Connection

Important information for Fallon Health physicians and providers January 2018

What's new

Fallon has formed three new Accountable Care Organization Partnership Plans

Fallon has formed Accountable Care Organization Partnership Plans with the following provider groups:

1. Reliant Medical Group and Southboro Medical Group to form **Fallon 365 Care**
2. Berkshire Health Systems, Community Health Programs and other community providers to form **Berkshire Fallon Health Collaborative**
3. Circle Health, Hallmark Health, Lowell Community Health Center, Lowell General Hospital, Lowell General Physician Hospital Organization, New England Quality Care Alliance (NEQCA), Tufts Floating Hospital for Children and Tufts Medical Center to form **Wellforce Care Plan**

Eligible members will be enrolled in the plans effective March 1, 2018. The goals are to improve care delivery and support integration of care. The partnerships allow for additional support, increased capacity and improved analytics for population health management.

Your MassHealth patients who are eligible for these ACOs should have received a letter in November or December saying their PCP is part of a specific ACO, and they will automatically be enrolled in the same plan.

In this issue

The benefits are the same with the new ACO partnerships as they have been with MassHealth. There is no cost to join any of the ACOs.

From a provider perspective, there will be many quality measures associated with this new product line. Fallon is working with each ACO to assist providers with reporting and improving their quality scores.

If your MassHealth patients are not sure what plan they are enrolled in, they should call MassHealth at 1-800-841-2900 (TTY: 1-800-497-4648) Monday–Friday, from 8 a.m. to 5 p.m., or visit masshealthchoices.com. ■

Summit ElderCare® Charlton to Webster transition

Fallon's Summit ElderCare location in Charlton will soon close and move to 108 Thompson Road in Webster. The opening of the Summit ElderCare PACE Center in Webster is conditional upon approval from CMS (Centers for Medicare & Medicaid Services) and the state's Executive Office of Health and Human Services.

Once open, the Webster location will offer new and enhanced features, such as:

- More space in the day rooms and increased capacity of the exam rooms
- An on-site hair salon
- An expanded building for services in one centralized location
- A larger rehabilitation center
- Expanded outdoor patio areas
- A new clinic waiting area
- A larger library

Some commonly asked questions:

Q. When will it open?
A. The site is under construction. Opening day is contingent upon approval from CMS and EOHHS.

Q. Will any of the services or benefits change when a member transfers to Webster?
A. No. Program coverage and care plan will not change.

Q. Will members have to enroll again when they transfer to Webster?
A. No. Transferring to a new PACE Center location does not mean that members will have to go through the enrollment process again. They will still be enrolled in Summit ElderCare.

Q. What if a member wants to attend a PACE Center other than Webster? How would that work?
A. If a member would like to attend a PACE Center other than Webster, they should let their primary nurse or social worker know. Their request will be reviewed, and the site staff will provide them with more information.

To learn more about Summit ElderCare or to make a referral, call 1-800-698-7566 (TRS 711), Monday–Friday, 8 a.m. to 5 p.m. or visit *fallonhealth.org/summit.* ■

Connection schedule change

Beginning with this issue, *Connection* will now be published on a quarterly basis, rather than six times a year. The posting schedule is as follows:

December 30, 2017
March 30, 2018
June 29, 2018
September 28, 2018

We will send a letter in the mail with any announcements that require a 60-day notice and do not fall within the above schedule.

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

Product spotlight

NaviCare and Fallon Senior Plan service area expansion

As of January 1, 2018, Fallon Health's NaviCare® program and Fallon Senior Plan™ product options will be available throughout the state of Massachusetts—with the exception of Dukes and Nantucket counties. The service area has expanded to include Berkshire County and all of Franklin County. NaviCare is the only product of its kind in Berkshire County. ■

Fallon Senior Plan–Hearing aid benefit

Beginning January 1, 2018, hearing aids will be covered through Fallon Senior Plan. This benefit is available to members of our direct pay and employer coverage plans for retirees. Hearing aids are available with a copayment that varies by model. Purchases must be made through our hearing aid partner, Amplifon.

