Connection

Important information for Fallon Health physicians and providers

October 2018

What's new

New Chief Medical Officer

Carolyn Langer, M.D., JD, MPH, has returned to Fallon Health as Senior Vice President and Chief Medical Officer after previously serving as the company's Medical Director from 2005 to 2008.

Dr. Langer is responsible for ensuring the quality and value of health care services to Fallon members, overseeing all activities and operations within the Care Services department, and the Program of All-Inclusive Care for the Elderly (PACE). She also fosters strong relationships with Fallon's provider partners.

Prior to her return to Fallon, Dr. Langer served as Chief Medical Officer at MassHealth and the Director of the Office of Clinical Affairs. In these roles, Dr. Langer provided leadership and oversight of medical policy, pharmacy, quality, utilization management, care management and clinical analytics teams, while serving as a MassHealth representative to several local, state and national committees on clinical, quality and policy initiatives.

In addition, Dr. Langer previously held health care leadership roles with Harvard Pilgrim Health Care, Tufts Health Care Institute and Blue Cross Blue Shield of Massachusetts. She is also a retired colonel and former flight surgeon in the Army National Guard.

Dr. Langer earned her Doctor of Medicine at Jefferson Medical College in Philadelphia and a Master of Public Health and a law degree from Harvard University. Dr. Langer received the 2016 Harvard T.H. Chan School of Public Health's Leadership in Public Health Practice Award and the 2012 Boston Business Journal Champion in Healthcare Award (Administrator category). She holds an appointment as an associate professor in the Department of Family Medicine and Community Health at UMass Medical School and as an instructor at the Harvard T.H. Chan School of Public Health, where she sits on the Occupational Medicine Residency Advisory Committee. ■

New Director of Provider Relations

Fallon Health is happy to announce that Kathy Bien is our new Director of Provider Relations. Kathy held this position from 2008 to 2010 and is thrilled to be back in the role. Kathy has extensive experience in Provider Relations and Contract Management at Fallon Health as well as with Harvard Pilgrim Health Care and UMass Memorial Health Care. Kathy earned a Bachelor of Science degree in Business Administration from UMass Dartmouth and a Master of Business Administration degree from Assumption College.

As Kathy settles into her new position, she looks forward to getting to know you, supporting provider partnerships and strengthening the provider experience at Fallon Health. Feel free to reach out to her by phone at 1-508-368-9061 or email at *kathleen.bien@fallonhealth.org*. ■

Provider Satisfaction Survey

We want to hear from you!

It is important to us to survey our providers on an annual basis. We welcome your feedback on what we are doing well and where we can improve. We will use the results from these surveys to help direct administrative and operational improvements and strengthen our provider partnerships.

The current survey is taking place now until November 15, 2018. Participants were randomly selected and mailed the survey which is administered by Symphony Performance Health. You can either mail back the postage-paid paper copy or complete the survey online, whichever is more convenient for you.

If you received this survey, please take a few minutes to participate. The first 200 respondents will receive a $10.00 Amazon gift card, and all participants will be entered into a drawing to win one of three iPad mini 4s.

We value your input, and look forward to using your feedback to help us provide the best service possible. ■

Improvements to the Provider section of fallonhealth.org

You, our contracted providers, and your employees are essential to the delivery of quality care to our members. Our provider website is an important tool you use to deliver that care.

We asked you and your office staff what you need from our website and your feedback was clear. You want quick and easy access to tools and resources that will help you do your job.

We listened and made the following improvements to our Provider website content to address your needs:

- A redesigned home page with quick links to the most frequently used tools and resources
- A criteria, policies and guidelines center
- Easier, clearer navigation
- Direct home page access to important news and announcements

Please take a minute to explore the updated *website*. ■

Product spotlight

NaviCare® Model of Care update

When your patients join Fallon Health's NaviCare® SCO or NaviCare® HMO SNP program, their Interdisciplinary Care Team (ICT) helps them meet their health goals. The program's philosophy is to assist older adults to function in the least restrictive setting at the highest level possible, meeting their defined goals of care. Each patient has a member-specific care plan.

