and Adult Foster Care.

Transportation to medical appointments is covered, along with 140 one-way trips per calendar year to health-related services, such as the pharmacy, gym or support groups within a 30-mile radius of the member's home.

NaviCare members get an entire Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as a coordinated care plan to reference and other Care Team members to communicate with to have the best information possible for each NaviCare patient.

Care Team members may include:

Navigator

- Educates patients about benefits and services
- Educates patients about—and obtains their approval for—their care plan
- Assists in developing patient's care plan
- Helps patients make medical appointments and access services
- Informs Care Team when patient has a care transition

Nurse Case Manager or Advanced Practitioner

- Assesses clinical and daily needs
- Teaches about conditions and medications
- Helps patients get the care they need after they're discharged from a medical facility

Primary Care Provider

- Provides overall clinical direction
- Provides primary medical services including acute and preventive care
- Orders prescriptions, supplies, equipment and home services
- Documents and complies with advance directives about the patient's wishes for future treatment and health care decisions
- Receives patient's care plan and provides input when needed

Geriatric Support Service Coordinator employed by local Aging Service Access Points (ASAPs) ***(if patient is living in own home)***

- Evaluates need for services to help patients remain at home and coordinates those services
- Helps patients with MassHealth paperwork
- Connects patients with helpful resources

Behavioral Health Case Manager (as needed)

- Identifies and coordinates services to support patients' emotional health and well-being
- Supports your patients through transition to older adulthood
- Helps connect patients with their Care Team and patients' mental health providers and substance-use counselors, if present

Facility liaison
(if patient lives in assisted living, long-term care or rest home setting)

- Connects the Care Team with the staff at your patient's facility

Clinical pharmacist ***(as needed)***

- Visits patients after care transition to perform a medication reconciliation and teaches them proper medication use ■

Doing business with us

Important reminder regarding PCP referral change for Medicare beneficiaries

For Medicare and NaviCare members only, effective January 1, 2020, PCP referrals must be submitted to Fallon Health for referrals made outside of the PCP's provider group, also referred to as a health care option (HCO)*.

PCP referrals should be submitted via our tool, ProAuth. ProAuth can also be used to submit prior authorization requests to the plan.

If you do not currently have access to ProAuth, please complete the *ProAuth enrollment form* and send it to *askfchp@fallonhealth.org*. Training is available upon request.

If you are unable to get access to ProAuth, referrals can be submitted on the standardized PA form and faxed in. Please note on the top of the form, "PCP Referral." Our intent is to transition to ProAuth. Should you fax in a PCP referral, we will reach out to you to discuss your access to ProAuth.

If you have any questions about this change, please contact your Provider Relations representative at 1-866-275-3247, prompt 4.

Please note: If a specialist claim is received from outside of the member's PCP provider group for a date of service post January 1, 2020, and a PCP referral was not submitted, **the claim will deny.** You have up to 30 days past the date of service of the specialist visit to enter the PCP referral.

** Some specialties are exempt from this requirement. These include obstetrics and gynecology, routine eye exams, and behavioral health. Exempt specialties also include emergency and urgent care services. Physical, occupational and speech therapy (when not provided as part of home health services), as well as chiropractic services, are also exempt, however a prescription is necessary for these services. For Medicare members, podiatry, kidney dialysis services outside of the area on a temporary basis, routine dental services, flu shots and pneumonia vaccinations, one supplemental routine eye exam and Medicare covered preventive services are exempt. For members in NaviCare SCO, routine women's health services, flu shots and pneumonia vaccinations are exempt.* ■

Reminder - Medicare opioid edits and programs for 2020

There are several opioid safety edits and programs for the 2020 Medicare Part D plan year. This impacts the following Fallon Medicare members: Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, Summit ElderCare® PACE and Fallon Health Weinberg PACE. These new programs are already in effect and will continue for 2020.

The criteria is used to identify members who may be at risk for opioid overuse. The edits are not a substitute for your professional judgment. You need to attest that the identified medications and doses are intended and medically necessary for the member.

Please be aware that network pharmacies, Fallon Pharmacy Department, our MTM vendor (Clinical Support Services (CSS)), and/or our Opioid Drug Management vendor and PBM (CVS Caremark, Enhanced Safety and Monitoring Solutions) may reach out to you for your assistance in resolving these safety edits and opioid management cases.

Please assist us by responding to pharmacy outreach related to opioid safety alerts in a timely manner, including educating your on-call staff. Some of these issues can be completed directly with the retail pharmacy by attesting that the medications and doses are intended and medically necessary for the member.

If you need to submit a Coverage Determination or an Exception request, please call 1-866-239-4707 or fax 1-855-633-7673.

Below is a summary of the new programs.

Point of Sale (POS) Opioid safety edits

CMS requires certain prospective safety edits. These edits will occur when the member is filling the prescription at the pharmacy. These edits require resolution. The pharmacist at the pharmacy may override some of the edits with appropriate codes, may need to consult with the provider, and may need to inform the provider that a prior authorization is required. Since these are safety edits, they will still apply during a member's transition period. This means the claims will still reject with the edits and require resolution. Buprenorphine for medication-assisted treatment (MAT) is not included in the safety edits. Hospice/palliative care, active cancer-related pain, sickle cell disease and LTC members are excluded from the safety edits. Members have coverage determination and appeal rights under this program.