Additional information:

- Hearing aid copays are $695, $795 and $995. They vary by model and manufacturer.
- Hearing aid coverage is in addition to the $0 annual supplemental routine hearing exam—when conducted by an in-network provider. Diagnostic exams are offered at a copayment.
- Fallon Senior Plan Premier members who receive retiree coverage through the GIC will have no changes to their existing hearing aid benefit. ■

Fallon Senior Plan–Dental and gym reimbursement

There is a new plan option available to direct pay members of our Medicare Advantage HMO product line. Fallon Senior Plan Flex Enhanced Rx HMO is available throughout our service area, with the exception of Barnstable and Berkshire counties.

This plan is similar in structure to other Fallon Senior Plan options, but offers a $180 gym membership benefit and a $180 dental services benefit. Members can request up to $180 in reimbursements per year for qualified gym memberships and/or preventive dental care like cleanings and exams.

All other plans include a free gym membership through the SilverSneakers® Fitness program. ■

NaviCare transportation benefit enhancement

Beginning January 1, 2018, members of Fallon Health's NaviCare program can now receive up to 90 round-trip rides per year—at no cost—to approved, **non-medical** locations like the gym, fitness classes, grocery store and more. (The previous benefit was 80 rides per year.) Rides must be within a 30-mile distance from the pickup location and no more than 60 miles round-trip. Free transportation is limited to one round-trip ride per day.

In addition to the benefit change, there is a new process to schedule transportation. **Beginning February 1, 2018,** members will arrange for a ride by calling our transportation vendor directly. (Members previously made arrangements through their Navigators.) Our vendor is Coordinated Transportation Solutions (CTS).

CTS will schedule and coordinate all medical and non-medical transportation. Members will arrange for a ride by calling CTS at 1-833-824-9440. For rides to medical appointments, the following steps will be taken:

1. Member calls CTS to schedule a ride.
2. CTS will call the physician's office to verify the appointment while the member is on hold.
3. If the appointment is not on the provider's schedule, CTS will ask the member to check the date and time of the appointment and call CTS back.

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

Doing business with us

Validating your practice information

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 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
- Panel status
- 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 may receive a friendly call to ensure your information is correct. This verification will also align Fallon Health with guidelines that have been set forth by the Centers for Medicare and Medicaid Services (CMS), the Division of Insurance (DOI) and the National Committee for Quality Assurance (NCQA). Some of these guidelines and requirements are that the health plan outreach to providers and engage them in reviewing and maintaining provider directory information. 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 Department Representative. ■

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*
960 Blue Gentian Road
Eagan, MN 55121

**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.* ■

Authorization updates

Removing prior authorization requirement for many CPT codes

Fallon has listened to you and continues to look for ways to improve the authorization process.

Fallon is currently in process of reviewing the CMS approved inpatient list as it relates to elective inpatient surgical procedures. Through this ongoing review, we have taken the prior authorization requirement off many CPT codes on this CMS listing.

The overall action of removing the PA requirement is based on the list of codes that are always considered inpatient. We reviewed the CPT codes we rarely deny, ultimately removing the prior authorization requirement.

This review process will be continuous throughout the year, which could remove the prior authorization requirement for additional inpatient CMS approved codes.

Moving forward, the only pieces of information we need are:

- the normal facility notification that a member has been admitted
- CPT code for procedure

An additional benefit for you—you will no longer need to put together and send the prior authorization request.

We encourage you to call our Prior Authorization department at 1-866-275-3247, prompt 3, to confirm the codes or level of care admission requirements.

Oral Nutritional Supplements

Beginning March 1, 2018, we are changing the way our NaviCare members obtain their oral nutritional supplements.

With a physician prescription, members will be able to pick up their oral nutritional supplements products (such as Ensure®, Boost® and Glucerna®) from a contracted pharmacy or through a contracted durable medical equipment (DME) provider without prior authorization. There will continue to be $0 co-pays for the products. Members may also utilize the mail away pharmacy.

