# CONNECTION

**Important information for Fallon Health physicians and providers**

January 2017

## In this issue



## What's new

### Pharmacy Safe Transitions Program helps keep patients safe at home

To augment the transitional care experience and reduce frequency of readmission, Fallon Health is launching a post-discharge, in-home medication reconciliation program called the Safe Transitions Program. It's for members recently discharged from an acute care or skilled nursing facility. This program will be available to Fallon Senior Plan™ members beginning January 2, 2017, and NaviCare® and Summit ElderCare® members later in the first quarter of 2017.

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Members enrolled in the program receive an in-home visit from a pharmacist, ideally within 72 hours of discharge. During the visit, the pharmacist evaluates the current health status of the member, including condition or disease-specific issues, co-morbidities, barriers to accessing medications and how the member is taking medications. The pharmacist will evaluate each medication for efficacy, safety, adherence and member-specific issues. In-person or telephonic follow-up appointments are scheduled with the member seven and 30 days after the initial visit. Members will receive contact information for the pharmacist to address any questions or concerns.

All recommendations and plans will be developed in collaboration with prescribing clinicians and case management teams. Providers receive telephonic, written or faxed recommendations based on acuity.

Our system identifies eligible members who are likely to benefit from the program. We also welcome referrals for your patients and look forward to working with you. For more information or to make a referral, please call our team at 1-800-333-2535, ext. 69689, Monday through Friday, from 8:30 a.m. to 5:00 p.m. You may also use our online Safe Transition referral form at *fallonhealth.org/providers/medical-management/forms*.

## Teladoc™

Effective January 1, 2017, Fallon Health will offer telemedicine visits with physicians through an agreement exclusively with Teladoc. Teladoc is the first and largest provider of telehealth medical consultations in the United States. Visits take place by phone, video within a secure member portal, or mobile app.

These visits, which have no time limits, are used to diagnose, treat and prescribe short-term medications* for common health issues such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection or ear infection. The doctors provide adult and pediatric general medical care. We believe telemedicine has an important role for uncomplicated common medical conditions at the fraction of the cost of an emergency room visit and at half the cost of urgent care.

Teladoc providers are U. S. board-certified in internal medicine, family practice, emergency medicine and pediatrics. They are U. S. residents and are licensed in Massachusetts, with an average of 20 years of practice experience. Teladoc does not replace the primary care provider, but it is a convenient option for care when our members cannot get in touch with their doctor, are feeling sick while on vacation, on a business trip or away from home, or are considering a visit to the emergency room or urgent care for a non-emergent issue.

Your patients who access Teladoc may show the consult information to you. Your patients have access to their electronic medical records and can download them or call Teladoc to have them mailed or faxed.

Please contact your Provider Relations Representative if you have any questions.

**Teladoc doctors will not prescribe substances controlled by the U. S. Drug Enforcement Administration, non-therapeutic or certain other drugs which may be harmful because of their potential for abuse.* ■

## WellTrack:
## Copay reimbursements for Fallon Senior Plan members with diabetes

Starting January 1, 2017, Fallon will begin participating in the Centers for Medicare and Medicaid Services' (CMS) Value-Based Insurance Design (VBID), an opportunity for Medicare Advantage members to be reimbursed for some copayments. Fallon's program is called WellTrack. Our goal is to help your patients prevent or delay some of the serious complications of diabetes such as heart, kidney and eye disease. WellTrack will help to ensure that your patients are receiving the tests and exams that are recommended by national diabetes experts. Reimbursing them for certain co-payments will help make their diabetes care more affordable.

Members are eligible for reimbursement if they meet the specific participation milestones identified in the program's scorecard within a calendar year. Reimbursements will occur three times a year starting in the summer 2017, and the member must be active with Fallon Health at the time of disbursement.

Eligible members must get all the tests listed on WellTrack's diabetic preventive health scorecard as a condition for getting copays reimbursed. This scorecard is based on recommendations made by the American Diabetes Association, in the *Standards of Medical Care in Diabetes–2016*.

Eligible members are enrolled in either Fallon Senior Plan Saver Enhanced Rx HMO-POS or Fallon Senior Plan Standard Enhanced Rx HMO. The service area is Worcester County and parts of Franklin County.