The edits include:

- Soft edit for concurrent opioid and benzodiazepine use – pharmacy can override
- Soft edit for duplicative long-acting (LA) opioid therapy – pharmacy can override
- Care coordination edit at 90 morphine milligram equivalents (MME) and four prescribers – pharmacy can override only after consultation with the prescriber, documentation of the discussion and if the prescriber confirms intent (the opioids and/or day supply is intended and medically necessary for the member) using an override code that indicates the prescriber has been consulted.
- Hard edit for a seven-day supply limit for initial opioid fills (opioid naïve) with a 90-day look-back –requires that a prior authorization be submitted. The provider needs to attest that the opioids and/or day supply is intended and medically necessary for the member. A member is considered opioid naïve if there are no opioid claims in the past 90 days.

Medication Therapy Management (Not applicable to PACE programs)

We are also including special eligibility criteria into our Medication Therapy Management Program (MTMP). In addition to traditional MTMP eligibility, members are eligible for MTMP if they have high opioid usage, defined as:

- Opioid pharmacy claims equal to or greater than 90 Morphine Milligram Equivalents (MME), and
- Three or more opioid prescribers, and
- Three or more opioid dispensing pharmacies

OR

- Opioid pharmacy claims equal to or greater than 90 Morphine Milligram Equivalents (MME), and
- Five or more opioid prescribers

OR

- Any MME level, and
- Seven or more opioid prescribers or seven or more opioid dispensing pharmacies

Comprehensive Addiction and Recovery Act of 2016 (CARA) – Drug Management Program

This is a comprehensive opioid management program required under the Comprehensive Addiction and Recovery Act of 2016 (CARA). It is a retrospective drug utilization review program to identify members at risk for frequently abused drugs and conduct case management. Frequently abused drugs are defined by CMS as opioids and benzodiazepines. Buprenorphine for medication-assisted treatment (MAT) is not included in the 90 MME accumulations.

The program excludes members with active cancer pain, palliative/hospice care, sickle cell disease, or who are in LTC. Once identified as at-risk, Dual/Low Income Subsidy (LIS) members are limited in their ability to change plans.

- Criteria for identification into the program include any of the below:
  - Members with opioid pharmacy claims equal to or greater than 90 MME and 3+ opioid prescribers and 3+ opioid dispensing pharmacies
  - Members with opioid pharmacy claims equal to or greater than 90 MME and 5+ opioid prescribers
  - Members with any MME level and 7+ opioid prescribers or 7+ opioid dispensing pharmacies
- Additional potentiator drugs included if identified as above – beneficiaries receiving gabapentinoids and benzodiazapines
- Program includes case management and clinical outreach to providers to determine if the member is at risk for opioid overutilization, notifications to the member, potential lock-in restrictions to specific provider(s), pharmacy(ies), and/or at the drug level. Members have coverage determination and appeal rights under this program. ■

Provider Pharmacy web page

Fallon Health has redesigned our Provider Pharmacy web page. The prior authorization (PA) information has been consolidated into one page and provides easy access to PA processes and contact information. All criteria and PA form documentation can be easily accessed via the online drug formulary. From the formulary, click the "PA" icon for criteria or the "ePA PA form" icon for links to the ePA or a fax form.

To view payment policies for claim edits, follow the steps above to the formulary page and click on the "CE" icon.

As always, the Massachusetts Standard PA Form is required for Commercial plan members. Please review the *criteria* posted on our formulary website prior to completing the PA form or submitting an ePA, and provide all relevant data for each part of the criteria. If there is no specific field for the data on the PA form, please use the "Additional information pertinent to this request" field.

Please remember to visit the "News" link for important pharmacy updates. ■

Accountable Care Organization formulary changes, effective January 1, 2020

Rapid acting insulins:

- Admelog®/Admelog® SoloStar® – Removed prior authorization.
- Afrezza® – Revised prior authorization criteria.
- Apidra®/Apidra® SoloStar® – Revised prior authorization criteria and termed prior authorizations of current members.
- Fiasp®/Fiasp® FlexTouch® – Revised prior authorization criteria and termed prior authorizations of current members.
- Humalog® Junior KwikPen®/Humalog® KwikPen®/Humalog® U-200 KwikPen® – Added prior authorization.
    - Current members on Humalog® U-200 KwikPen® will be able to continue on it without needing a prior authorization submitted.
- Insulin Lispro/Insulin Lispro Pen – Added prior authorization.
- NovoLog®/NovoLog® FlexPen® – Revised prior authorization criteria and termed prior authorizations of current members.
- NovoLog® Mix 70-30/NovoLog® Mix 70-30 FlexPen – Removed prior authorization.