Program benefits include both traditional Medicare covered benefits and Medicaid benefits, such as homemakers, Meals on Wheels, activities of daily living assistance, transportation to medical appointments and long-term custodial care. Our Navigators can provide additional details about how to access our NaviCare benefits and how to communicate with our Care Team.

Updated roles of the Care Team members are listed below.

Navigator

- Educates your patients about their benefits and services
- Helps your patients make medical appointments and get care and services
- Assists in developing your patients' care plans
- Advocates for your patients' needs

Nurse Case Manager (or Advanced Practitioner)

- Assesses your patients' clinical and daily needs
- Teaches your patients about their medications and conditions
- Makes sure your patients get the care and services they need after a stay in a medical facility

Geriatric Support Service Coordinator (if needed)

- Evaluates and coordinates your patients' needs for in-home services
- Helps your patients with MassHealth paperwork
- Connects your patients with helpful resources

Primary Care Provider

- Directs your patients' care
- Provides routine medical services
- Refers your patients to specialists

Behavioral Health Case Manager (as needed)

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

Facility liaison (if needed)

- Connects your patient's team with the staff at their long-term-care, rest home or assisted living facility

Clinical pharmacist (if needed)

- Visits your patients after care transition to review medications and work with their medical providers

If you have questions about NaviCare benefits, or how to work with our Care Team, contact NaviCare Enrollee Services at 1-877-700-6996. ■

Doing business with us

WellTrack update

Fallon is getting ready to start on its third year in the WellTrack program. WellTrack is the Centers for Medicare & Medicaid Services' (CMS) Value-Based Insurance Design (VBID) model. This program is an opportunity for Medicare Advantage members with diabetes to be reimbursed for certain copayments. By reimbursing copays, Fallon assists members in obtaining high-quality services, while ensuring that they are able to maintain their treatment regimen.

For the 2019 calendar year, there is one less scorecard requirement: members no longer need to complete a fasting lipid profile to qualify for the copay reimbursement. 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
- Urine test once per year
- Diabetic eye exam once per year

This scorecard is based on recommendations made by the American Diabetes Association. Eligible plans are Fallon Senior Plan™ Saver Enhanced Rx HMO-POS and Fallon Senior Plan Standard Enhanced Rx HMO. Since the service area these WellTrack members live in only includes Worcester and Franklin counties, providers from these two counties are more likely to have patients in this program than providers from other counties.

As a reminder, members may see providers for services eligible for copay reimbursements during the entire calendar year. Once the member completes the required scorecard services, 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 reimbursements are:

- All PCP visit copays for covered services
- All 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 does 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, three times a year directly to the member.

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

Billing Reminder: electronic claim adjustments

UB and CMS 1500 claim adjustments can be sent to Fallon Health electronically by using bill type 7 or the claim frequency of 7 in the CLM05-3 segment, accordingly.

Adjusted claim must have:

- Same patient control/account number as original claim
- Same billing provider/pay to

All claim lines need to be submitted.

Adjustment examples include:

- Procedure and diagnosis changes
- Removing or adding charges
- Updating a member
- Updating an authorization after the original claim was processed

Note the original claim must have a finalized status on order to submit any adjustment.

For more information, contact Fallon's EDI Coordinators at *Edi.Coordinator@fallonhealth.org* or 1-866-275-3247, prompt 6. ■

Validating your practice information

Changes happen in your practice, and we want your patients to have access to the most current information in our *Provider Directory* and online "Find a doctor" tool. Please visit 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 from one of our representatives to ensure your information is correct. This verification aligns Fallon Health with requirements that have been set forth by the Centers for Medicare & Medicaid Services (CMS), the Massachusetts Division of Insurance (DOI) and the National Committee for Quality Assurance (NCQA)*. The regulations are designed to ensure health care consumers have current and accurate provider demographic information. If you have any questions, please do not hesitate to contact your Provider Relations Representative.