Historically, you had to fill out our NaviCare HMO SNP and SCO Oral Nutritional Supplements Form. This form was the prescription to fill the request. Now you will complete a prescription via your usual method, and send the script either to the member's pharmacy or to a contracted DME provider. The PA requirement will go away.

New Opioid Strategy

This is a reminder of a change that was previously communicated in November. Effective February 1, 2018, Fallon Health will implement a new opioid strategy for Commercial, Medicaid and Exchange lines of business. Please note: this does not include members who are enrolled in a Medicare plan. The new strategy will require prior authorization (PA) for:

- opioids that exceed 90 morphine milligram equivalents (MME) per day with a limit of 200 MME/day;
- extended release opioids where there is no previous claim for an immediate release opioid;
- immediate release opioids exceeding seven days.

Opioids that are less than these limits will process without PA. This strategy does not apply to members undergoing treatment for cancer, those in palliative or hospice care or for drugs prescribed for opioid abuse treatment, such as Suboxone®. Our previous opioid criteria will be retired on January 31, 2018. Please visit our *website* for the latest criteria and PA forms.

All non-LifeScan test strips to require Prior Authorization

Effective March 1, 2018, glucose test strips, other than LifeScan strips, will require prior authorization for Medicaid plans. The current step requirement will be removed. Claims that have processed under the step requirement will reject for PA. These members will be notified via U. S. mail of this change. LifeScan test strip products will process if the claim is under five strips per day. LifeScan test strip products over five strips per day will continue to require PA. All non-LifeScan test strips will require a PA regardless of quantity. Please visit our Provider *website* for the latest criteria and PA forms.

Seebri™ Neohaler® and Tudorza® Pressair® to require Prior Authorization

Effective March 1, 2018, Seebri™ Neohaler® and Tudorza® Pressair® will require prior authorization for all of our Commercial, Exchange and Medicaid members. Please note: this does not include members who are enrolled in a Medicare plan. Patients currently taking these medications will be able to continue, provided criteria for approval is met based on prescriber-submitted documentation of diagnosis and trial/failure or contraindication to one of our preferred products. Our preferred products include Incruse® Ellipta®, Spiriva®, and Spiriva® Respimat®. Please visit our *website* for the latest criteria and PA forms.

Venlafaxine Extended Release tablets to require Step Therapy Prior Authorization

Effective March 1, 2018, Venlafaxine Extended Release tablets will require a Step Therapy Prior Authorization (PA) for all of our Commercial, Exchange and Medicaid members. Please note: this does not include members who are enrolled in a Medicare plan. Patients currently taking this medication will be able to continue, provided criteria is met based on prescriber-submitted documentation of trial/failure or contraindication to Venlafaxine Extended Release capsules. Please visit our Provider *website* for the latest criteria and PA forms.

Victoza® and Trulicity® to become our Preferred GLP-1 Products

Effective March 1, 2018, Victoza® and Trulicity® will become our preferred glucagon-like peptide-1 (GLP-1) receptor agonist products for all our Commercial, Exchange and Medicaid plans. Please note: this does not apply to Medicare plans. These medications will require step therapy through metformin. Members who are currently on these medications will be able to receive their medication at a decreased copayment.

Jardiance®, Invokana®, Invokamet®, Synjardy® and Synjardy XR® to become our Preferred SGLT-2 Products.

Effective March 1, 2018, Jardiance®, Invokana®, Invokamet®, Synjardy® and Synjardy XR® will become our preferred Sodium Glucose co-transporter 2 (SGLT-2) inhibitor products for all our Commercial, Exchange and Medicaid plans. These medications will require step therapy through metformin. Please note: this does not apply to Medicare plans. Members who are currently on these medications will be able to receive their medication at a decreased copayment.