Long acting insulins:

- Basaglar® KwikPen® U-100 – Removed prior authorization.
- Lantus®/Lantus® SoloStar® – Added prior authorization.
- Levemir®/Levemir® FlexTouch® – Revised prior authorization criteria and termed prior authorizations of current members.
- Toujeo® SoloStar®/Toujeo® Max SoloStar® – Added prior authorization.
- Tresiba®/Tresiba® FlexTouch® U-100/Tresiba® FlexTouch® U-200 – Removed prior authorization.

SGLT2 inhibitors:

- FARXIGA® – Revised prior authorization criteria and termed prior authorization of current members.
- INVOKAMET®/INVOKAMET® XR – Changed from step therapy required to prior authorization required and termed authorizations of current members.
- INVOKANA® – Changed from step therapy required to prior authorization required and termed authorizations of current members.
- JARDIANCE® – Changed from step therapy required to prior authorization required and termed authorizations of current members.
- Synjardy®/Synjardy® XR – Changed from step therapy required to prior authorization required and termed authorizations of current members.
- Segluromet™ – Changed from prior authorization required to step therapy required.
- Steglatro™ – Changed from prior authorization required to step therapy required.

Steroid – Beta Agonist inhalers:

- Advair Diskus®/Advair® HFA – Revised prior authorization criteria.
- Breo Ellipta – Added prior authorization.
- Symbicort® – Added prior authorization.

Anticholinergic inhalers:

- Incruse Ellipta – Removed prior authorization.
- Seebri® Neohaler® – Revised prior authorization criteria..
- Spiriva®/Spiriva® Respimat® – Added prior authorization.
- Tudorza® Pressair® – Revised prior authorization criteria and termed prior authorizations of current members.

Anticholinergic beta agonist combos:

- Anoro Ellipta – Added prior authorization.
- Bevespi Aerosphere® – Added quantity limit.
- Stiolto® Respimat® – Added quantity limit.
- Utibron® Neohaler® – Added prior authorization.

Corticosteroid inhalers:

- Alvesco® – Revised prior authorization criteria.
- Armonair Respiclick – Added prior authorization.
- Asmanex®/Asmanex® HFA – Revised prior authorization criteria and termed prior authorizations of current members.
- Flovent® Diskus®/Flovent® HFA – Added prior authorization.
    - Current utilizers on Flovent Diskus/Flovent HFA will be able to continue on it without needing a prior authorization.
- Pulmicort Flexhaler® – Added prior authorization. ■

Submission of Health Insurance Prospective Payment System (HIPPS) codes

Medicare Advantage Organizations (MAOs) are required to submit Health Insurance Prospective Payment System (HIPPS) codes on Skilled Nursing Facility (SNF) and Home Health (HH) encounters submitted with "from" dates of service on or after July 1, 2014. Specifically, HIPPS codes for SNF and HH encounters should come from the initial Omnibus Budget Reconciliation Act (OBRA)-required comprehensive assessment (Admission assessment) and Outcome and Assessment Information Set (Start of Care assessment), respectively.

Medicare Fee-for-Service (FFS) is introducing new payment methods for HH and SNF services. For FFS SNF and HH providers, the SNF Patient Driven Payment Model (PDPM) was effective October 1, 2019, and the HH Patient Driven Groupings Model (PDGM) was effective January 1, 2020. These new payment models introduce new HIPPS code sets for HH and SNF services.

With the September 27, 2019 release of the Medicare Advantage Encounter Data System (EDS)1, CMS updated the HIPPS code sets used in the EDS. In order to allow providers and Medicare Advantage Organizations (MAOs) maximum flexibility in the submission of HIPPS codes on encounter data, CMS will accept the existing HIPPS codes, as well as the new HIPPS codes.

- SNF encounters with "from" dates on or after October 1, 2019, and HH encounters with "from" dates of service on or after January 1, 2020 may be submitted using the existing HIPPS codes or the new HIPPS codes.
- SNF encounters with "from" dates of service prior to October 1, 2019 should continue to be submitted with existing HIPPS codes.
- HH encounters with "from" dates of service prior to January 1, 2020 should continue to be submitted with existing HIPPS codes.
- For SNF stays lasting 14 days or less in which an admission assessment was not completed prior to discharge, MAOs should follow the guidance outlined in the December 4, 2014 HPMS memorandum with the subject line: "Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System." As noted in that memo, MAOs may submit the HIPPS code from another assessment that took place during the stay or submit a default HIPPS code.
- The default HIPPS code for encounters with a "from" date of service prior to October 1, 2019 is "AAA00." The default HIPPS code for encounters with a "from" date of service on or after October 1, 2019 is "ZZZZZ."

Please send any questions related to this guidance to *encounterdata@cms.hhs.gov*, and specify "Updated Information on Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Medicare Advantage Encounter Data System – September 2019" in the subject line.

Under 42 C.F.R. § 422.310, Medicare Advantage Organizations (MAOs) and other entities under Part C rules are required to submit encounter data for each item and service provided to an MA enrollee. As required under § 422.310(b): Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician or other practitioner. Additionally, under § 422.310(d): MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. ■

Where to send live checks

If you have live checks to send to Fallon, please send them to us at 10 Chestnut Street, Worcester, MA 01608, attention Finance Department. Please do not send them to Smart Data. ■

Additional option to bill covering physician services

Currently, our process for billing covering physician services is to drop your claim to paper and write "covering" on the claim form prior to submission. Effective immediately, you have another option to bill covering services, whether it be on paper or electronically: you may append a Q5 modifier to the E&M claim line. This will indicate the rendering provider is working in a covering capacity for the PCP.

