Connection

Important information for Fallon Health physicians and providers

January 2019

What's new

MHQP Patient Experience Awards

Massachusetts Health Quality Partners, (MHQP) has announced the winners of its first annual MHQP Patient Experience Awards, recognizing the primary care practices that perform highest on their annual Patient Experience Survey. This is the only statewide survey of patient experience in primary care in Massachusetts.

Awards have been given to the adult and pediatric practices that performed highest in each of nine performance categories, as well as an overall performance category determined by the practices with the most best-in-class results across multiple categories.

The following award recipients were celebrated at MHQP's joint Board and Council meeting in November:

Adult Practices

Top Overall Performers:

Elm Street Adult Medicine,
Northampton

Grove Medical Associates,
Auburn

Hahnemann Medical Group,
Worcester

Newton Wellesley Primary Care,
Newton

Personal Physicians Health Care,
Chestnut Hill

Distinction in Patient-Provider Communications:

Hahnemann Medical Group,
Worcester

Hilltown Community Health Centers,
Worthington

Reliant Medical Group,
Webster

Distinction in Coordinating Patient Care:

Beth Israel Deaconess Healthcare,
Dorchester

Personal Physicians Health Care,
Chestnut Hill

Reliant Medical Group,
Webster

Distinction in How Well Providers Know Their Patients:

Beth Israel Deaconess Family Medicine,
Medfield

Hahnemann Medical Group,
Worcester

Personal Physicians Health Care,
Chestnut Hill

Distinction in Assessment of Patient Behavioral Health Issues:

Brewster Medical Associates,
Brewster

Newton Wellesley Primary Care,
Newton

North Shore Physicians Group,
Saugus

Distinction in Ease of Access to Care:

Elm Street Adult Medicine,
Northampton

Newton Wellesley Primary Care,
Newton

Personal Physicians Health Care,
Chestnut Hill

Distinction in Empowering Patient Self Care:

CHP Health Center,
Great Barrington

Mount Auburn Healthcare,
Cambridge

North Shore Physicians Group,
Saugus

Distinction in Office Staff Professional Excellence:

Newton Wellesley Primary Care,
Newton

One Medical Group,
Boston

Personal Physicians Health Care,
Chestnut Hill

Pediatric Practices

Top Overall Performers:

Belmont Cambridge Health Care,
Cambridge

Blackstone Valley Family Physicians,
Northbridge

East Boston Neighborhood Health Center,
East Boston

East Milton Pediatric Associates,
Milton

Hanover Pediatrics – Healthcare South,
Hanover

South County Pediatrics,
Webster

Worcester Pediatrics,
Worcester

Distinction in Patient-Provider Communications:

Blackstone Valley Family Physicians,
Northbridge

Pediatric Medical Care Inc.,
Chelsea

Pediatric Professional Associates,
Methuen

Distinction in Coordinating Patient Care:

Blackstone Valley Family Physicians,
Northbridge

Hanover Pediatrics – Healthcare South,
Hanover

South Boston Community Health Center,
South Boston

Distinction in How Well Providers Know Their Patients:

Blackstone Valley Family Physicians,
Northbridge

Chair City Family Medicine,
Gardner

Pediatric Primary Care University Benedict,
Worcester

Distinction in Ease of Access to Care:

Chandler Pediatrics,
Worcester

Pediatric Services of Springfield,
East Longmeadow

Worcester Pediatrics,
Worcester

Distinction in Empowering Patient Self Care:

East Boston Neighborhood Health Center,
East Boston

South Boston Community Health Center,
South Boston

South County Pediatrics,
Webster

Distinction in Office Staff Professional Excellence:

Chandler Pediatrics,
Worcester

Community Pediatrics of Milford,
Milford

Worcester Pediatrics,
Worcester

Distinction in Pediatric Preventative Care:

Middleboro Pediatrics,
Lakeville

Tri-County Pediatric Associates,
Stoughton

Worcester Pediatrics,
Worcester

Distinction in Assessment of Child Development:

Pediatric Associates of Hampden County Inc.,
West Springfield

Southern Jamaica Plain Health Center,
Jamaica Plain

Tri-County Pediatric Associates,
Stoughton

Congratulations to all the winners of MHQP Patient Experience Awards! ■

Summit ElderCare® opens new PACE Center in Webster

Fallon's Summit ElderCare, a Program of All-Inclusive Care for the Elderly (PACE), provides medical care, adult day health, social supports, in-home services, transportation and health insurance for adults ages 55 and over who live in our service area and qualify for a nursing home level of care but want to live at home.

We recently opened a new PACE Center in Webster to replace a smaller location in Charlton. Fallon is the largest PACE provider in New England and fifth largest in the country. With more than 1,200 participants, Summit ElderCare PACE Centers are located in Leominster, Lowell, Springfield and Worcester, in addition to Webster. We also operate Fallon Health Weinberg-PACE in western New York.

There is no financial eligibility for the PACE program and many participants qualify for financial assistance. The monthly plan premium varies depending on an individual's income and assets, and once enrolled there are no copayments, deductibles or coinsurance for covered services.