Januvia®, Janumet® and Janumet XR® to be included as Preferred DDP-4 Products

Effective March 1, 2018, Januvia®, Janumet® and Janumet XR® will be included along with Tradjenta®, Jentadeuto® and Jentadeuto XR® as our preferred dipeptidyl peptidase-4 (DDP-4) enzyme inhibitor products for all of our Commercial, Exchange and Medicaid plans. These medications will require step therapy through metformin. Please note: this does not apply to Medicare plans. Members who are currently on Januvia®, Janumet® and Janumet XR® will be able to receive their medication at a decreased copayment. ■

Quality focus

Clinical Practice Guideline update

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

ACCF/AHA Guideline for the Management of Heart Failure: Updates in August 2017 include revision to the sections on biomarkers; new therapies indicated for stage C heart failure with reduced ejection fraction (HF*r*EF); updates on heart failure with preserved ejection fraction (HF*p*EF); new data on important comorbidities, including sleep apnea, anemia and hypertension; and new insights into the prevention of heart failure.

Our Clinical Practice Guidelines are available *here*:

For a paper copy, please contact Robin Byrne at 1-508-368-9103. ■

NaviCare Clinical Practice Initiatives

Providers in our NaviCare network have the convenience of viewing the updated Clinical Practice Initiatives for 2018 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. ■

High-risk medication use in older adults

The NaviCare pharmacy team is working with primary care providers (PCPs) to reduce adverse drug reactions by reducing the use of high-risk medications in our members. Adverse drug reactions due to polypharmacy and the use of high-risk medications are responsible for significant morbidity and mortality in older adults. It is important to recognize high-risk medications, understand the rationale for the risk, and determine if alternative medications, lower doses, or discontinuing medications altogether may be better options.

The *2015 Beers Criteria* provides recommendations about the risk of potentially inappropriate medication use in older adults. This resource should be used, in conjunction with clinical judgment, as a tool to help improve prescribing patterns and ultimately patient care.

Previously, we have outreached to providers for some of the more common high-risk medications that frequently appear as outliers on CMS reports. We are now targeting the entire list of potentially inappropriate medications included in the Beers Criteria and sending letters to the PCPs of our members who have filled prescriptions for one or more of these potentially high-risk medications. In some cases the PCP may not be the prescriber of the medication or even know it has been prescribed by another provider.

We are asking PCPs to acknowledge receipt of these letters, consider the potential risk versus the potential benefit of continued use of the specific medication, then consider prescribing alternative medications or discontinuing high-risk medications when medically appropriate. We are asking PCPs to return the letter informing us what they decided to do with the information provided. We are also considering prior authorization criteria for certain high-risk medications.

We are hopeful that these interventions will help ensure appropriate use of medications deemed high-risk and contribute to safe and effective high quality care in order to positively impact clinical outcomes. ■

Compliance

NaviCare Model of Care

New members of NaviCare are matched with a team of experts, called a Care Team, which is dedicated to helping them meet their health goals. The Care Team works together to create a care plan based on the needs and health records of each member. The team reviews this plan together regularly, to make any adjustments based on how the member is responding to the treatment and services.

By having a shared record of the member's complete and up-to-date health information, and by meeting and deciding treatment plans regularly, the Care Team is able to make the best decisions about continued and preventive care. NaviCare allows providers access to the shared record, called the Centralized Enrollee Record. Contact your Provider Relations Representative to obtain access.