Should you have any questions regarding this, you may contact your Provider Relations representative. ■

Quality focus

CMS Star ratings

Striving for a 5-Star rating from CMS is among our quality benchmarks as an organization. We want you to know why getting a 5-Star rating from CMS is important.

What is SATISFACTION in the 5-Star measures?

Satisfaction measures our members' experience, or how happy our members are with Fallon and with their providers. The experiences measured include interactions between the member and Fallon, and the member and his or her providers.

How is member satisfaction measured?

For the purpose of the CMS 5-Star rating, member satisfaction is calculated by the results of the Consumer Assessment of Healthcare Providers or Systems (CAHPS). This is a 68-question survey focusing on the experience our members have as patients.

The survey is mailed every year in February to a random sampling of about 1,000 of our members who are selected by CMS. We at Fallon don't know who receives the survey. Typically, 30-40 percent complete it.

The survey is provided in both English and Spanish. Some of the questions indicate:

- How well the member feels they are treated by Customer Service
- How quickly the member is able to get an appointment with his or her doctor
- How much a member pays for prescriptions
- How a member feels about their health coverage
- If a member feels they aren't receiving the care he or she needs
- How easy it is to get a prescription drug that the member needs

Some examples of questions in past surveys and how answers affect our rating:

Q: In the last six months, how often was it easy to get the care, tests, treatment you needed?
Answer choices: Never, Sometimes, Usually, Always

A "Usually" or "Always" answer will reflect well on Fallon. A "Never" or "Sometimes" answer could indicate we need improvement.

Q: In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?
Answer choices: Never, Sometimes, Usually, Always

A "Usually" or "Always" answer will reflect well on Fallon. A "Never" or "Sometimes" answer could be interpreted as Fallon needing improvement.

Q: Have you had a flu shot since July 1, 2017
Answer choices: Yes, No, Don't Know

A "Yes" answer would reflect well on Fallon. A "No" or "Don't know" answer could be interpreted as Fallon needing improvement.

In what areas do we excel and where do we need help?
Historically, we have done well in the CAHPS survey, even though there are varying factors that make scores unpredictable from year to year.

Typically, we score well in these two areas:

- Overall Quality of Healthcare
- Customer Service

And, we tend to see lower scores in these areas:

- Getting Needed Care
- Rating of Health Plan

Because the CAHPS survey measures members' perception of us and of their health care, it takes creativity and thinking ahead to improve scores.

What do our CAHPS scores look like?
Historically, Fallon Health performs well in the CAHPS survey. But it's important to note that our score is also impacted by the overall health of our member population and how well other health plans perform in the survey. If all of our members provided the same survey responses for two years in a row, but a competitor got higher scores than the previous year, then our overall score would drop and the competitor's score would improve.

Using our CAHPS score
Even though there are a fair amount of unknowns in the scores, we have discovered that we can make some correlations between member experience and our scores.

For instance, if a member is asked if he or she is offered preventive screenings by the doctor, and he or she responds negatively, we may get a lower score. Or if a member has low copays but is taking many prescriptions, he or she may feel that the cost of health care is too high and again we may get a bad score.

We take those scores as feedback and have, at times, made changes to our services to improve our members' experience with us.

What are we doing to improve our SATISFACTION score?

Our CAHPS scores are reviewed and analyzed every year so that we can look at ways to improve the member experience. Some things that we have done as a result of information gathered in the CAHPS survey include:

- Lowering the cost of 90-day mail-order prescriptions for Medicare HMO members
- Removing prior authorizations for many medical services
- Sending reminders to members about the care and coverage available to them as plan members
- Working with providers to give members more access to care ■

Medicare Health Outcomes Survey

Each spring, a random sample of Medicare beneficiaries is contacted for the Medicare Health Outcomes Survey (HOS). The goal of the Medicare HOS is to gather reliable and clinically meaningful health status data from Medicare Advantage members. We are asking for support from our providers, during the annual Medicare wellness visit, on two significant patient discussions:

- **Reducing the risk of falling:** it is vital to discuss strategies to prevent falls and address problems with balance or walking
- **Improving bladder control:** it is important to discuss tactics to address urinary incontinence

Please consider discussing these topics with your Medicare patients. For more information, contact your Provider Relations representative. ■

NaviCare Clinical Practice Initiatives

Providers in our NaviCare network have the convenience of viewing the updated Clinical Practice Initiatives for 2020 from the provider section of our website, and can easily print PDF versions of each topic. *Here* you'll find the most current version of the following initiatives:

- Abuse and neglect
- Alcohol abuse prevention and treatment
- Care for older adults
- Chronic obstructive pulmonary disease
- Dementia
- Depression
- Diabetes
- Heart failure
- Medication management
- Osteoporosis
- Preventive screening for adults