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

NaviCare skilled home health care prior authorization clarification

The July issue of *Connection*, page 11, listed items for which Fallon added the prior authorization notification, effective September 1. Many of these items are related to skilled nursing and home health care. **To clarify, due to our NaviCare *Evidence of Coverage*, we can't implement prior authorization review for NaviCare members for contracted skilled home health care agencies at this time.** If we receive requests for prior authorization from contracted agencies, we will fax back a cover sheet saying prior authorization for NaviCare is not required. **Please note: non-contracted skilled home health care agencies still do require prior authorization.**

If you have any questions, please contact your Provider Relations Representative. ■

Quality focus

Osteoporosis Management in Women who have had a Fracture (OMW): Bone Mineral Density Screenings

Fallon's Health Promotions department and Magellan Rx Management are offering free and voluntary in-home bone mineral density (BMD) screenings for our female Fallon Senior Plan and NaviCare enrollees who are between the ages of 67 and 85, and who have had a bone fracture within the past 180 days. Eligible females are identified from a monthly claims file. BMD screenings within six months for older women who have had a fracture is part of the OMW (Osteoporosis Management in Women Who Had a Fracture) HEDIS measure under the National Committee for Quality Assurance (NCQA) and a CMS 5 Star measure.

The BMD screening is a quick procedure utilizing a portable ultrasonic device (not an X-ray) to assess bone density in the heel of the foot. This is a screening tool only (it is not meant to diagnose osteoporosis), whereby low bone density results suggest greater risk of future fracture. During the in-home visit, the enrollee gets the results of her BMD screening, along with education on osteoporosis and its risk factors. Results are also sent to the enrollee's PCP. Participants are encouraged to review their results with their PCP, who can determine if any further testing is needed or what treatment options may prevent future fractures.

If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4, or Tyler Smith in Health Promotions at 1-508-368-9719. ■

Comprehensive Diabetes Care (CDC): Retinal Eye Test

Our Health Promotions department is conducting a free and voluntary retinal eye test program for our diabetic NaviCare enrollees. A diabetic retinal eye test is crucial to detect disease and prevent further damage to the eye(s). Eligible enrollees are identified from a claims file. Similar to our Osteoporosis Management in Women program, retinal eye testing for enrollees with diabetes is a component of the CDC HEDIS measure per NCQA and a CMS 5 Star measure.

This program offers an in-home retinal eye test using the RetinaVue™ 100 Imager by Welch Allyn. This test is a quick and painless procedure, the results of which can be used to diagnose diabetic retinopathy. The camera captures an image of the retina, which is then transmitted to a board-certified ophthalmologist for interpretation. A copy of the diagnostic report is sent to both the enrollee and the enrollee's PCP once results become available. Enrollees are encouraged to meet with their PCP to discuss the test results and treatment, if indicated.

This test is not meant to be a substitution for an in-person eye exam. We continue to encourage enrollees who have this test to schedule visits with an eye professional for comprehensive eye care. Fallon provides coverage for the test as well as other types of eye exams based on benefit plan design.

If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4, or Tyler Smith in Health Promotions at 1-508-368-9719. ■

Colorectal Cancer Screening: InSure® ONE kit™

Fallon Health is conducting a free and voluntary colorectal cancer screening program for our Fallon Senior Plan and NaviCare enrollees. Colorectal cancer screening is a HEDIS measure per NCQA and a CMS 5 Star measure. Health experts recommend colon cancer screening for healthy individuals between the ages of 50 and 75. Enrollees who have not received colorectal cancer screening are identified from a claims file using current HEDIS technical specifications. Enrollees can meet HEDIS requirements by having one of the following tests: a colonoscopy every ten years, a flexible sigmoidoscopy or CT colonography (virtual colonoscopy) every five years, a stool DNA test every 3 years (Cologuard®), or a fecal occult blood test yearly.

Our program uses a fecal occult blood test: the InSure ONE kit provided by Quest Diagnostics™. Enrollees receive this kit in the mail to screen for colorectal cancer and other sources of lower gastrointestinal bleeding. The InSure ONE is designed to be simpler and more user-friendly than other screenings specific for human hemoglobin. More importantly, the InSure ONE requires only one stool sample and does not require fecal handling, or dietary or medication restrictions. Results are interpreted by Quest Diagnostics, and Fallon Health will send the results to the member's PCP. Providers are encouraged to review the results with their patients.