For more information about Summit ElderCare, visit *fallonhealth.org/summit*. ■

How does Summit ElderCare help with transitions of care?

Summit Eldercare is a community based model of care. In line with Summit's mission, the Interdisciplinary Care Team consistently formulates and implements innovative strategies to provide community based care and maintain community living. When a participant is in need of a higher level of care, such as a hospital or skilled nursing facility, they are followed by a Transitions of Care Coordinator (TCC).

The TCC is a registered nurse who follows the participant along the continuum of inpatient care, coordinating the many aspects of these transitions. The goal is for the participant to safely return to the community setting and minimize or eliminate associated complications from an inpatient stay.

TCC responsibilities include:

- Facilitating transitions to and from inpatient facilities
- Collaborating with providers and the Interdisciplinary Care Team on the participant's progress
- Communicating with facilities and caregivers regarding the participant's plan of care
- Visiting with participants and staff on site
- Coordinating transportation
- Suspending and resuming community services as needed
- Implementing services
- Coordinating medical equipment
- Assigning and approving the appropriate level of care
- Attending family meetings for discharge planning
- Exploring alternative strategies and settings that reduce the number of acute hospitalizations and produce better participant outcomes ■

Product spotlight

NaviCare® – Model of Care Training

NaviCare's philosophy is to assist our members to function 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 and more. Transportation to medical appointments is covered, along with 90 round-trip supplemental rides to health-related services such as the pharmacy, gym or support groups within a 30-mile radius of the member's home.

Requirements of the Primary Care Provider and roles of the Care Team are outlined below. The member centric care plan is sent to the Primary Care Provider by the Navigator, and feedback is welcome. Providers can communicate with the Care Team by calling 1-877-700-6996. Advantages for members and providers include care coordination by the Care Team at the time of member care transition and the support we provide.

Below are the roles and responsibilities of the Care Team:

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 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 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 the patient's facility

Clinical Pharmacist *(as needed)*

Visits patients after care transitions to perform a medication reconciliation and teach them proper medication use ■

Telemedicine coverage

Effective March 1, 2019, Fallon will be expanding its telemedicine coverage to include synchronous, real-time office visits with our network providers who have the technology platform to securely provide these services. Please refer to the revised Telemedicine Payment Policy, effective March 1, 2019, for complete details on our coverage.

Telemedicine is a broad term used to define an array of electronic communication between medical personnel and patients at different locations. This can be inclusive of, but not limited to, secured internet communication, video conferencing and remote monitoring.

Fallon will be covering only the following CPT codes:

99201	99212
99211	99213

We will reimburse at 80% of the contracted rate. Mid-level practitioners (nurse practitioners, physician assistants, etc.) will further have their payment reduced to 85% of physician reimbursement in alignment with other reimbursement policies. The claims must be billed with modifier 95 and place of service 2. The Plan expects the services performed to be equivalent to the standards set forth in the Evaluation and Management coding guidelines. The Plan expects documentation in the medical record supporting the E/M code level of care and accordingly the member will be responsible for the same cost-share as an in-person visit. Billing practices may be reviewed and audited. ■

Doing business with us

Important Information about sequestration payment reductions

Pursuant to the Budget Control Act of 2011, the Centers for Medicare & Medicaid Services (CMS) imposed a two percent (2%) reduction in Medicare fee-for-service payments to providers for premiums received by Medicare Advantage health plans. This reduction, which became effective in 2013, is known as sequestration.

Beginning March 1, 2019, Fallon Health will implement this 2% sequestration reduction on claim payments based on current Medicare payment methodologies, e.g., fee schedules, Diagnosis Related Groups (DRG), Prospective Payment System (PPS), etc. This change pertains to providers who are contracted with Fallon Health for Fallon Senior Plan. This also applies to providers who are only contracted with Fallon Health for other products, such as Commercial and MassHealth, but may receive reimbursement for authorized, out-of-network covered services for Fallon Senior Plan.

The 2% reduction will be applied to final payment which is reduced by coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. This reduction amount will be reflected in the "Withheld/Sequest" field of the *Remittance Advice Summary* and will be identified by the Claim Adjustment Reason Code 253 (Sequestration – reduction in federal payment) on the *Electronic Remittance Advice* (835 file).

Any future changes made by CMS with respect to the administration of sequestration will be applied accordingly. Providers who are reimbursed less than 100% of a current Medicare rate are exempt from this sequestration reduction, unless otherwise provided for in the provider's contract.

If you have questions, please refer to the *Sequestration Payment Policy* or contact Fallon Health's Provider Relations Department at 1-866-275-3247, prompt 4.

Sequestration is not balance billable to the member. ■

New Medicare opioid edits and programs for 2019

There are several new opioid safety edits and programs that will be introduced for the 2019 Medicare Part D plan year. This will impact all Fallon Medicare members: Fallon Senior Plan, Navicare, Summit ElderCare and Fallon Health Weinberg PACE. These new programs go into effect on January 1, 2019.