While on our site, please take a few minutes to browse our various tools and resources that can help you stay informed and interact with us more smoothly. If you have any questions, please contact your Provider Relations representative for assistance at 1-866-275-3247, option 4. ■

Behavioral Health services for NaviCare members

Fallon's Behavioral Health Case Managers and Behavioral Health partner, Beacon Health Options, are assisting NaviCare members who have been recently hospitalized for mental health reasons. Members may receive phone calls from Beacon's Aftercare Coordinators or a home visit from a NaviCare Behavioral Health Case Manager. The Case Manager will provide support and assistance scheduling follow-up appointments with a behavioral health provider to make sure your patients receive care shortly after leaving the hospital. ■

Compliance

New technology to help fight fraud

Effective January 1, 2020, Fallon, in partnership with Cotivity, Inc., began using an integrated solution that combines data analysis, decisions and insights with rules and algorithms to create a dynamic fraud, waste and abuse (FWA) solution. Fallon is now able to identify potential problems and assess the need for investigation or other actions. This include solutions for preventing fraud and abuse before payment is made.

In early 2020, providers could receive a documentation request from Cotiviti on Fallon's behalf. It is important to respond to the request as soon as possible, with all documentation needed to support the services billed. ■

Caregiving

In this new Caregiving section of the Connection, we'll talk about how physicians and hospitals can identify and support the caregivers among their patients. We encourage providers to talk to patients who may be caregivers and help them through the stress that it can cause. This is an important and growing issue.

Do you have patients who are caregivers?

Caregivers can be under great strain when they're helping to care for someone with an illness/injury or a decline in physical or cognitive function. They may not have time or energy to deal with anything but their loved one's needs.

Too often they put their personal health needs on the back burner—while also managing other family and work responsibilities at the same time. They don't necessarily recognize that not taking care of themselves puts them at higher risk for developing health issues that could prevent them from continuing the work of caregiving.

Do you have patients in this situation? You may not know, because many caregivers won't even bring it up and don't label themselves with the word "caregiver."

That's where a few questions from you can make a world of difference. "Are you helping take care of a loved one? Is there someone who relies on you for household chores, shopping, transportation, help with medication? Are you a caregiver?"

Starting that conversation gives you a fuller view of how your patients' circumstances could be impacting their physical and emotional health. The knowledge that a patient is a caregiver gives you an opportunity to arm them with education and resources that can help them stay on the road to better health.

Fallon's *Caregiver Connection* blog may be helpful to your patients. ■

Coding corner

New 2020 CPT/HCPCS codes

All new codes will require prior authorization until a final review is performed by Fallon Health. By January 1, Fallon reviewed and assigned the appropriate coverage and determined prior authorization requirements for all new codes. Fallon will notify all contracted providers of this determination via the March issue of the Connection newsletter and in the *Provider Manual* on the Fallon Health website.

HCPCS code A4456

In accordance with Medicare regulations, HCPCS code A4456 (Adhesive remover, wipes, any type, each) is only covered when billed with an appropriate diagnosis related to tracheostomy or ostomy supplies. Effective March 1, 2020, the Plan will deny any claims billed with a non-related primary diagnosis for Medicare Plus or Commercial Plan types.

Coding updates

Effective October 1, 2019, the following codes *will be covered and will require plan authorization:*

Code	Description
0105U	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)
0106U	Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion
0107U	Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method
0108U	Gastroenterology (Barrett's esophagus), whole slide–digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer
0109U	Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger, and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species
0110U	Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus
0115U	Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
0116U	Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug-to-drug interactions for prescribed medications

Code	Description
0117U	Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA
0119U	Cardiology, ceramides by liquid chromatography–tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter
0121U	Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood
0122U	Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood
0123U	Mechanical fragility, RBC, shear stress and spectral analysis profiling
0124U	Fetal congenital abnormalities, biochemical assays of 3 analytes (free beta-hCG, PAPP-A, AFP), time-resolved fluorescence immunoassay, maternal dried-blood spot, algorithm reported as risk scores for fetal trisomies 13/18 and 21
0125U	Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, maternal serum, algorithm reported as risk scores for fetal trisomies 13/18, 21, and preeclampsia
0126U	Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk scores for fetal trisomies 13/18, 21, and preeclampsia
0127U	Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia
0128U	Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk score for preeclampsia
0129U	Hereditary breast cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)

Code	Description
0130U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)
0131U	Hereditary breast cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)
0132U	Hereditary ovarian cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure.)
0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure.)
0134U	Hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure.)
0135U	Hereditary gynecological cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure.)
0136U	ATM (ataxia telangiectasia mutated) (e.g., ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0137U	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure.)