Here is what the Care Team looks like:

Navigator

- Organizes benefits and services
- Advocates for patients so they receive the care they need
- Helps patients make medical appointments and arranges transportation

Nurse Case Manager or Advanced Practitioner

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

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 paperwork
- Connects patients with resources for elders

Primary Care Provider

- Contributes to and approves the individualized plan of care for the patient at time of program enrollment and ongoing
- 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

Behavioral Health Case Manager *(as needed)*

- Coordinates services to address mental health and substance use disorder needs
- Coordinates with the team and mental health and substance use providers

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

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

Visit *fallonhealth.org/navicare* for more information. ■

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*. ■

Nondiscrimination requirements from ACA

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*. ■

Coding corner

Coding updates

Effective January 1, 2018, the following codes will be set up as *deny vendor liable* for all lines of business. These codes will be set up as *not a covered benefit:*

Code	Description
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure.)
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed
0482T	Absolute quantitation of myocardial blood flow, positron emission tomography (PET), rest and stress (List separately in addition to code for primary procedure.)
0483T	Trans catheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including trans septal puncture, when performed
0484T	Trans catheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (e.g., thoracotomy, trans apical)
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral
0487T	Biomechanical mapping, transvaginal, with report
0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands
0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq. cm. or less
0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq. cm., or part thereof (List separately in addition to code for primary procedure.)

Code	Description
0493T	Near-infrared spectroscopy studies of lower extremity wounds (e.g., for oxyhemoglobin measurement)
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (e.g., pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure.)
0497T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; in-office connection
0498T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or more separately reported high-risk HPV types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (i.e., genotyping)
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission

Code	Description
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report

Effective March 1, 2018, the following codes *will be covered* and *will require plan authorization:*

Code	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post processing under concurrent supervision; not requiring image post processing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post processing under concurrent supervision; requiring image post processing on an independent workstation
99082	Unusual travel (e.g., transportation and escort of patient)
Q1004	New technology intraocular lens category 4 as defined in Federal Register notice
Q1005	New technology intraocular lens category 5 as defined in Federal Register notice
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens
V2632	Posterior chamber intraocular lens

Effective January 1, 2018, the following codes will be set up as *covered* and *will require plan authorization:*

Code	Description
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed

Effective March 1, 2018, the following codes *will be considered not a covered benefit:*

Code	Description
A0998	Ambulance response and treatment, no transport
A4210	Needle-free injection device, each
A4232	Syringe with needle for external insulin pump, sterile, 3 cc
A4252	Blood ketone test or reagent strip, each
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system
A4570	Splint
A4580	Cast supplies (e.g., plaster)
A4590	Special casting material (e.g., fiberglass)
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing
D0418	Analysis of saliva sample
D5991	Topical medicament carrier
S0265	Genetic counseling, under physician supervision, each 15 minutes
S3005	Performance measurement, evaluation of patient self-assessment, depression
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family
S3870	Comparative genomic hybridization (CGD) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability
S9083	Global fee urgent care centers
S9088	Services provided in an urgent care center (list in addition to code for service)
S9529	Routine venipuncture for collection of specimen(s), single homebound, nursing home, or skilled nursing facility patient

Effective January 1, 2018, the following codes *will be covered* and *will require plan prior authorization:*

Code	Description
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)
81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (e.g., HPA-5a/b (K505E))
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (e.g., exon 12)
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (e.g., drug metabolism), gene analysis, common variant(s) (e.g., *2, *22)
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *7)
81232	DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (e.g., *2A, *4, *5, *6)
81238	F9 (coagulation factor IX) (e.g., hemophilia B), full gene sequence

Code	Description
81247	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; common variant(s) (e.g., A, A-)
81248	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; known familial variant(s)
81249	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; full gene sequence
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
81283	IFNL3 (interferon, lambda 3) (e.g., drug response), gene analysis, rs12979860 variant
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (e.g., adverse drug reaction), gene analysis, common variant(s) (e.g., *5)
81334	RUNX1 (runt related transcription factor 1) (e.g., acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (e.g., exons 3-8)
81335	TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3)
81346	TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)
81361	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (e.g., HbS, HbC, HbE)
81362	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
81363	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
81364	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
81448	Hereditary peripheral neuropathies (e.g., Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (e.g., BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score

Code	Description
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy

Effective January 1, 2018, the following codes will be *set up as covered* and *will require prior plan authorization:*

Code	Description
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
33928	Removal and replacement of total replacement heart system (artificial heart)
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure.)
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein)
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (e.g., great saphenous vein, accessory saphenous vein), same leg
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure.)

