Connection

Important information for Fallon Health physicians and providers

May 2017

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What's new

Fallon Health celebrates 40 years of making communities healthy

Fallon Health celebrates its 40th anniversary this year as it continues the health care innovation that has been the hallmark of its history. Founded in 1977 as a local community health plan with one location in Worcester, Fallon is now a nationally recognized not-for-profit health care services organization with 10 locations throughout Massachusetts and western New York. Fallon has been consistently rated in the top 10 percent of health plans in the nation by the National Committee for Quality Assurance (NCQA)*.

Fallon's very creation was an innovation supported by forward-thinking providers. Health care leaders in central Massachusetts wanted to bring together all components of the health care system so that we could work together to provide high-quality care at an affordable cost. The result was Fallon Community Health Plan, a provider-payer partnership launched by Fallon Clinic, which is now Reliant Medical Group. Fallon became an independent health care organization in 2004 (and shortened its name to Fallon Health in 2014), expanding its system of integrated care by partnering with a wider range of providers.

Fallon has been a leader in the health insurance industry throughout its existence:

- In 1980, it became the first HMO in the country to offer a Medicare plan.
- In 1995, Fallon became the first health plan in the country to offer a Program for All-Inclusive Care for the Elderly (PACE).
- In 2002, Fallon was the first plan in Massachusetts to offer a limited network, which provides affordable care by emphasizing the use of high-quality, community-based providers.
- In 2008, Fallon became one of the few commercial health insurers in Massachusetts to offer a Senior Care Options (SCO) plan.
- Before risk-sharing between providers and health plans became a mainstream practice, Fallon was making innovative risk-sharing arrangements with hospitals.
- Fallon was the first—and still the only—health plan in Massachusetts that is both an insurer and a provider.

"We're grateful to the provider community for being an integral part of our heritage and our future," said Richard Burke, President and CEO of Fallon Health, who is in his 19th year at Fallon. "Because Fallon has valued and invested in provider partnerships throughout the years, we've been able to offer products and services to care for people of all ages, income levels and health statuses. We look forward to our continued collaboration with providers to deliver great care at an affordable cost to the communities we serve."

** National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS® is the most widely used performance measurement tool in health care. NCQA's website, ncqa.org, contains information to help consumers, employers and others make more informed health care choices.* ■

Fallon sponsors caregiver symposium June 6

Fallon is sponsoring The Costs of Caregiving, a symposium being held at the Doubletree by Hilton Boston-Westborough Hotel on Tuesday, June 6, from 7 a.m. to 12 noon. The symposium will center around the personal and financial impacts that caring for a frail elder has on the community, the workplace and the caregiver, and what we can all do to help.

The keynote speaker will be Gail Gibson Hunt, President and CEO of the National Alliance for Caregiving, a non-profit coalition dedicated to conducting research and developing national programs for family caregivers and the professionals who serve them. Prior to heading the Alliance, Ms. Hunt was President of her own aging services consulting firm for 14 years. She conducted corporate eldercare research for the National Institute on Aging and the Social Security Administration, developed training for caregivers with AARP and the American Occupational Therapy Association, and designed a corporate eldercare program for EAPs with the Employee Assistance Professional Association.

The discussion panel will include Alice Bonner, Secretary Elder Affairs. Ms. Bonner began her current position in June 2015. Previously, she directed the nursing home division for the federal Centers for Medicare & Medicaid Services.

This event is invitation only, as seating is limited. If you'd like to receive an invitation, contact us at *Caregiversymposium@fallonhealth.org*. ■

Quality focus

Care coordinators—health care champions

Staying healthy can be complicated.

Annual physicals and screenings, eye exams, transportation to doctors' visits, getting help at home, accessing nutritious meals and exercise—all are health care benefits designed to keep your patients healthy. They can also seem overwhelming if your patients are managing a chronic condition such as asthma or diabetes for themselves, for a child or a frail parent.

Keeping track of appointments with doctors and specialists, sifting through and interpreting information, understanding costs, continuous communication to make sure everyone and everything works together effectively can become a full-time job and more than one person can handle.