Effective October 1, 2019, the following pharmacy codes *will be covered and will require plan prior authorization:*

Code	Description
J0222	Injection, Patisiran, 0.1 mg
J0593	Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)
J1303	Injection, ravulizumab-cwvz, 10 mg
J3111	Injection, romosozumab-aqqg, 1 mg
J9118	Injection, calaspargase pegol-mknl, 10 units
J9119	Injection, cemiplimab-rwlc, 1 mg
J9204	Injection, mogamulizumab-kpkc, 1 mg

Code	Description
J9210	Injection, emapalumab-lzsg, 1 mg
J9269	Injection, tagraxofusp-erzs, 10 micrograms
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg
Q5118	Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg

Effective October 1, 2019, the following codes *will be considered not a covered benefit:*

Code	Description
J7331	Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg
J7332	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg

Effective October 1, 2019, these codes *will be covered and will require plan prior authorization:*

Code	Description
Q4205	Membrane graft or membrane wrap, per square centimeter
Q4208	Novafix, per square centimeter
Q4209	Surgraft, per square centimeter
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter
Q4211	Amnion bio or Axobiomembrane, per square centimeter
Q4214	Cellesta cord, per square centimeter
Q4216	Artacent cord, per square centimeter
Q4217	Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter
Q4218	Surgicord, per square centimeter
Q4219	Surgigraft-dual, per square centimeter
Q4220	BellaCell HD or Surederm, per square centimeter
Q4221	Amniowrap2, per square centimeter
Q4222	Progenamatrix, per square centimeter
Q4226	MyOwn skin, includes harvesting and preparation procedures, per square centimeter

Effective October 1, 2019, the follow codes *will be deny vendor liable* for all lines of business:

Code	Description
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)2
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)2
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)2
3051F	Most recent hemoblobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
3052F	Most recent hemoblobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)2

Effective January 1, 2020, the following codes *will require plan prior authorization:*

Code	Description
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities
81307	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; full gene sequence
81308	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; known familial variant
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (e.g., colorectal and breast cancer) gene analysis, targeted sequence analysis (e.g., exons 7, 9, 20)

Code	Description
81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis
0139U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 6 central carbon metabolites (i.e., α-ketoglutarate, alanine, lactate, phenylalanine, pyruvate, and succinate), LC-MS/MS, plasma, algorithmic analysis with result reported as negative or positive (with metabolic subtypes of ASD)
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected
0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target), amplified probe technique, each target reported as detected or not detected
0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service

Code	Description
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0151U	Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal and antibiotic resistance genes with limited semi-quantitative results
0152U	Infectious disease (bacteria, fungi, parasites, and DNA viruses), DNA, PCR and next-generation sequencing, plasma, detection of >1,000 potential microbial organisms for significant positive pathogens
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement
0154U	FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3)
0155U	PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (e.g., breast cancer) gene analysis (i.e., p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y)
0156U	Copy number (e.g., intellectual disability, dysmorphology), sequence analysis
0157U	APC (APC regulator of WNT signaling pathway) (e.g., familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0158U	MLH1 (mutL homolog 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0159U	MSH2 (mutS homolog 2) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0160U	MSH6 (mutS homolog 6) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure.)
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure.)

Code	Description
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure.)
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability)
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability); with concurrently acquired computed tomography transmission scan
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure.)
92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)

Effective January 1, 2020, the following codes *will be deny vendor liable for all lines of business:*

Code	Description
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral
0564T	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on percent of cytotoxicity observed, a minimum of 14 drugs or drug combinations
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound
0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound

Code	Description
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure.)
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed
0572T	Insertion of substernal implantable defibrillator electrode
0573T	Removal of substernal implantable defibrillator electrode
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter
0577T	Electrophysiological evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results
0580T	Removal of substernal implantable defibrillator pulse generator only
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous

Code	Description
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters
0591T	Health and well-being coaching face-to-face; individual, initial assessment
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Effective October 1, 2019, the codes below *will no longer require prior authorization:*

Code	Description
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation

Effective March 1, 2020, the codes below *will require prior authorization:*

Code	Description
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos

Effective January 1, 2020, the following codes *will require plan prior authorization:*

Code	Description
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)
C1824	Generator, cardiac contractility modulation (implantable)
C1839	Iris prosthesis
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
C9758	Blinded procedure for nyha class iii/iv heart failure; transcatheter implantation of interatrial shunt or placebo control, including right heart catheterization, trans-esophageal echocardiography (tee)/ intracardiac echocardiography (ice), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study
E0787	External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing
G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg. esketamine nasal self-administration, includes 2 hours post-administration observation
K1001	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type

Code	Description
K1002	Cranial electrotherapy stimulation (CES) system, includes all supplies and accessories, any type
K1003	Whirlpool tub, walk-in, portable
K1004	Low frequency ultrasonic diathermy treatment device for home use, includes all components and accessories
P9099	Blood component or product not otherwise classified

Effective January 1, 2020, these following codes *will be deny vendor liable for all lines of business:*

Code	Description
G2021	Health care practitioners rendering treatment in place (tip)
G2022	A model participant (ambulance supplier/provider), the beneficiary refuses services covered under the model (transport to an alternate destination/treatment in place)
G2089	Most recent hemoglobin a1c (hba1c) level 7.0 to 9.0%
G2090	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2091	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2092	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy prescribed or currently being taken
G2093	Documentation of medical reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons)
G2094	Documentation of patient reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., patient declined, other patient reasons)
G2095	Documentation of system reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., other system reasons)
G2096	Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy was not prescribed, reason not given
G2097	Children with a competing diagnosis for upper respiratory infection within three days of diagnosis of pharyngitis (e.g., intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or UTI