If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4. ■

Follow-up after hospitalization for mental illness: outpatient appointments within seven and 30 days of discharge

Fallon Health is working with our behavioral health vendor, Beacon Health Options (Beacon), to increase seven- and 30-day follow-up appointment rates with outpatient behavioral health providers for our NaviCare enrollees who are hospitalized for treatment of selected mental illness. Beacon staff may outreach to select inpatient and outpatient behavioral health providers, as well as identified enrollees, in order to help facilitate timely receipt of behavioral health, medical and additional support services in an appropriate setting. Follow-up with a behavioral health provider after hospitalization for mental illness is also a HEDIS measure under the National Committee for Quality Assurance (NCQA).

If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4. ■

Disease Management Program empowers your patients

The Fallon Health Disease Management Program is a proactive, patient-centered program for individuals diagnosed with chronic diseases—including asthma, diabetes, chronic obstructive pulmonary disease (COPD), cardiac disease or heart failure. It reinforces standards of care by providing health education, health coaching and self-management skills. We work toward empowering your patients to take a more active role in improving and maintaining their health.

We welcome referrals for your patients, our Fallon members, to our Disease Management Program 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. 69898, Monday through Friday from 8:30 a.m. to 5 p.m. You also may use our online *Disease Management/Health Promotions Referral Form*. ■

Access to complex case management

Another program we offer to your patients who need a lot of care and resources is the Complex Case Management Program. You may refer a patient to this program if he/she has a "critical event or diagnosis"—for example, a car accident, a fall that results in serious injury, cancer or serious health decline. We'll do a brief assessment to confirm eligibility.

Our nurse case managers and social workers coordinate care in collaboration with caregivers and you. We want to help ensure that your patients receive all the appropriate services and have access to all the resources needed to resolve their health issues in the best way possible.

For more information, or to ask about enrolling in the program, you may call us at 1-800-333-2535, ext. 78002 (TRS 711), Monday-Friday, 8:30 a.m.-5:00 p.m. Or you may use our online *Case Management Referral Form*.

Thank you for your referrals. ■

Important links to information about care

We hope you'll take this time to explore fallonhealth.org to learn how we work with you and your patients to ensure the quality and safety of clinical care. If you'd like to receive a copy of this information, please call Provider Relations at 1-866-275-3247, option 4.

- **Clinical criteria for utilization care services.** Fallon uses national, evidence-based criteria reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care. Criteria are available *here* or as a paper copy upon request.
- **Quality programs.** Fallon is proud of its long history of quality accomplishments, including our accreditation from the National Committee for Quality Assurance (NCQA). A detailed description of our quality programs, goals and outcomes is available *here*. We also welcome suggestions from our physicians about specific goals or projects that may further improve the quality of our care and services.
- **Members' rights.** Fallon members have the right to receive information about an illness, the course of treatment and prospects for recovery in terms that they can understand. They have the right to actively participate in decisions regarding their own health and treatment options, including the right to refuse treatment. View a complete list of Fallon members' rights and responsibilities *here*. ■

Utilization Management incentives

Fallon Health affirms the following:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage.
- Fallon Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization. ■

Compliance

Exclusion screening requirements

Statutory background

For more than 40 years, the Federal government has prohibited physicians and other practitioners from participation in Medicare and Medicaid following a conviction for program-related crimes. These "exclusions" have since expanded to all Federal health care programs and to individuals and entities convicted of various types of misconduct. Such exclusions may also allow for the U.S. Department of Health and Human Services' Office of the Inspector General (OIG) to impose sanctions or Civil Money Penalties (CMP) against individuals and entities who submit false or fraudulent claims for Medicare or Medicaid payment, or against organizations that employ or contract with such individuals.