Point of Sale (POS) opioid safety edits

CMS requires certain prospective safety edits beginning in 2019. These edits will occur when the member is filling the prescription at the pharmacy and they require resolution. The pharmacist at the pharmacy may override some of the edits with appropriate codes, may need to consult with the provider and/or 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, meaning the claims will still get rejected 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 and LTC members are excluded from the safety edits. Members have coverage determination and appeal rights under this program.

The edits that we will be utilizing 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 4 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—this will require a prior authorization to be submitted. The provider needs to attest that the opioids and/or day supply is intended and medically necessary for the member. The member is considered opioid naïve if there are no opioid claims in the past 90 days.

Medication Therapy Management Program (MTMP)

We are also adding special eligibility criteria to our 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)
- Three or more opioid prescribers and three or more opioid dispensing pharmacies

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

This is a new comprehensive opioid management program required under the *Comprehensive Addiction and Recovery Act of 2016* (CARA). This is a retrospective drug utilization review (DUR) 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, and in long term care (LTC). Dual/Low Income Subsidy (LIS) members are limited in ability to change plans to avoid intervention once identified as at-risk.

Criteria for identification into the program includes any of the following:

- Members with opioid pharmacy claims equal to or greater than 90 MME, three or more opioid prescribers and three or more opioid dispensing pharmacies
- Members with opioid pharmacy claims equal to or greater than 90 MME and five or more opioid prescribers
- Members with any MME level and seven or more opioid prescribers or seven or more opioid dispensing pharmacies
- Additional potentiator drugs - 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.

Please be aware that network pharmacies, Fallon's Pharmacy Department, our MTMP vendor, Clinical Support Services (CSS), or our opioid drug management vendor and pharmacy benefit manager, CVS Caremark, Enhanced Safety and Monitoring Solutions may outreach to you for your assistance in resolving these safety edits and opioid management cases. ■

Important changes regarding claims with Zelis™ edits

Fallon Health began using an integrated claims editing tool offered by Zelis in 2018 to further evaluate claims for adherence to industry-recognized edits and guidelines and to ensure compliance with payment policies and standard coding practices.

Beginning March 1, 2019, providers will find a message on the Remittance Advice Summary and the Electronic Remittance Advice (835 file) indicating an edit was applied by Zelis. Should a provider have questions related to an edit, please feel free to call Zelis toll free at 1-866-489-9444.

If a provider elects to submit a formal appeal related to a Zelis edit, please submit the request in writing within 120 days of the initial Remittance Advice Summary containing all of the following:

- A completed *Request for Claim Review Form* explaining the reason for the dispute including contact information and a fax number
- A copy of the original claim billed
- A copy of the Remittance Advice Summary including the denial
- All pertinent medical records and or reports necessary for reconsideration of the claim

Please submit the written appeals to:

Zelis Claims Integrity, Inc.
2 Crossroads Drive
Bedminster, NJ 07921
Attn: Appeals Department
Fax: 1-855-787-2677

Zelis will respond directly to the provider by fax with the appeal determination.

If a provider elects to submit a corrected claim after a Zelis edit, please submit a completed Claim Review Form within 120 days of the initial Remittance Advice Summary and the new claim to the address above.

If the billed charges on the claim exceed $100, please submit the pertinent medical records necessary for reconsideration of the claim.

Should you have questions on this information, please call Provider Relations at 1-866-275-3247, prompt 4. ■

Medication confusion and your patients' safety

Fallon Health's Safe Transitions pharmacists have been proactively visiting Fallon Senior Plan and NaviCare members at their homes after a hospital or SNF discharge. Our pharmacists have sometimes found that patients are confused about their medications.

When a new medication is prescribed, or a dose changed, pharmacies are not always notified of the change. With the prevalence of pharmacy auto-refills, old prescriptions can continue to be refilled and picked up by unsuspecting patients. Not notifying the pharmacy can cause confusion and increase the potential risk for the patient to take the wrong dose, wrong medication or duplicate medications.

To minimize these risks, it's important to communicate any medication change to your patient's pharmacy. Pharmacies cannot make any changes to medications unless there is notification from a provider stating the change. To communicate with the pharmacy, you may call, fax or include the change on the new prescription. ■

Change in Adult Day Health Care

NaviCare members will no longer qualify for, or be eligible for health promotion and prevention (HPP) level of Adult Day Health (ADH) Care services as of January 1, 2019, according to the updated *MassHealth ADH Program Regulations* effective July 27, 2018.

As outlined in the Commonwealth of Massachusetts MassHealth Provider Manual Services – Adult Day Health Manual Program Regulations (130 CMR 404.000), NaviCare members must meet the updated clinical eligibility found in the Adult Day Health Program Regulations in order to receive ADH services after December 31, 2018. The Clinical Eligibility Criteria of the Program Regulations, revised by MassHealth and in effect on July 27, 2018, can be found in section 404.405 of the MassHealth Regulations. ■

Updates to the Provider section of our website

Please note that the *Pharmacy* section of the Provider website has been updated. The prior authorization page now contains only PA forms and the electronic PA link. To view criteria, please use the online drug *formulary*. Choose a formulary, search for the drug by name or class, then click the PA symbol.