Code	Description
G2098	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2099	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2100	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2101	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2102	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
G2103	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
G2104	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
G2107	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2109	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2110	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2112	Patient receiving <=5 mg daily prednisone (or equivalent), or RA activity is worsening, or glucocorticoid use is for less than 6 months
G2113	Patient receiving >5 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

Code	Description
G2114	Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2115	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2116	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2117	Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2118	Patients 81 years of age and older with a evidence of frailty during the measurement period
G2119	Within the past 2 years, calcium and/or vitamin D optimization has been ordered or performed
G2120	Within the past 2 years, calcium and/or vitamin D optimization has not been ordered or performed
G2121	Psychosis, depression, anxiety, apathy, and impulse control disorder assessed
G2122	Psychosis, depression, anxiety, apathy, and impulse control disorder not assessed
G2123	Patients 66-80 years of age and had at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2124	Patients 66-80 years of age and had at least one claim/encounter for frailty during the measurement period and a dispensed dementia medication
G2125	Patients 81 years of age and older with evidence of frailty during the measurement period
G2126	Patients 66 years of age or older and had at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2127	Patients 66 years of age or older and had at least one claim/encounter for frailty during the measurement period and a dispensed dementia medication

Code	Description
G2128	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g., history of gastrointestinal bleed, intra-cranial bleed, blood disorders, idiopathic thrombocytopenic purpura (ITP), gastric bypass or documentation of active anticoagulant use during the measurement period)
G2129	Procedure-related BP not taken during an outpatient visit. Examples include same day surgery, ambulatory service center, GI lab, dialysis, infusion center, chemotherapy
G2131	Patients 81 years and older with a diagnosis of frailty
G2132	Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2133	Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2134	Patients 66 years of age or older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2135	Patients 66 years of age or older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2136	Back pain measured by the visual analog scale (VAS) at three months (6 to 20 weeks) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater
G2137	Back pain measured by the visual analog scale (VAS) at three months (6 to 20 weeks) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated a change of less than an improvement of 5.0 points
G2138	Back pain as measured by the visual analog scale (VAS) at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated a change of 5.0 points or greater
G2139	Back pain measured by the visual analog scale (VAS) pain at one year (9 to 15 months) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated a change of less than 5.0

Code	Description
G2140	Leg pain measured by the visual analog scale (VAS) at three months (6 to 20 weeks) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater
G2141	Leg pain measured by the visual analog scale (VAS) at three months (6 to 20 weeks) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated less than an improvement of 5.0 points
G2142	Functional status measured by the oswestry disability index (ODI version 2.1a) at one year (9 to 15 months) postoperatively was less than or equal to 22 or functional status measured by the ODI version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated a change of 30 points or greater
G2143	Functional status measured by the oswestry disability index (ODI version 2.1a) at one year (9 to 15 months) postoperatively was greater than 22 and functional status measured by the ODI version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated a change of less than 30 points
G2144	Functional status measured by the oswestry disability index (ODI version 2.1a) at three months (6 to 20 weeks) postoperatively was less than or equal to 22 or functional status measured by the ODI version 2.1a within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated a change of 30 points or greater
G2145	Functional status measured by the oswestry disability index (ODI version 2.1a) at three months (6 to 20 weeks) postoperatively was greater than 22 and functional status measured by the ODI version 2.1a within three months preoperatively and at three months (6 to 20 weeks) postoperatively demonstrated a change of less than 30 points
G2146	Leg pain as measured by the visual analog scale (VAS) at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater
G2147	Leg pain measured by the visual analog scale (VAS) at one year (9 to 15 months) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated less than an improvement of 5.0 points
G2148	Performance met: multimodal pain management was used
G2149	Documentation of medical reason(s) for not using multimodal pain management (e.g., allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during PACU stay, other medical reason(s))
G2150	Performance not met: multimodal pain management was not used
G2151	Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care
G2152	Performance met: the residual change score is equal to or greater than 0

Code	Description
G2153	In hospice or using hospice services during the measurement period
G2154	Patient received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period
G2155	Patient had history of at least one of the following contraindications any time during or before the measurement period: anaphylaxis due to Tdap vaccine, anaphylaxis due to Td vaccine or its components; encephalopathy due to Tdap or Td vaccination (post tetanus vaccination encephalitis, post diphtheria vaccination encephalitis or post pertussis vaccination encephalitis.)
G2156	Patient did not receive at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period; or have history of at least one of the following contraindications any time during or before the measurement period: anaphylaxis due to Tdap vaccine, anaphylaxis due to Td vaccine or its components; encephalopathy due to Tdap or Td vaccination (post tetanus vaccination encephalitis, post diphtheria vaccination encephalitis or post pertussis vaccination encephalitis.)
G2157	Patients received both the 13-valent pneumococcal conjugate vaccine and the 23-valent pneumococcal polysaccharide vaccine at least 12 months apart, with the first occurrence after the age of 60 before or during the measurement period
G2158	Patient had prior pneumococcal vaccine adverse reaction any time during or before the measurement period
G2159	Patient did not receive both the 13-valent pneumococcal conjugate vaccine and the 23-valent pneumococcal polysaccharide vaccine at least 12 months apart, with the first occurrence after the age of 60 before or during measurement period; or have prior pneumococcal vaccine adverse reaction any time during or before the measurement period
G2160	Patient received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period
G2161	Patient had prior adverse reaction caused by zoster vaccine or its components any time during or before the measurement period
G2162	Patient did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period; or have prior adverse reaction caused by zoster vaccine or its components any time during or before the measurement period
G2163	Patient received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period
G2164	Patient had a prior influenza virus vaccine adverse reaction any time before or during the measurement period
G2165	Patient did not receive an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period; or did not have a prior influenza virus vaccine adverse reaction any time before or during the measurement period