Effective January 1, 2018, the following codes will be set up as *deny vendor liable* and *will not require plan authorization:*

Code	Description
G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
G9890	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity
G9891	Documentation of medical reason(s) for not performing a dilated macular examination
G9892	Documentation of patient reason(s) for not performing a dilated macular examination
G9893	Dilated macular exam was not performed, reason not otherwise specified
G9894	Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate
G9895	Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g., salvage therapy)
G9896	Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate
G9897	Patients who were not prescribed/administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate, reason not given
G9898	Patient age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period
G9899	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results documented and reviewed
G9900	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified
G9901	Patient age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period
G9902	Patient screened for tobacco use and identified as a tobacco user
G9903	Patient screened for tobacco use and identified as a tobacco non-user
G9904	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
G9905	Patient not screened for tobacco use, reason not given
G9906	Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)
G9907	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

Code	Description
G9908	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given
G9909	Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other medical reason)
G9910	Patients age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54 or 56 anytime during the measurement period
G9911	Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy
G9912	Hepatitis b virus (HBV) status assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy
G9913	Hepatitis b virus (HBV) status not assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy, reason not given
G9914	Patient receiving an anti-tnf agent
G9915	No record of HBV results documented
G9916	Functional status performed once in the last 12 months
G9917	Documentation of medical reason(s) for not performing functional status (e.g., patient is severely impaired and caregiver knowledge is limited, other medical reason)
G9918	Functional status not performed, reason not otherwise specified
G9919	Screening performed and positive and provision of recommendations
G9920	Screening performed and negative
G9921	No screening performed, partial screening performed or positive screen without recommendations and reason is not given or otherwise specified
G9922	Safety concerns screen provided and if positive then documented mitigation recommendations
G9923	Safety concerns screen provided and negative
G9924	Documentation of medical reason(s) for not providing safety concerns screen or for not providing recommendations, orders or referrals for positive screen (e.g., patient in palliative care, other medical reason)
G9925	Safety concerns screening not provided, reason not otherwise specified
G9926	Safety concerns screening positive screen is without provision of mitigation recommendations, including but not limited to referral to other resources
G9927	Documentation of system reason(s) for not prescribing warfarin or another FDA-approved anticoagulation due to patient being currently enrolled in a clinical trial related to af/atrial flutter treatment
G9928	Warfarin or another FDA-approved anticoagulant not prescribed, reason not given

Code	Description
G9929	Patient with transient or reversible cause of af (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)
G9930	Patients who are receiving comfort care only
G9931	Documentation of cha2ds2-vasc risk score of 0 or 1
G9932	Documentation of patient reason(s) for not having records of negative or managed positive tb screen (e.g., patient does not return for mantoux (PPD) skin test evaluation)
G9933	Adenoma(s) or colorectal cancer detected during screening colonoscopy
G9934	Documentation that neoplasm detected is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma
G9935	Adenoma(s) or colorectal cancer not detected during screening colonoscopy
G9938	Patients age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period
G9939	Pathologists/dermatopathologists is the same clinician who performed the biopsy
G9940	Documentation of medical reason(s) for not on a statin (e.g., pregnancy, in vitro fertilization, clomiphene RX, ESRD, cirrhosis, muscular pain and disease during the measurement period or prior year)
G9941	Back pain was measured by the visual analog scale (vas) within three months preoperatively and at three months (6–20 weeks) postoperatively
G9942	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy
G9943	Back pain was not measured by the visual analog scale (vas) within three months preoperatively and at three months (6 - 20 weeks) postoperatively
G9944	Back pain was measured by the visual analog scale (vas) within three months preoperatively and at one year (9 to 15 months) postoperatively
G9945	Patient had cancer, fracture or infection related to the lumbar spine or patient had idiopathic or congenital scoliosis
G9946	Back pain was not measured by the visual analog scale (vas) within three months preoperatively and at one year (9 to 15 months) postoperatively
G9947	Leg pain was measured by the visual analog scale (vas) within three months preoperatively and at three months (6 to 20 weeks) postoperatively
G9948	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy
G9949	Leg pain was not measured by the visual analog scale (vas) within three months preoperatively and at three months (6 to 20 weeks) postoperatively
G9954	Patient exhibits 2 or more risk factors for post-operative vomiting