All of this has given rise to a new job in health care—care coordinators. They have become an indispensable resource helping those trying to manage a chronic condition, or care for a frail loved one.

Based on our experience caring for vulnerable populations, Fallon Health recognizes the value of integrated, coordinated care, and we have been a leader in introducing care coordinators to the health care equation. Over the past decade, we've made strategic investments in this kind of care, and care coordinators now represent nearly 10 percent of our workforce, up from zero in 2005. And that percentage is climbing all the time.

What do care coordinators do?

The care coordinator's list of responsibilities is broad, but can be boiled down to one goal: being the champion of your patient's health.

The care coordinator first works with your patient to create a plan, which becomes the blueprint for the patient's care. The care coordinator uses the plan to identify and provide the resources necessary for your patient to stay healthy.

The care coordinator also acts as a liaison between your patient and a network of providers. Working closely with your patient, the care coordinator helps identify any changes in health and recommends action before a small concern becomes a potentially serious health risk.

Recognizing that no detail is too small when dealing with someone's health, the care coordinator makes sure nothing falls through the cracks—talking to doctors and other clinicians, booking follow-up appointments, coordinating services and answering questions.

The use of care coordinators has been shown to keep people out of the hospital. In one study, Fallon Health found that its members who were discharged from a local hospital to a skilled nursing facility (SNF), reduced their average length of stay from 15 days to 8 days with the support of a Fallon care coordination program. Also, after learning that 60 percent of members enrolled in Fallon's Medicare Advantage plan were being readmitted to the hospital because of medication issues, we now send a pharmacist to members' homes to coordinate medication management. (See success stories in this issue.)

The care coordinator's job does not stop at clinical care. A study conducted by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute determined that 80 percent of health outcomes are related to behavioral, emotional, financial, educational and other non-clinical issues.

Care coordinators attend to individuals in an array of circumstances—from an 8-year-old boy struggling with asthma to a 48-year-old man needing help to quit smoking to an 88-year-old woman coping with a complicated medication regimen.

Care coordinators come in all kinds of stripes at Fallon: Navigators, nurse case managers, coaches, and disease case managers to name a few, but they all have one thing in common: they provide personal care tailored to your patients.

Care coordinators are *taking the complicated out of health care.* ■

Safe Transitions Program success stories

Fallon Health's Safe Transitions Program was created to reduce hospital and SNF readmissions using pharmacist in-home post-discharge medication reconciliation and education. Post-discharge adverse events are a major driver for avoidable hospital readmissions, and most of these events are related to medications. The Safe Transitions Program works with patients and providers to assure patients are taking medications correctly.

Here are a few examples of how the program is helping patients during transition from hospital/SNF admission to the home setting:

- Patient with COPD stopped taking prescribed inhaler due to cost. Our pharmacist helped the patient switch from higher tier inhalers to lower tier medications and improved adherence.
- Patient with heart failure stopped taking diuretic, assuming that one month supply was all that was needed because hospital prescription had no refills. We intervened and clarified continuation of diuretic, and patient restarted medication.
- Patient with diabetes and on sliding scale insulin was unclear about the correct sliding scale to be used after discharge. We intervened and clarified which sliding scale dose to use and helped patient monitor blood glucose.
- Patient with coronary artery disease had no antiplatelet on the medication list and no history of contraindication to aspirin. Our pharmacist intervened and recommended evaluating risk/benefit of adding aspirin to the drug regimen.
- During a home visit, a recently discharged member received delivery of medications prescribed prior to hospital admission. Our pharmacist noted several discrepancies between these medications and those ordered post-discharge. The pharmacist clarified medications, doses and directions with the PCP. Changes were communicated to the VNA nurse who helped the member fill out pill boxes. New prescriptions were called into the pharmacy by the PCP who also discontinued old prescriptions.

For more information about the Safe Transitions Program, call 1-800-333-2535, ext. 69689, Monday–Friday, 8:30 a.m.–5:00 p.m. ■

Pulse survey – We like your feedback. Keep it coming!