The scorecard identifies tests that are necessary for the appropriate treatment of a diabetic condition. To be eligible for the copay reimbursement, diabetic enrollees will need to meet each of the following scorecard requirements within a calendar year:

- Hemoglobin A1c at least once per year
- Fasting lipid profile once per year
- Urine test once per year
- Diabetic eye exam once per year

Members see providers for services eligible for copay reimbursements during the entire calendar year. Cost sharing will be reduced to $0 through reimbursement of in-network, out-of-pocket expenses for eligible covered services with a maximum reimbursement amount of $200 per year. The eligible visits for copay reimbursements are:

- PCP visit copays for covered services
- Endocrinologist visit copays for covered services
- All covered office visit copays for medically necessary foot care done by a qualified provider, such as a podiatrist
- Copay for one covered routine eye exam per year performed by an ophthalmologist or optometrist

The reimbursement will not occur at the point of service, but will be issued in the amount of the copays to a maximum amount of $200 per year. This back-end process significantly minimizes any required actions by your office staff.

By participating in WellTrack, Fallon will be able to significantly affect change by engaging members in a disease management program that focuses on the services which have the greatest impact on the treatment of diabetes.

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

## Fallon ending partnership with Catasys®, Inc.

The partnership between Fallon and Catasys®, Inc. has ended effective December 31, 2016. Catasys is a specialized behavioral health management services company that offers a program for substance use disorder. Your patients who are currently in a 12-month program with Catasys will be able to complete it in full. Please call your Provider Relations Representative if you have any questions. ■

# Compliance

## Nondiscrimination requirements from Affordable Care Act should be in place

For providers who receive Federal financial assistance from the Department of Health and Human Services (HHS), there are requirements from Section 1557 of the Affordable Care Act that should now be in place in your offices and on your websites. Section 1557 is a rule that prohibits discrimination based on race, color, national origin, sex, disability and age by any health care program or activity that receives Federal funding from HHS. (Examples of Federal funding are Medicaid, Medicare Parts A, C and D, grants and credits, such as meaningful use payments.)

The requirements were to be completed by October 16, 2016. They include, but are not limited to:

- Posting printed nondiscrimination notices in visible locations, such as a waiting room.
- Adding a link to the notice on your website's homepage.
- Providing free and timely interpretation and translation services.
- For practices with 15 or more employees, assigning a compliance coordinator and establishing grievance procedures.

Below are websites you may reference if you have any questions.

- *lexology.com*
- *rezlegal.com*
- *aoanow.org*

## Notification procedures for outpatients receiving observation services

The Medicare Outpatient Observation Notice (MOON) is a standardized notice that informs patients that they are an outpatient receiving observation services and are not an inpatient of a hospital or critical access hospital (CAH).

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. The NOTICE Act requires all hospitals and CAHs to provide written and oral notification under specified guidelines.

- Hospitals and CAHs are required to furnish the MOON to a patient who is insured with Medicare and has been receiving observation services as an outpatient for more than 24 hours. The patient must receive the notice before 36 hours has elapsed, but the hospital doesn't have to provide the notice until the member has been in observation for 24 hours. Once the patient has been in observation for 24 hours, there is a 12-hour timeframe to get the notice out to the patient to be in compliance.
- An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice. Additionally, a signature must be obtained from the individual, or a person acting on such individual's behalf, to acknowledge receipt. In cases where the individual refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

For additional information, visit *cms.gov*. ■

## Balance billing for dual-eligible enrollees

All Medicare Advantage Organizations (MAO) are required to educate providers about balance billing protections regarding dual eligible enrollees.

- "Dual eligible enrollees" are individuals who are enrolled in both Medicare and Medicaid. **The law bars Medicare providers from collecting Medicare Part A and Part B deductibles, coinsurance or copayments from anyone enrolled in a Qualified Medicare Beneficiaries (QMB) program.**
- QMB is a Medicaid program for Medicare beneficiaries which exempts them from Medicare cost-sharing charges.
- These deductible, coinsurance and copayment charges are called "balance billing."
- This law applies to all Medicare and Medicare Advantage providers, not only those who accept Medicaid.
- Providers may not charge QMB individuals even if the benefit comes from a different state than the state in which the services are rendered.