Pharmacy updates will now be included in the *Providers News and Announcements* page on our website. Please visit this site on a regular basis for the latest information on the pharmacy formulary, prior authorizations, clinical programs, and important updates. ■

Validating your practice information

Changes happen in your practice, and we want your patients to have access to the most current information in our *Provider Directory* and "Find a doctor" tool. Please use the tool on our website to update your practice information. It's quick and easy. Just go to the *Find a doctor* page, check out your information, then fill out the online form on the new *Update your practice information* page. Please be sure to hit the submit button at the bottom. Updates will be made within 30 days if there are no questions about the information you have provided.

Changes to the following can be made via the tool or through the *Standardized Provider Information Change Form*:

- Your ability to accept new patients
- Street address
- Phone number
- Specialty
- Hospital affiliations
- Languages spoken by you or your staff
- Product participation
- Any other change that impacts your availability to patients

In addition to receiving your updates via our online tool or other means of notification, you will receive a call from one of our representatives periodically to ensure your information is correct. This verification aligns Fallon Health with requirements that have been set forth by the Centers for Medicare & Medicaid Services (CMS), the Massachusetts Division of Insurance (DOI) and the National Committee for Quality Assurance (NCQA)*. The regulations are designed to ensure health care consumers have current and accurate provider demographic information. If you have any questions, please do not hesitate to contact your Provider Relations Representative.

**NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used performance measure tool in health care.* ■

Medicare formulary changes effective 1/1/2019

PCSK9:

- Praluent added as Preferred Brand, PA required
- Repatha removed from formulary – negative change

DDP-4:

- Janumet updated to Preferred Brand and Step Therapy requirement was removed
- Janumet XR added as Preferred Brand
- Januvia updated to Preferred Brand and Step Therapy requirement was removed
- Jentadueto and Jentadueto XR added as Preferred Brand

GLP-1:

- Bydureon added as Preferred Brand
- Ozempic added as Preferred Brand
- Trulicity added as Preferred Brand
- Victoza added as Preferred Brand
- Byetta removed from formulary – negative change

SGLT-2:

- Farxiga updated to Preferred Brand
- Synjardy and Synjardy XR added as Preferred Brand
- Xigduo added as Preferred Brand

Anticoagulants:

- Eliquis updated to Preferred Brand
- Xarelto updated to Preferred Brand

Immune suppressants:

- Xeljanz and Xeljanz XR added as Preferred Brand, PA required
- Kineret removed from formulary – negative change
- Orencia removed from formulary – negative change
- Otezla removed from formulary – negative change

Respiratory Tract/Pulmonary agents:

- Symbicort updated to Preferred Brand
- Trelegy updated to Preferred Brand

Ophthalmic Antiglaucoma agents:

- Azopt updated to Preferred Brand
- Simbrinza updated to Preferred Brand
- Istalol removed from formulary – negative change

Ophthalmic Prostaglandin and Prostamide analogs:

- Lumigan updated to Preferred Brand
- Travatan Z updated to Preferred Brand

High-risk medications:

- Prior authorization requirement added to:
  - Glyburide and glyburide/metformin – negative change
- Prior authorization requirement that only applies to new starts added to:
  - Methocarbamol
  - Nitrofurantoin
  - Amitriptyline
  - Doxepin
  - Hydroxyzine
  - Hydroxyzine Pamoate
  - Benztropine
  - Zolpidem
  - Zaleplon
  - Eszopiclone
  - Digoxin

Topical products:

- Quantity limits added to:
  - Calcipotriene cream, ointment and solution
  - Clobetasol gel, ointment and solution
  - Diclofenac gel
  - Fluocinonide cream, gel and solution
  - Ketoconazole cream
  - Santyl ointment ■

Quality focus

5-Star rating from CMS

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 member is with us. 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

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 Health Care
- 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 forward-thinking to improve scores.

What do our CAHPS scores look like?

It is important to note that our scores are impacted by our members' perceptions of their overall experiences while with Fallon and how well other health plans perform in the survey. For example, if our members gave us the same score, say 80%, two years in a row, and the average score for all plans improved the second year, the results that awarded us a 4-Star rating the first year may only result in a 3-Star rating the following year.

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 recently as a result of information gathered in the CAHPS survey include:

- Lowering the cost of 90-day mail-order prescriptions for Fallon Senior Plan 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 ■

NaviCare Clinical Practice Initiatives

Providers in our NaviCare network have the convenience of viewing the updated Clinical Practice Initiatives for 2019 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. ■

Compliance

CMS Preclusion List

Beginning January 1, 2019, CMS will be implementing and maintaining a Preclusion List identifying prescribers and individuals or entities who fall within the following categories:

1. Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
2. Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

Notification that a provider has been precluded will come directly from CMS. However, Fallon Health will screen our providers against the list immediately upon publication at the beginning of each month. If you, or one of your providers, is identified, Fallon is required to 1) provide notification to members you've seen in the past 12 months, 2) provide a 90-day grace period for those members, and 3) terminate the contract.