Thank you to all of you who have sent in your feedback through our surveys, provider representatives and other means. We appreciate it, and we want it even more often. To help capture your thoughts and ideas, we will begin to post **"pulse" surveys** on our provider portal. The surveys will be short and easy.

Sample questions:

How are we doing with our communications?

Do you know our Provider Relations team?

We will announce the surveys in the "News and announcements" section of our website. Watch for them beginning in June. ■

Product spotlight

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.

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. ■

Doing business with us

WellTrack reminder

Beginning January 1, 2017, Fallon began participating in the Centers for Medicare and Medicaid Services' (CMS) Value-Based Insurance Design (VBID), a copayment reimbursement program for Medicare Advantage members who have diabetes. 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 helps to ensure that your patients are receiving the tests and exams that are recommended by national diabetes experts. Reimbursing them for certain copayments will help make their diabetes care more affordable.

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.

For additional details, please reference the January 2017 issue of *Connection*. ■

Pharmacy prior authorization requests

In order for PA requests to be processed efficiently, the requests must be submitted via the appropriate fax line. That is determined by type of patient (Commercial, Medicaid or Medicare) and type of benefit.

We have two general types of Pharmacy PAs for medications:

Pharmacy Benefit – these are medications that the patient will self-administer. These are usually oral and topical medications, but also include some injectable medications that the patient self-administers (i.e., insulins, Humira, etc.).

Medical Benefit – these are medications that are professionally administered. These are usually medications that require IM or IV administration (i.e., Botox, Euflexxa, etc.). It also includes diabetic supplies for Medicare members only.

Our *website* separates criteria and PA forms into two tabs based on these two general types of PAs. If you are uncertain as to which type of PA the medication belongs, please use the website to locate the drug. The tab under which the drug is listed will determine the type of PA and where to fax it. Some drugs may be listed on both tabs (i.e., Epoetin), as they may be self-administered or professionally administered. Some drugs may not be listed. In both of these cases, fax to the number that corresponds to how it is being administered. Please only use the PA forms that are posted on our website. Please discard all old PA forms that you may have in your office.

It is of the utmost importance to fax PA requests to the correct fax number so that they may be processed most efficiently. PA requests that are sent to the incorrect fax location cause delayed processing, delayed patient access to medication, and potentially result in a denial. Inappropriate denials then need to follow the Appeals process, further delaying patient access.

- **Pharmacy Benefit** PAs are faxed to CVS Caremark at one of the numbers in the below chart.

	Sample Plan names	Fax
Medicare Part D plans	Fallon Senior Plan™ HMO Fallon Senior Plan PPO NaviCare® Summit ElderCare®	**1-855-633-7673**
Medicaid plans	MassHealth	**1-855-762-5204**
Commercial plans	Direct Care Fallon Companion Care Select Care Fallon Preferred Care PPO Steward Community Care Tiered Choice	**1-888-836-0730**
Commercial and Medicaid plans: Specialty (self-administered) drugs only	See above	**1-866-249-6155**

- **Medical Benefit** PAs are faxed to Fallon Health at **1-508-791-5101.** Only Medical Benefit PAs are to be faxed to this number.

If you are uncertain where to fax a PA request, please consult our website or call Pharmacy Services at 1-866-275-3247, option 5, then option 2. ■

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. ■

Updates to Provider Tools

We've updated the Eligibility Verification tool to improve how it looks on your mobile device. Future enhancements will be coming. ■

DEX™ Tool (formerly McKesson)

A notification was sent in August, 2016 announcing Fallon's introduction of the DEX™ Diagnostics Exchange (formerly McKesson) to register genetic and molecular diagnostics tests for laboratories. The process was effective October 1, 2016. Any provider who bills for genetic testing must register in DEX. This process allows Fallon to better identify and evaluate tests for appropriate coverage and payment.

If a servicing laboratory is new to DEX, registration is required at *app.mckessondex.com/login*. Once you register your organization, within a week you will receive an email with a username and temporary password, plus instructions outlining how to use the tool and how you can add tests to the tool. Test types submitted will be assigned a unique Z-Code identifier.