Code	Description
G2166	Patient refused to participate at admission and/or discharge; patient unable to complete the neck fs prom at admission or discharge due to cognitive deficit, visual deficit, motor deficit, language barrier, or low reading level, and a suitable proxy/recorder is not available; patient self-discharged early; medical reason
G2167	Performance not met: the residual change score is less than 0
M1106	The start of an episode of care documented in the medical record
M1107	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1108	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1109	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery or hospitalized
M1110	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems or reason unknown)
M1111	The start of an episode of care documented in the medical record
M1112	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1113	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1114	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery or hospitalized
M1115	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown)
M1116	The start of an episode of care documented in the medical record
M1117	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1118	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1119	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery or hospitalized
M1120	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems or reason unknown)
M1121	The start of an episode of care documented in the medical record

Code	Description
M1122	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1123	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1124	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery
M1125	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown)
M1126	The start of an episode of care documented in the medical record
M1127	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1128	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1129	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery
M1130	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown)
M1131	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1132	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1133	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery
M1134	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown
M1135	The start of an episode of care documented in the medical record
M1136	The start of an episode of care documented in the medical record
M1137	Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS or Parkinson's diagnosed at any time before or during the episode of care
M1138	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only)
M1139	Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown)

Code	Description
M1140	Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery for surgery or hospitalized
M1141	Functional status was not measured by the oxford knee score (OKS) at one year (9 to 15 months) postoperatively
M1142	Emergent cases
M1143	Initiated episode of rehabilitation therapy, medical, or chiropractic care for neck impairment
M1144	Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only

Effective January 1, 2020, the following code *will be deny vendor liable, excluding: all Medicare HMO-PSP, NaviCare and PACE:*

Code	Description
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month.). (Use G2058 in conjunction with 99490). (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491).

Effective January 1, 2020, the following code *will not be a covered benefit for Commercial, MLTC or Summit ElderCare®:*

Code	Description
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each ■

Payment policies

Revised policies – effective March 1, 2020:

The following policies have been updated. Details about the changes are indicated on the policies.

- ***Assistant Surgeon* –** Updated referral/notification/prior authorization section.
- ***Counseling and/or Risk Factor Reduction* –** Updated coverage rules for smoking cessation.
- ***Drugs and Biologicals* –** Updated MassHealth NDC exclusions and Table A required codes.
- ***Evaluation and Management* –** Updated reimbursement and coding/billing sections.
- ***Gastroenterology* –** Clarified reimbursement section.
- ***Hearing Aids* –** Updated Commercial coding section.

- ***Home Delivered Meals –*** Updated code tables.
- ***Home Health –*** Updated definitions.
- ***Hospice –*** Updated Medicare Advantage branding.
- ***Incontinence Products –*** Updated Referral/notification/prior authorization requirements section.
- ***Infertility –*** Updated covered services, definitions and coding.
- ***Non-Covered Services –*** Updated code report.
- ***Nurse Practitioner –*** Updated reimbursement and billing/coding sections.
- ***Obstetrics/Gynecology –*** Updated billing/coding section.
- ***Physician Assistant –*** Updated reimbursement and billing/coding sections.
- ***Preoperative Autologous Blood Donation –*** Clarified which plan types are covered.
- ***Transportation Services –*** Updated financial waiver of liability, NaviCare Reimbursement and Referral sections. ■

Annual Review

The following policies were reviewed as part of our annual review process and no significant changes were made:

- ***Post-Operative Nasal Debridement***
- ***Preventative Services***
- ***Registered Nurse First Assistant***
- ***Sequestration***
- ***Telemedicine***
- ***Timely Filing***
- ***Transplant***
- ***Unlisted Procedures and Services***
- ***Well Baby/Well Child***

Retired policies

- ***Physician Standby***

Connection is an online quarterly publication for all Fallon Health ancillary and affiliated providers.

Send information to:

Provider Relations
Fallon Health
10 Chestnut St.
Worcester, MA 01608

or

Email your Provider Relations representative

Richard Burke
President and CEO

Dr. Carolyn Langer
Senior Vice President and Chief Medical Officer

Susan Keser
Vice President, Network Development and Management

Kathy Bien
Director, Provider Relations

fallonhealth.org/providers

Questions?

1-866-275-3247

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19-665-044 Rev. 00 12/19