If you have questions, please contact your Provider Relations representative or Contract Manager. ■

MassHealth

Adult foster care accreditation requirements

Pursuant to the *Adult Foster Care Bulletin 14* issued in March 2018, as of June 30th, 2019, all Adult Foster Care providers are required to provide evidence of accreditation to MassHealth as required in 130 CMR 408.404(A)(11). Accreditation must be obtained by a nationally recognized accreditation organization determined acceptable by MassHealth, including the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF). Below is the timeline for accreditation milestones as outlined in this bulletin:

- By December 31, 2018, the AFC provider must submit documentation to the LTSS Provider Portal demonstrating that they have scheduled an onsite survey date with the accrediting body.
- By February 1, 2019, the AFC provider must submit documentation to the LTSS Provider Portal that they have performed an initial gap analysis and received a report from the accrediting organization that reflects process gaps necessary to achieve accreditation.

- By June 30, 2019, the AFC provider must submit a copy of the final report and determination to the LTSS Provider Portal. The final report and determination will serve as evidence of accreditation for purposes of 130 CMR 408.404(A)(11).

AFC providers should contact the MassHealth LTSS Provider Services Center with questions or concerns related to this requirement:

Phone: Toll-free 1-844-368-5184
Email: *support@masshealthltss.com*
Portal: *MassHealthLTSS.com*
Mail: MassHealth LTSS, PO Box 159108, Boston, MA 02215 ■

Coding corner

Helpful correct coding information

The Health Insurance Portability & Accountability Act (HIPAA) Transaction & Code Set Rules require providers to report only the procedure and diagnosis codes which most accurately reflect the information in their clinical records. HIPAA requires providers to use the codes that are valid at the time the service is provided. Fallon adheres to HIPAA standards regarding coding, billing, claim processing and payment.

In accordance with Fallon Payment Policies, providers are expected to adhere to industry standard guidelines related to Correct Coding and coding to the greatest specificity as intended by ICD10 Guidelines.

The Plan requires accurate and appropriate submission of claims codes.

Physicians and facilities are expected to submit claims appropriately billed as required by the Plan and in adherence with industry standards for services rendered. If requested by the Plan, providers and facilities are required to supply the Plan with any documentation for the purpose of coding analysis.

Fallon applies the standards of the AMA CPT, ICD10, published National CMS policies (i.e., National Coverage Determinations [NCDs], Regional CMS policies, Local Coverage Determinations [LCDs]) industry publications (various professional societies, etc.) to ensure claim accuracy. When the above-noted sources do not fully cover or delineate a coding situation, Fallon applies information derived from evidence-based published medical literature, such as UpToDate, and coding standards which are publicly available, such as Milliman guidelines, EncoderPro, HCPro and others.

Fallon currently uses claims editing software based on the above-noted sources to create claims edits, which are used for automated claims coding verification and to ensure that Fallon is processing claims in compliance with general industry standards.

Some examples of what Fallon claim edits are based on:

1. NCCI comprehensive/incidental PTP rules
2. CMS medically unlikely units (MUE) rules
3. CMS professional fee schedule status designation
4. CMS assistant and co-surgeon rules
5. AMA CPT add on code rules
6. AMA CPT designated separate procedures
7. Procedure-Diagnosis matching rules

The procedure-diagnosis matching edits match procedures with compatible diagnoses based on LCDs, NCDs, standard coding guidelines, and published evidence-based medical literature. When a code pair is denied as "not compatible" it often represents a coding error, whereby a nonspecific diagnosis or procedure code is reported, and there is a more specific ICD or CPT code available which would better reflect the clinical information, and thus would be considered "compatible. "

Fallon Coding Policies are available *here*. ■

Coding updates

Update for HCPS C9257

Providers should not automatically bill HCPS C9257, Avastin7, with five units. Please bill with the correct units/dosage based on the service rendered. If a claim is submitted with code J3490 or J9035, the claim will not be changed to code C9257, as previously processed by Fallon Health.

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

Code	Description
C9036	Injection, patisiran, 0.1 mg
C9037	Injection, risperidone (perseris), 0.5 mg
C9038	Injection, mogamulizumab-kpkc, 1 mg
C9039	Injection, plazomicin, 5 mg
C9408	Iodine i-131 iobenguane, therapeutic, 1 millicurie
J0517	Injection, benralizumab, 1 mg
J0567	Injection, cerliponase alfa, 1 mg
J0584	Injection, burosumab-twza 1 mg
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units
J1301	Injection, edaravone, 1 mg
J1628	Injection, guselkumab, 1 mg
J1746	Injection, ibalizumab-uiyk, 10 mg
J3245	Injection, tildrakizumab, 1 mg

Code	Description
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
J3316	Injection, triptorelin, extended-release, 3.75 mg
J3397	Injection, vestronidase alfa-vjbk, 1 mg
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg
J9057	Injection, copanlisib, 1 mg
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
J9173	Injection, durvalumab, 10 mg
J9229	Injection, inotuzumab ozogamicin, 0.1 mg
J9311	Injection, rituximab 10 mg and hyaluronidase
J9312	Injection, rituximab, 10 mg
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg
J3591	Unclassified drug or biological used for esrd on dialysis

Effective January 1, 2019, the following codes *will be covered* and *will require plan preauthorization:*