Effect of exclusion

Federal health care program dollars cannot be used to pay for any items or services furnished, directed or prescribed by an excluded individual or entity. These include payments made by Medicare Advantage plans (MA), Prescription Drug Plans (PDP), Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Managed Care Organizations (MCO), or Medicaid Accountable Care Organizations (ACO). In its Special Advisory Bulletin on the *Effect of Exclusion from Participation in Federal Health Care Programs* issued on May 8, 2013, the OIG listed the examples below as excluded items and services:

- Services performed directly or indirectly by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, whether such services are related to administrative duties, preparation of surgical trays or review of treatment plans reimbursed directly or by a Federal health care program;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any Federal health care program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Federal health care program;
- Services performed for Federal program beneficiaries by excluded individuals who sell, deliver or refill orders for medical devices or equipment, reimbursed by a Federal health care program;

- Services performed by excluded social workers who are employed by health care entities to provide services to Federal program beneficiaries, and whose services are reimbursed, directly or indirectly, by a Federal health care program;
- Administrative services, including the processing of claims for payment, performed for a Medicare intermediary or carrier, or a Medicaid fiscal agent, by an excluded individual;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program;
- Items or services provided to a program beneficiary by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Federal health care program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a Federal health care program.

Violation of an exclusion

If items or services furnished by an excluded individual or entity are subsequently billed to a Federal health care program or subcontractor, like Fallon, CMPs may be imposed against the excluded person or entity. With the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 and Balanced Budget Act (BBA) in 1997, the OIG's ability to levy sanctions expanded to include health care providers or entities that employ or enter into contracts with excluded individuals for the provision of services or items to Federal program beneficiaries.

An exclusion from participating in Federal health care programs will result in prohibition from employment by, or contracting with, an organization that receives payment or reimbursement, directly or indirectly, from any Federal health care program.

In 2018 alone, the settlements below have been reached regarding excluded individuals. In all cases, the OIG's investigation revealed that the excluded individual provided items or services that were billed to Federal health care programs.

- **$189,445.68** resolving allegations that Immediate Home Care employed a **home health nurse** who was excluded from participating in any Federal health care program
- **$257,874** resolving allegations that Alameda Health System employed an **eligibility clerk** who was excluded from participating in any Federal health care program
- **$11,406.26** resolving allegations that ASAP Home Nurses, Inc. employed a **state tested nurse** aide who was excluded from participating in any Federal health care program
- **$314,205.76** resolving allegations that Pharmex Pharmacy, LLC employed a **pharmacist** who was excluded from participating in any Federal health care programs
- **$189,805.55** resolving allegations that Arkansas Convalescent Center employed a **licensed practical nurse** who was excluded from participating in any Federal health care program
- **$141,986.36** resolving allegations that Southwest Trinity Management, through a skilled nursing facility it owns and manages in Oklahoma City, Oklahoma, employed a **licensed practical nurse** who was excluded from participating in any Federal health care program

Regulatory requirement to screen against state and federal exclusion databases

The OIG imposes substantial financial consequences on federal contractors for violating exclusions requirements to ensure that beneficiaries of health care programs receive services from qualified individuals and entities as well as to prevent fraud, waste or abuse. It is therefore critical that health plans, providers and other contractors routinely screen their employees, volunteers, contractors, vendors, providers and governing body members against all applicable exclusion databases. Centers for Medicare & Medicaid Services (CMS), issued *guidance* to organizations to check all employees, volunteers, contractors, vendors, providers and governing body members prior to hire or contracting, and monthly thereafter, against the exclusion databases.

Fallon's requirement

By contracting with Fallon Health for **any lines of business,** you have agreed to screen, at the time of hire and monthly thereafter, all employees, volunteers, contractors, vendors, providers and governing body members against the *OIG List of Excluded Individuals and Entities (LEIE)*, the General Services Administration (GSA) *System for Award Management (SAM) database*, as well as all applicable State exclusion lists, like the *MassHealth List of Suspended and Excluded Providers* or *NY OMIG List of Restricted and Excluded Providers Search.*

For more information on exclusion screening, please review the *Fallon Provider Manual* section on *Key compliance and regulatory requirements for providers* or contact your contract manager. ■

Coding corner

Coding updates

New 2019 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. Fallon will notify all contracted providers of this determination via the April issue of the *Connection* newsletter and on the Fallon Health website in the *Provider Manual*.