Existing Diagnostics Exchange laboratories need to validate their participation with Fallon. This can be done by navigating to the *My Organization – Payer Options* tab. Highlight "Fallon Health" and select the "Add" button. Once this is done, continue to submit new tests for Z-Code identifiers.

Z-Codes must be included on all electronic claim submissions beginning April 5, 2017.

If you are not the performing lab, and send out molecular diagnostic testing to a reference lab, you may "Request Sharing" from that lab to see the test details and view the Z-Codes. Here is how you may Request Sharing:

- Login to the DEX Diagnostics Exchange.
- Select "Labs & Manufacturers".
- Search for any of your reference labs.
- Click on that lab name link OR
- Select the "+" sign to expand a parent organization's individual facilities, find the facility to which you physically send the specimen for processing.
- Select the "Request Sharing" button at the top right corner.
- Once the reference lab "accepts" your sharing request, you will have access to all of the Z-Codes for the testing they perform and you bill.

If you have any questions, please contact Christine Canton in Provider Relations at *christine.canton@fallonhealth.org* or 1-866-275-3247, Option 4. ■

MassHealth notification of birth and coverage of newborns

Reminder: When a baby is born to a mother who is eligible for MassHealth, the delivering hospital must fill out the MassHealth *Notification of Birth Form*. The form must be faxed/mailed to the state no later than 30 calendar days from the date of delivery. The purpose of the form is:

- to process newborn MassHealth eligibility
- provide hospitals with a mechanism for receiving a newborn member ID for claims submission
- enroll newborns into MCOs
- track federally required birth weight and race information ■

Prior authorization for Fluoxetine 20mg tablets

Effective July 1, 2017, fluoxetine 20mg tablets *will require prior authorization for all of our Commercial and Medicaid members.* Please note: this does not include members who are enrolled in a Medicare plan.

Fluoxetine 20mg is available as a tablet and capsule formulation. However, the capsule formulation is much more cost effective. The average cost of a 30-day supply of the 20mg tablets is $122, and the average cost for the 20mg capsules is $2.60. Patients currently taking this medication should be changed to the 20mg capsule. Criteria for use are currently being developed and will be available soon on our website. ■

Billing Practices for Qualified Medicare Beneficiaries

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual-eligible program which exempts individuals from Medicare cost-sharing liability. (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997). Balance billing prohibitions may likewise apply to other dual-eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing. See 42 CFR §422.504(g)(1)(iii).

"Qualified Medicare Beneficiaries", or QMBs, are individuals who are enrolled in both Medicare and Medicaid. All Medicare and Medicaid payments that providers receive for their services to a QMB beneficiary, including those received from a Medicare Advantage Organization, are considered payment in full. Providers are subject to sanctions if they bill a QMB beneficiary for amounts above the sum total of all Medicare and Medicaid payments—even if Medicaid pays nothing.

For more information on QMBs and QMB billing, please visit: *cms.gov* ■

Coding corner

Edinburgh Postnatal Depression Scale

MassHealth Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations require that all providers offer to screen MassHealth enrolled children under age 21 for behavioral health concerns using a standardized behavioral health screening tool. The administration of these standardized tools is payable in addition to a well visit or office visit code. Providers are directed to select a standardized screening tool from the menu of tools listed in Appendix W to the All Provider regulations (the EPSDT Schedule). Fallon is required to follow these policies, echoing MassHealth's payment rules, and menu of approved screening tools. MassHealth has just completed a review of its menu of screening tools, and an updated list was published in *Appendix W*.