Code	Description
L8608	Miscellaneous external component, supply or accessory for use with the Argus II retinal prosthesis system
L8698	Miscellaneous component, supply or accessory for use with total artificial heart system
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated

Effective January 1, 2019, the following codes will be *deny vendor liable for all lines of business* and *will not require plan prior authorization:*

Code	Description
M1000	Pain screened as moderate to severe
M1001	Plan of care to address moderate to severe pain documented on or before the date of the second visit with a clinician
M1002	Plan of care for moderate to severe pain not documented on or before the date of the second visit with a clinician, reason not given

Code	Description
M1003	TB screening performed and results interpreted within twelve months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA
M1004	Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient who has recently completed a course of anti-TB therapy)
M1005	TB screening not performed or results not interpreted, reason not given
M1006	Disease activity not assessed, reason not given
M1007	>=50% of total number of a patient's outpatient RA encounters assessed
M1008	<50% of total number of a patient's outpatient RA encounters assessed
M1009	Patient treatment and final evaluation complete
M1010	Patient treatment and final evaluation complete
M1011	Patient treatment and final evaluation complete
M1012	Patient treatment and final evaluation complete
M1013	Patient treatment and final evaluation complete
M1014	Patient treatment and final evaluation complete
M1015	Patient treatment and final evaluation complete
M1016	Female patients unable to bear children
M1017	Patient admitted to palliative care services
M1018	Patients with an active diagnosis or history of cancer (except basal cell and squamous cell skin carcinoma), patients who are heavy tobacco smokers, lung cancer screening patients
M1019	Adolescent patients 12 to 17 years of age with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5
M1020	Adolescent patients 12 to 17 years of age with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. Either phq-9 or phq-9m score was not assessed or is greater than or equal to 5
M1021	Patient had only urgent care visits during the performance period.
M1022	Patients who were in hospice at any time during the performance period
M1023	Adolescent patients 12 to 17 years of age with major depression or dysthymia who reached remission at six months as demonstrated by a six month (+/-60 days) phq-9 or phq-9m score of less than five
M1024	Adolescent patients 12 to 17 years of age with major depression or dysthymia who did not reach remission at six months as demonstrated by a six month (+/-60 days) phq-9 or phq-9m score of less than five. Either phq-9 or phq-9m score was not assessed or is greater than or equal to five.
M1025	Patients who were in hospice at any time during the performance period
M1026	Patients who were in hospice at any time during the performance period
M1027	Imaging of the head (CT or MRI) was obtained

Code	Description
M1028	Documentation of patients with primary headache diagnosis and imaging other than CT or MRI obtained
M1029	Imaging of the head (CT or MRI) was not obtained, reason not given
M1030	Patients with clinical indications for imaging of the head
M1031	Patients with no clinical indications for imaging of the head
M1032	Adults currently taking pharmacotherapy for OUD
M1033	Pharmacotherapy for OUD initiated after June 30th of performance period
M1034	Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days
M1035	Adults who are deliberately phased out of medication assisted treatment (MAT) prior to 180 days of continuous treatment
M1036	Adults who have not had at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days
M1037	Patients with a diagnosis of lumbar spine region cancer at the time of the procedure
M1038	Patients with a diagnosis of lumbar spine region fracture at the time of the procedure
M1039	Patients with a diagnosis of lumbar spine region infection at the time of the procedure
M1040	Patients with a diagnosis of lumbar idiopathic or congenital scoliosis
M1041	Patient had cancer, fracture or infection related to the lumbar spine or patient had idiopathic or congenital scoliosis.
M1042	Functional status measurement with score was obtained utilizing the oswestry disability index (ODI version 2.1a). Patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1043	Functional status measurement with score was not obtained utilizing the oswestry disability index (ODI version 2.1a) patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively
M1044	Functional status was measured by the oswestry disability index (ODI version 2.1a). Patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1045	Functional status measurement with score was obtained utilizing the oxford knee score (OKS). Patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1046	Functional status measurement with score was not obtained utilizing the oxford knee score (OKS). Patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1047	Functional status was measured by the oxford knee score (OKS). Patient reported outcome tool within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1048	Functional status measurement with score was obtained utilizing the oswestry disability index (ODI version 2.1a). Patient reported outcome tool within three months preoperatively and at three months (6 to 20 weeks) postoperatively.