All Medicare and Medicaid payments you receive for providing services to a QMB beneficiary, including those received from a MAO, are considered payment in full. You will be subject to sanctions if you bill a QMB beneficiary for amounts above the sum total of all Medicare and Medicaid payments—even if Medicaid pays nothing.

For more information, visit *cms.gov*. ■

# Doing business with us

## Please keep your practice information current

Changes happen in your practice, and we want your patients to have access to the most current information in the *Provider Directory* hard copy and on our website's electronic provider directory via the "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 in 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
- Panel status
- Languages spoken by you or your staff
- Any other change that impacts your availability to patients ■

## Reminder: Claims submissions address

Fallon Health has a Post Office Box for all paper claim submissions, adjustments and appeals for all lines of business. These include, but are not limited to, Commercial, PPO, NaviCare, Fallon Senior Plan and non-contracted chiropractors.

The P.O. Box is:

Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908

When shipping paper claims that are not deliverable to a P.O. Box, (via FedEx/overnight/air, etc.), please send to the following street address:

Fallon Health Claims
Smart Data Solutions*
2401 Pilot Knob Road, Suite 140
Mendota Heights, MN 55120

**Smart Data Solutions (SDS) is Fallon Health's vendor for paper claims. SDS keys the claims into an electronic claims file (HIPAA 837) for processing at Fallon Health.* ■

### Reminder for Home Health Providers

Please remember, effective October 1, 2013, Medicare billing guidelines were updated discontinuing Type of Bill (TOB) 033X for outpatient services. Please use TOB 032X for home health episodes. The 032X Type of Bill was redefined to mean "Home Health Services under a Plan of Treatment."

Fallon follows Medicare guidelines. Please refer to *cms.gov* for more information. ■

## Quality focus

### Medication monitoring

Medication monitoring for your patients who are prescribed certain common medications can help identify toxicity and prevent complications. Monitoring plans may vary depending on the age and condition of the patient, and more frequent monitoring may be necessary. CMS recommends the following:

| Medication or class of medications | Laboratory tests |
|---|---|
| Digoxin | Basic metabolic panel and a serum digoxin level every six months. |
| Diuretics | Basic metabolic panel within the first month of therapy, then every six months. |
| Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARB) | Serum potassium, creatinine and BUN within the first month of therapy, then every six months. ■ |

## Clinical Practice Guidelines update

Our Clinical Practice Guidelines are available on *fallonhealth.org/providers/medical-management/health-care-guidelines*. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

**Recent updates:**

Fallon's Clinical Quality Improvement Committee endorsed and approved the following evidence based Clinical Practice Guidelines:

- Massachusetts Health Quality Partners 2017 Pediatric and Adult Preventive Care Guidelines
- Massachusetts Health Quality Partners 2017 Perinatal Care Guidelines
- 2016 ACA AHA HFSA update on New Pharmacological Therapy for Heart Failure: An update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure ■

# Product spotlight

## NaviCare® success story

Every once in a while, we like to highlight a member who has benefited from our NaviCare program and its dedicated staff. This is a story from Maureen Palla, one of our Nurse Case Managers.

"I have a member who lives with one of his two daughters, and has been a member of NaviCare for just over a year. When our team first met him, he was lying on a mattress on the floor in his room and barely got up all day. The mattress was on the floor because the member had a stroke. He had a history of falling due to weakness and vision loss on one side of his body, and his daughters were worried that he would fall out of bed. At that time he had sporadic medical care, and wasn't taking his medications properly. In addition, the member did not engage in any social activities and was bedbound and isolated all day.

When we started to work with him, we scheduled his medical appointments, provided transportation to get to them, ordered incontinence supplies and a new glucometer so his daughters could check his blood sugar. We helped his daughters better understand his medical conditions. We implemented the *Personal Care Attendant* (PCA) program, had him assessed by VNA for home safety equipment and got him a hospital bed and a wheelchair. We scheduled an appointment with a dentist to get fitted for dentures.