Effective December 1, 2018, the following code *will require prior authorization:*

Code	Description
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (e.g., balloon dilation)

Effective December 1, 2018, the following codes *will require prior authorization:*

Code	Description
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space

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

Code	Description
A4601	Lithium ion battery for nonprosthetic use, replacement
A4608	Transtracheal oxygen catheter, each
A9280	Alert or alarm device, not otherwise classified
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
E0617	External defibrillator with integrated electrocardiogram analysis
E1902	Communication board, nonelectronic augmentative or alternative communication device
E2291	Back, planar, for pediatric size wheelchair including fixed attaching hardware
E2293	Back, contoured, for pediatric size wheelchair including fixed attaching hardware
E2294	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware
E2609	Custom fabricated wheelchair seat cushion, any size
E2610	Wheelchair seat cushion, powered
S8210	Mucus trap

Effective December 1, 2018, the following codes *will require plan authorization for Medicaid members:*

Code	Description
A6250	Skn sealnt protct moisturzr ointmnt
E0636	Mx pstn pt supp sys lift pt cntrl
E0656	Seg pneumat applinc w/comprs trunk
E0657	Seg pneumat applinc w/comprs chest
E2101	Bld glu mon intgrt lancing/bld samp
T4521	Adlt sz dispbl incont brf/diaper sm
T4522	Adlt sz dispbl incont brf/diaper md
T4523	Adlt sz dispbl incont brf/diaper lg
T4524	Adlt dispbl incont brf/diaper x-lg
T4525	Adlt szd dispbl incont undwear sm
T4526	Adlt szd dispbl incont undwear med
T4527	Adlt szd dispbl incont undwear lg
T4528	Adlt szd dispbl incont undwear x-lg
T4529	Ped sz dispbl incont brf/diaper s/m
T4530	Ped sz dispbl incont brf/diaper lg
T4531	Ped sz dispbl incont undwear sm/med
T4532	Ped sz dispbl incont undwear lg ea
T4533	Youth szd dispbl incont brf/diaper
T4534	Youth szd dispbl incont undwear ea
T4535	Dispbl liner/pad/undgrmnt incont ea
T4537	Incont prod undpad reusbl bed sz ea
T4541	Incont product dispbl undpad lg ea
T4542	Incont prod dispbl undpad sm sz ea
E2100	Bld glu mon integrt voice syntheszr

Effective July 1, 2018, the following codes *are covered* and *require plan authorization:*

Code	Description
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score
0046U	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)
0049U	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation
0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)
0057U	Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative
0059U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging (SFDI) and multi-spectral analysis

Effective July 1, 2018, the following pharmacy codes *are covered* and *require plan prior authorization:*

Code	Description
C9030	Inj copanlisib
C9031	Lutetium Lu 177 dotatate, tx
C9032	Voretigene neparvovec-rzyl

Effective July 1, 2018, the following codes *are covered* and *require plan prior authorization:*

Code	Description
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units

Payment policy updates

Revised policies – effective December 1, 2018

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

Adult Day Health – Updated the NaviCare reimbursement section.

Ambulatory Surgery (Facility) – Removed operative note request process.

Autism – Updated referral section.

Drugs and Biologicals – Policy is now applicable to in-patient services, policy name changes from Outpatient Drugs to Drugs and Biologicals.

Evaluation and Management – Updated coverage of codes 99050/99051 for MassHealth/ NaviCare.

Group Adult Foster Care – Clarified services are still covered when the member elects hospice.

Hearing Aids – Updated NaviCare authorization requirements.

Hospice – Clarified Medicaid services are reimbursable for NaviCare during hospice election.

Modifiers – Removed pre-claim adjudication operative note review for all modifiers.

Non-Covered Services – Updated code list.

Nurse Practioner – Removed references to credentialing and added language regarding FQHC and CHCs.

Observations – Updated the referral section.

Obstetrics – Clarified reimbursement for ante-partum visits 1-3. Added observation codes to the not separately reimbursable list.

Personal Care Assistant (PCA) – Clarified services are still covered when the member elects hospice.

Physical and Occupational Therapy – Clarified claims should be billed with individual dates of service and not date ranges.

Physician Assistant – Removed references to credentialing and added language regarding FQHC and CHCs.

Skilled Nursing Facility – Clarified hospice services are not included in the Per Diem.

Sleep Management Services – Updated mailing addresses, updated products covered.

Vaccines – Updated/clarified addendums B and C. ■

Annual policies

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

Clinical Trials

Palliative Care Consultation ■

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

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