Code	Description
M1049	Functional status measurement with score was not obtained utilizing the oswestry disability index (ODI version 2.1a). Patient reported outcome tool within three months preoperatively and at three months (6 to 20 weeks) postoperatively.
M1050	Functional status was measured by the oswestry disability index (ODI version 2.1a). Patient reported outcome tool within three months preoperatively and at three months (6 to 20 weeks) postoperatively.
M1051	Patient had cancer, fracture or infection related to the lumbar spine or patient had idiopathic or congenital scoliosis.
M1052	Leg pain was not measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1053	Leg pain was measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively.
M1054	Patient had only urgent care visits during the performance period.
M1055	Aspirin or another antiplatelet therapy used.
M1056	Prescribed anticoagulant medication during the performance period, history of GI bleeding, history of intracranial bleeding, bleeding disorder and specific provider documented reasons: allergy to aspirin or anti-platelets, use of non-steroidal anti-inflammatory agents, drug-drug interaction, uncontrolled hypertension > 180/110 mmhg or gastroesophageal reflux disease
M1057	Aspirin or another antiplatelet therapy not used, reason not given.
M1058	Patient was a permanent nursing home resident at any time during the performance period.
M1059	Patient was in hospice or receiving palliative care at any time during the performance period.
M1060	Patient died prior to the end of the performance period.
M1061	Patient pregnancy
M1062	Patient immunocompromised
M1063	Patients receiving high doses of immunosuppressive therapy
M1064	Shingrix vaccine documented as administered or previously received.
M1065	Shingrix vaccine was not administered for reasons documented by clinician (e.g., patient administered vaccine other than shingrix, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons).
M1066	Shingrix vaccine not documented as administered, reason not given.
M1067	Hospice services for patient provided any time during the measurement period.
M1068	Adults who are not ambulatory
M1069	Patient screened for future fall risk.
M1070	Patient not screened for future fall risk, reason not given.
M1071	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy.

Effective January 1, 2019, the flowing codes will be set up as *covered* and *will require plan prior authorization:*

Code	Description
E0447	Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)
E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions
G0068	Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0069	Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0070	Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
G2000	Blinded administration of convulsive therapy procedure, either electroconvulsive therapy (ECT, current covered gold standard) or magnetic seizure therapy (MST, non-covered experimental therapy), performed in an approved IDE-based clinical trial, per treatment session

Effective January 1, 2019, the following codes will be set up as *deny vendor liable for all lines of business, except for Medicare and Navicare products,* and *will not require plan prior authorization:*

Code	Description
G0076	Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0077	Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0078	Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0079	Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

Code	Description
G0080	Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0081	Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0082	Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0083	Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0084	Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0085	Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0086	Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0087	Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

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

Code	Description
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour. (List separately in addition to code for primary procedure.)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure.)

Code	Description
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure.)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure.)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure.)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

Code	Description
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

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

Code	Description
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure.)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure.)
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure.)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure.)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure.)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

Code	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

Effective January 1, 2019, the following codes *will require plan prior authorization:*

Code	Description
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads

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

Code	Description
0362T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service.)
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient

Effective October 1, 2018, the following codes *require plan prior authorization:*

Code	Description
C9750	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation and peri-operative interrogation and programming; complete system (includes device and electrode)
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score
0063U	Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder
0064U	Antibody, Treponema pallidum, total and rapid plasma reagin (RPR), immunoassay, qualitative
0065U	Syphilis test, non-treponemal antibody, immunoassay, qualitative (RPR)
0066U	Placental alpha-micro globulin-1 (PAMG-1), immunoassay with direct optical observation, cervico-vaginal fluid, each specimen
0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score
0068U	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C tropicalis, and C. auris), amplified probe technique with qualitative report of the presence or absence of each species
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, common and select rare variants (i.e., *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure.)
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure.)

Code	Description
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure.)
0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure.)
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 5′ gene duplication/multiplication) (List separately in addition to code for primary procedure.)
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 3′ gene duplication/ multiplication) (List separately in addition to code for primary procedure.)
0077U	Immunoglobulin paraprotein (M-protein), qualitative, immunoprecipitation and mass spectrometry, blood or urine, including isotype
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (i.e., ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification

Effective January 1, 2019, the following code will be set up as *not a covered benefit for Commercial plans only. For other lines of business, this code will be set up as covered and will require plan authorization.*

Code	Description
83722	Lipoprotein, direct measurement; small dense LDL cholesterol

Effective January 1, 2019, the following codes will be set up as *deny vendor liable for all lines of business* and *will not require plan prior authorization:*

Code	Description
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)
0510T	Removal of sinus tarsi implant
0511T	Removal and reinsertion of sinus tarsi implant
0512T	Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound
0513T	Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure.)

Code	Description
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing
0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only

Code	Description
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only
0533T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration, download review, interpretation and report
0534T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; set-up, patient training, configuration of monitor
0535T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; data upload, analysis and initial report configuration
0536T	Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; download review, interpretation and report
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day
0538T	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)
0539T	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous
0541T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous
0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report

Effective March 1, 2019, the following codes *will require plan authorization for Medicaid and Navicare members only:*

Code	Description
A9283	Foot pressure off loading/supportive device, any type, each
L8032	Nipple prosthesis, reusable, any type, each
L8035	Custom breast prosthesis, post mastectomy, molded to patient model

Effective October 1, 2018, the following codes were set up as *not separately reimbursed for all lines of business:*

Code	Description
G9978	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9979	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9980	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9981	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.

Code	Description
G9982	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9983	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9984	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9985	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.

Code	Description
G9986	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9987	Bundled Payments for Care Improvement Advanced (BPCI Advanced) model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only for a BPCI Advanced model episode of care; may not be billed for a 30-day period covered by a transitional care management code.