With this update, **effective for dates of service on or after April 17, 2017,** MassHealth has added the Edinburgh Postnatal Depression Scale (EPDS) to the menu of tools. The EPDS may be

administered with caregivers of infants up to the age of six months, will count as the required behavioral health screening tool for that visit, and **must be claimed using CPT code 96110.**

With the addition of the EPDS to the menu, MassHealth is directing providers to **no longer use CPT code S3005 when administering the EPDS with caregivers of infants.**

In order to allow MassHealth to track the frequency with which the EPDS is selected, MassHealth **has added the requirement for providers to use a second modifier (UD) when claiming for the administration of the EPDS under CPT code 96110.** The UD modifier must be used in addition to the appropriate modifier from the series U1-U8, as indicated by the result of the screening, and the provider type administering the screening. ■

Coding updates

Effective July 1, 2017, the following codes *will be added to the FCHP Auxiliary Fee schedule.* The fee schedule amount for these items will not be increased, but will always pay the 100% rate. Providers are no longer required to submit an invoice for Intrauterine Devices (IUDs).

Code	Description	Rate
J7300	Intrauterine copper contraceptive	702.05
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg	650.32
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	771.52
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	729.46
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	487.50

Effective July 1, 2017, the following codes *will be removed from the FCHP Auxiliary Fee Schedules:*

Code	Description	Reason
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	Not separately reimbursed as of 5/1/16.

Code	Description	Reason
99058	Office services provided on an emergency basis.	Not separately reimbursed as of 5/1/16.
90471	Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine	Has a Medicare rate as of 1/1/17.
90472	Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular and jet injections); each additional vaccine	Has a Medicare rate as of 1/1/17.
90473	Immunization administration by intranasal or oral route; one vaccine	Has a Medicare rate as of 1/1/17.
90474	Immunization administration by intranasal or oral route; each additional vaccine.	Has a Medicare rate as of 1/1/17.

Effective February 1, 2017, the following codes *will be covered with plan prior authorization:*

Code	Description
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA, 125 II, follicle stimulating hormone, human epididymis protein 4 transferrin), utilizing serum algorithm reported as a likelihood score

Effective July 1, 2017, the following codes will be *not a covered benefit for Commercial plans:*

Code	Description
83695	Lipoprotein (a)
87304	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (e.g., by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed

Effective April 1, 2017, the following codes *will require plan prior authorization:*

Code	Description
C9484	Injection, eteplirsen
C9485	Injection, olaratumab
C9487	Ustebinumab IV inj, 1mg

Effective September 1, 2017, the following code *will covered and will require plan prior authorization:*

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

Payment policy updates

New policies – effective July 1, 2017:

- ***Group Adult Foster Care***
- ***Retroactive Authorization Requests*** ■

Revised policies – effective July 1, 2017:

- ***Adult Foster Care –*** Added instructions to bill MassHealth directly for specific codes.
- ***Aging Service Access Points (ASAP) –*** Updated prior authorization section.
- ***Counseling/Risk Factor Reduction Intervention Services –*** Added instructions to bill MassHealth directly for specific codes.
- ***Durable Medical Equipment –*** Added requirements for power mobility device reimbursement.
- ***Newborn Services –*** Added information regarding submitting the notification of birth form to MassHealth and added licensed practitioner language.
- ***Non-Covered Services –*** Updated the code report.
- ***Obstetrics and Gynecology –*** Clarified circumcision coverage and updated IUD information.
- ***Personal Care Attendant –*** Clarified timely filing language, updated the reimbursement section, and added the definition of a nurse case manager.
- ***Speech Therapy –*** Updated authorization requirements and added GN modifier.
- ***Transportation Services –*** Added instructions to bill MassHealth directly for non-emergency transportation. Added guidelines for non-emergent/social transportation for NaviCare members.
- ***Vaccine –*** Added code 90625 to Addendum A, Table 1.
- ***Vision Services –*** Updated refraction reimbursement language. ■

Annual Review

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

- ***Dermatology***
- ***Diabetes Self-Management Education/Training***
- ***Emergency Department***
- ***Global Surgical***
- ***Hospital Acquired Conditions***
- ***Preventive Services***
- ***Ventricular Assist Devices*** ■

Retiring the following policy:

- ***Special Services, Procedures and Reports*** ■

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

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fallonhealth.org/providers

Questions?

1-866-275-3247

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