I think, however, the best thing we did was find an adult day health center for him to go to six days a week. He is now thriving in that environment. When we visited him there, he introduced us to his friends. He now talks about his girlfriend, who also lives there, and tells his daughter that he can't wait until the next day to go to his "job."

His daughters couldn't be happier with our plan, and they tell us how great their dad is doing every time we see them. Adult day health gives him the socialization he needs, along with nursing oversight. It also gives one of his daughters, a single mom, some time throughout the day to tend to her disabled son and go to work. My team and I are very happy to have this member with us, and we are proud of the wonderful things NaviCare has been able to do for him and his family." ■

### NaviCare benefit changes

NaviCare has enhanced and added a number of key supplemental benefits for our membership in 2017.

- Our supplemental transportation benefit, which provides non-emergent transport to non-medical locations, such as fitness facilities, has been enhanced from 70 round trips to 80 round trips annually.
- Under our DME benefit, NaviCare will now cover the seat lift recliner chair up to $600 per lifetime when the seat lift has been authorized.
- Dental coverage has been enhanced to include additional preventive and X-ray visits, coverage of dental implants and associated services with prior authorization.
- We will be providing our members with the NaviCare "Save Now" OTC card, which will allow them to spend up to $42 per quarter on qualified OTC items, such as oral care and pain relief items, in popular retail establishments such as Rite Aid and CVS.

For additional details, please contact your Provider Relations Representative. ■

## Coding corner

### Coding updates

**Effective March 1, 2017,** the following code *will no longer be separately reimbursed:*

| Code | Description |
|---|---|
| **S0265** | Genetic counseling, under physician supervision, each 15 minutes |

**Effective March 1, 2017,** the following pharmacy code *will require plan prior authorization:*

| Code | Description |
|---|---|
| **J9310** | Injection, rituximab, 100 mg |

**Effective October 1, 2016,** the following pharmacy codes *are covered and require plan prior authorization:*

| Code | Description |
|---|---|
| **C9481** | Injection, reslizumab, 1 mg |
| **C9483** | Injection, atezolizumab, 10 mg ■ |

## New ICD-10-CM and ICD-10 PCS codes effective 10/1/2016

CMS has released the new ICD 10-CM and ICD 10-PCS codes effective 10/1/16. Please visit the CMS website to review the new codes.

**2017 ICD-10-CM and GEMs:**
*https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html*

Click on 2017 Addendum (zip.1mb)

**2017 ICD-10 PCs and GEMs:**
*https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html*

Click on 2017 ICD-10-PCS Addendum (zip.766kb) ■

## New 2017 CPT/HCPCS codes

All new codes will require prior authorization until a final review is performed by Fallon Health. Fallon will review and assign the appropriate coverage and determine prior authorization requirements for all new codes by January 1, 2017. Fallon will notify all contracted providers of this determination via the March issue of the *Connection* newsletter and on the Fallon Health website. ■

# Payment policy updates

## New policy – effective March 1, 2017:

- ***Personal Care Attendant (PCA)*** ■

## Revised policies – effective March 1, 2017:

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

- ***Claims Auditing Software*** – Updated the reimbursement section.
- ***Clinical Trials*** – Added CED and IDE A study information.
- ***Coding Analysis*** – Updated policy title.
- ***Fraud, Waste, and Abuse*** – Updated policy title and policy section.
- ***Home Healthcare*** – Updated the billing/coding guidelines.
- ***Hospice*** – Added guidelines for NaviCare members.
- ***Laboratory and Pathology*** – Updated reimbursement section.
- ***MassHealth Provider Preventable Conditions*** – Reviewed list of conditions for consistency with Massachusetts Department of Public Health. Updated the CMS list of Hospital Acquired Conditions in this policy accordingly.
- ***Obstetrics/Gynecology*** – Updated the billing/coding guidelines.
- ***Outpatient Drugs*** – Updated the prior authorization requirements section.
- ***Provider Audit*** – Updated the policy section.
- ***Vaccine*** – Updated Addendum A, Table 1. ■

## Annual review

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

- ***Hearing Aids and Exam***
- ***Serious Reportable Events*** ■

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

## Send information to:

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Worcester, MA 01608

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***fallonhealth.org/providers***

## Questions?

**1-866-275-3247**

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