Code	Description
G9955	Cases in which an inhalational anesthetic is used only for induction
G9956	Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively
G9957	Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)
G9958	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively
G9959	Systemic antimicrobials not prescribed
G9960	Documentation of medical reason(s) for prescribing systemic antimicrobials
G9961	Systemic antimicrobials prescribed
G9962	Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy
G9963	Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy
G9964	Patient received at least one well-child visit with a PCP during the performance period
G9965	Patient did not receive at least one well-child visit with a PCP during the performance period
G9966	Children who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report
G9967	Children who were not screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report
G9968	Patient was referred to another provider or specialist during the performance period
G9969	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred
G9970	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred
G9974	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity
G9975	Documentation of medical reason(s) for not performing a dilated macular examination
G9976	Documentation of patient reason(s) for not performing a dilated macular examination
G9977	Dilated macular exam was not performed, reason not otherwise specified

Effective January 1, 2018, the following codes *will be covered* and *will require plan prior authorization:*

Code	Description
C9738	Adjunctive blue light cystoscopy with fluorescent imaging agent (List separately in addition to code for primary procedure.)
C9748	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy
L7700	Gasket or seal, for use with prosthetic socket insert, any type, each
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each
Q2040	Tisagenlecleucel, up to 250 million car-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion
Q4176	Neopatch, per square centimeter
Q4177	Floweramnioflo, 0.1 cc
Q4178	Floweramniopatch, per square centimeter
Q4179	Flowerderm, per square centimeter
Q4180	Revita, per square centimeter
Q4181	Amnio wound, per square centimeter
Q4182	Transcyte, per square centimeter

Effective January 1, 2018, the following pharmacy codes *will be covered* and *will require plan prior authorization:*

Code	Description
J1428	Injection, eteplirsen, 10 mg
J1555	Injection, immune globulin (cuvitru), 100 mg
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J2326	Injection, nusinersen, 0.1 mg
J2350	Injection, ocrelizumab, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J9022	Injection, atezolizumab, 10 mg
J9023	Injection, avelumab, 10 mg
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg
J9285	Injection, olaratumab, 10 mg

Effective January 1, 2018, the following pharmacy codes *will be covered* and *will require plan prior authorization:*

Code	Description
0024U	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")
0027U	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15
0028U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (i.e., CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (i.e., CYP2C9, CYP4F2, VKORC1, rs12777823)
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(e.g., drug metabolism) gene analysis, common variants (i.e., *1F, *1K, *6, *7)
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (e.g., citalopram metabolism) gene analysis, common variants (i.e., HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G])
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(e.g., thiopurine metabolism), gene analysis, common variants (i.e., TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk ■

Payment policy updates

New Policies – effective March 1, 2018

Acupuncture

Incontinence Products ■

Revised policies – effective March 1, 2018

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

Assistant Surgeon – Added definitions

Gastroenterology – Removed moderate sedation exclusion

Home Health – Clarified authorization requirements

Laboratory and Pathology – added limits to presumptive testing, changed to calendar year for limits

Non-Covered Services – Updated coding

Preoperative Autologous Blood Donation – Clarified service is not covered for MassHealth

Provider Audit – Clarified policy section ■

Annual Review

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

Modifiers

Physician Standby

Post-Operative Nasal Debridement

Registered First Nurse Assistant

Skilled Nursing Facility

Timely Filing

Transplants

Unlisted Services and Procedures

Well Baby/Well Child Visits ■

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17-665-011 Rev. 00 12/17