Effective January 1, 2019, the following codes will be set up *covered* and *will require plan prior authorization:*

Code	Description
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (e.g., expanded size and methylation status)
81173	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence

Code	Description
81174	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant
81177	ATN1 (atrophin 1) (e.g., dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81178	ATXN1 (ataxin 1) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81179	ATXN2 (ataxin 2) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81180	ATXN3 (ataxin 3) (e.g., spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81181	ATXN7 (ataxin 7) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81183	ATXN10 (ataxin 10) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; full gene sequence
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; known familial variant
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (e.g., myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81188	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81189	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; full gene sequence
81190	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; known familial variant(s)
81204	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (e.g., expanded size or methylation status)
81233	BTK (Bruton's tyrosine kinase) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., C481S, C481R, C481F)
81234	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., diffuse large B-cell lymphoma) gene analysis, common variant(s) (e.g., codon 646)
81239	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; characterization of alleles (e.g., expanded size)
81271	HTT (huntingtin) (e.g., Huntington disease) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles

Code	Description
81274	HTT (huntingtin) (e.g., Huntington disease) gene analysis; characterization of alleles (e.g., expanded size)
81284	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles
81285	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; characterization of alleles (e.g., expanded size)
81286	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; full gene sequence
81289	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; known familial variant(s)
81305	MYD88 (myeloid differentiation primary response 88) (e.g., Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant
81306	NUDT15 (nudix hydrolase 15) (e.g., drug metabolism) gene analysis, common variant(s) (e.g., *2, *3, *4, *5, *6)
81312	PABPN1 (poly[A] binding protein nuclear 1) (e.g., oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81320	PLCG2 (phospholipase C gamma 2) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., R665W, S707F, L845F)
81329	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; dosage/deletion analysis (e.g., carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed
81333	TGFBI (transforming growth factor beta-induced) (e.g., corneal dystrophy) gene analysis, common variants (e.g., R124H, R124C, R124L, R555W, R555Q)
81336	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; full gene sequence
81337	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; known familial sequence variant(s)
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81344	TBP (TATA box binding protein) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81345	TERT (telomerase reverse transcriptase) (e.g., thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (e.g., promoter region)
81443	Genetic testing for severe inherited conditions (e.g., cystic fibrosis, Ashkenazi Jewish-associated disorders [e.g., Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (e.g., ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy

Code	Description
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver
82642	Dihydrotestosterone (DHT)
76391	Magnetic resonance (e.g., vibration) elastography
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

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

Code	Description
Q4183	Surgigraft, per square centimeter
Q4184	Cellesta, per square centimeter
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc
Q4186	Epifix, per square centimeter
Q4187	Epicord, per square centimeter
Q4188	Amnioarmor, per square centimeter
Q4190	Artacent ac, per square centimeter
Q4191	Restorigin, per square centimeter
Q4193	Coll-e-derm, per square centimeter
Q4194	Novachor, per square centimeter
Q4195	Puraply, per square centimeter
Q4196	Puraply am, per square centimeter
Q4197	Puraply xt, per square centimeter
Q4198	Genesis amniotic membrane, per square centimeter
Q4200	Skin te, per square centimeter
Q4201	Matrion, per square centimeter
Q4203	Derma-gide, per square centimeter
Q4204	Xwrap, per square centimeter

Effective January 1, 2019, the following code will be *deny vendor liable excluding: FHW PACE, Medicaid, FHW MLTC, NaviCare and PACE*

Code	Description
T4545	Incontinence product, disposable, penile wrap, each

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

Code	Description
Q4189	Artacent ac, 1 mg
Q4192	Restorigin, 1 cc
Q4202	Keroxx (2.5g/cc), 1cc

Effective March 1, 2019, the following codes will be set up as *not a covered benefit:*

Code	Description
S0340	Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter/stage
S0341	Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter/stage
S0342	Lifestyle modification program for management of coronary artery disease, including all supportive services; fourth quarter/stage ■

Payment policy updates

Revised policies – effective March 1, 2019:

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

- ***Clinical Trials –*** Updated MassHealth reimbursement and billing sections
- ***Early Intervention –*** Clarified which codes require authorization
- ***Evaluation and Management –*** Added new 2019 codes
- ***Gastroenterology –*** Removed termed code from billing section
- ***Hearing Aids –*** Removed exclusion for code V5266, added 2019 HCPCS codes
- ***Hospice –*** Updated NaviCare reimbursement section
- ***Non Covered Services –*** Updated code list
- ***Obstetrics and Gynecology –*** Added codes related to delivery and post-partum combined care
- ***Preventative Services –*** Added detailed coding
- ***Telemedicine –*** Added outpatient services
- ***Transportation Services –*** Clarified Senior HMO chairvan billing, MassHealth coverage of code A0434, NaviCare social transportation changed to supplemental transportation and criteria updated ■

Annual Review

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

- ***Assistant Surgeon***
- ***Home Delivered Meals***
- ***Physician Standby Services***
- ***Post-Operative Nasal Debridement***
- ***Pre-Operative Autologous Blood Donation***
- ***Registered Nurse First Assistant***
- ***Timely Filing***
- ***Transplants***
- ***Unlisted Procedures/Services***
- ***Well Baby/Well Child Visits*** ■

New Policies: Effective March 1, 2019

- ***Sequestration*** ■

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

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