CONNECTION

Important information for Fallon Health physicians and providers

September 2016

In this issue

Doing business with us

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.

fallonhealth

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 at *fallonhealth.org/providers/medical-management/forms*.

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 their 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 at *fallonhealth.org/providers/medical-management/forms*.

Thank you for your referrals.

IUD billing and reimbursement reminder

Since January 1, 2011, you have been required to submit an invoice for IUDs with your initial claim submission. Fallon Health keeps a copy of the invoice on file and continues to reimburse the invoice cost. If the cost changes, you'll need to submit a new invoice.

Fallon Health reserves the right to audit the cost of the IUDs to ensure that we are paying the provider's invoice cost equivalent. Fallon Health will conduct all audits within 18 months from the date of payment. If you have any questions, please contact Provider Relations at 1-866-275-3247.

Code	Name of devices for which Fallon requires an invoice
J7297	Mirena – 3 year
J7298	Mirena – 5 year
J7300	Paragard T380A
J7301	Skyla
J7306	Norplant II
J7307	Implanon or Nexplanon

Update your practice information

Please notify us of any changes to your contact or panel information. These would include, but not be limited to:

- your ability to accept new patients
- street address
- phone number
- specialty
- hospital affiliations
- panel status
- languages spoken by you or your staff
- any other change that impacts your availability to patients

In order for Fallon Health to be compliant with regulatory requirements, changes must be communicated in writing as soon as possible. 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.

How to update your information

You can check your current practice information by going to the *Find a doctor* tool. If that information is not correct, please update it as soon as possible by completing the *Provider Update Form*, and returning it to us at:

Fax: 1-508-368-9902

Mail:
Fallon Health
10 Chestnut St.
Worcester, MA 01608
Attention: Provider Relations ■

Required training for NaviCare Model of Care

Fallon requires all NaviCare providers to receive annual NaviCare Model of Care training. There are two ways you can do it:

If you have an account, log on to *The University* and take the course. It should take you about 15-30 minutes. For instructions on how to set up an account, visit *fallonhealth.org*.

Or, you can contact your Provider Relations Representative to set up a training session. The session will take about 30-60 minutes, depending on questions. Please remember, we ask you to have a NaviCare refresher training every year in order to remain current with any changes to the Model of Care. If you have any questions, please contact your Provider Relations Representative. ■

Let's connect

How pediatricians can help with postpartum depression

You may recall the *article* in the May issue of *Connection* about postpartum depression (PPD). The American Psychological Association reports that one in seven women experience postpartum depression. PPD doesn't go away without treatment. PPD can appear days or even months after delivering a baby, and it can last for many weeks or months if left untreated.

Many women who have PPD are not diagnosed. There are several reasons for this. The woman may feel there is a stigma attached to depression. She may not know she has PPD. She may not be able to get to a mental health professional.

A mother's mental health is vital to her child. If she is depressed, she is much less likely to properly care for her baby. She is also less likely to play, sing and talk with her baby. These are essential activities for the proper development of a child. Without them, a child is at risk for performing lower on cognitive, emotional and behavioral assessments. He or she is also more likely to have mental health problems, social adjustment problems and difficulty in school later in life.

Pediatricians can help determine if a woman is in need of PPD treatment. They can incorporate screening and treatment with well-child visits. In fact, in a recent article in the *Journal of Developments and Behavioral Pediatrics*, Dr. Michael W. Yogman says screening parents for PPD should be the new standard of quality care for pediatricians. Dr. Yogman believes PPD is a hidden epidemic, underdiagnosed and undertreated.

Medicaid has recently agreed to pay for PPD screenings that use the Edinburgh Postpartum Depression Scale. The scale is now part of a more comprehensive infant screening called the SWYC/MA, given at one, two, four and six months. In addition, the Massachusetts legislature has funded an extension of the Massachusetts Child Psychiatry Access Project (MCPAP for MOMS) that will provide counsel for pediatricians for parental referrals and treatment.*

Factors that may put some women at a higher risk for depression include:

- Being a teen mom
- Having a baby with a birth defect or disability
- Pregnancy and birth complications
- Having a baby or infant hospitalized
- A history of depression or anxiety, either during pregnancy or at other times
- Family history of depression or anxiety
- A difficult pregnancy or birth experience

- Giving birth to twins or other multiples
- Relationship problems with partner
- Financial problems
- Receiving little or no support from family or friends to help you care for your baby
- Unplanned pregnancy

Once a parent, either mother or father (yes, men can get it, too), has tested positive for PPD, the pediatrician can refer him or her to a primary care provider, obstetrician or behavioral health specialist.

For more information about pediatrician screening for PPD, visit the *American Academy of Pediatrics*, or contact your local medical society.

**Journal of Developments and Behavioral Pediatrics, Postpartum Depression Screening by Pediatricians: Time to Close the Gap, by Michael W. Yogman, MD. February/March 2016.* ■

Quality focus

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.**

• **Learn more about our quality programs.** Fallon is proud of its long history of quality accomplishments, including our accreditation from the National Committee for Quality Assurance. 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.

• **Know our 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. ■

Clinical Practice Guideline update

Our Clinical Practice Guidelines are available *here*. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

Recent updates:

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

- *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder ©2007*
- *Practice Guideline for the Treatment of Patients with Major Depressive Disorder ©2007*
- *Global Initiative for Chronic Obstructive Lung Disease (G.O.L.D.), from the Global Strategy for the Diagnosis, Management and Prevention of COPD, ©2016* ■

Save money for your patients and reduce health care costs!

Did you know that metformin comes in different extended-release formulations? However, there is no evidence to suggest that any of these products will result in a clinically significant difference. But the cost of the products is something that deserves attention.

Currently, the reasonably priced generic Glucophage XR only comes in 500mg and 750mg. Some patients are being prescribed the 1,000mg tablet, which automatically goes to the more expensive products. **We ask that you please indicate Glucophage XR tablets on your prescription orders. In the case of patients who require 1,000mg, prescribe two of the 500mg tablets**. In Massachusetts, and most other states, the pharmacy will automatically substitute the generic metformin product. See price information below.

Product description	Average 30-day supply cost
Glucophage XR 500 mg TB24	$ 50.70
Metformin ER 500mg TB24	$ 2.70
Glucophage XR 750mg TB24	$ 54.30
Metformin ER 750mg TB24	$ 6.10
Fortamet 500mg TB24	$ 1,195.00
Metformin ER (OSM) 500mg TB24	$ 216.00
Fortamet 1000mg TB24	$ 1,195.00
Metformin ER (OSM) 1,000mg TB24	$ 300.00
Glumetza 500mg TB24	$ 1,850.00
Metformin ER (MOD) 500mg TB24	$ 1,250.00
Glumetza 1,000mg TB24	$ 4,000.00
Metformin ER (MOD) 1,000mg TB24	$ 3,600.00 ■

Antipsychotics and diabetes

Individuals with severe mental illness may be at risk for complications due to medications.

Those living with schizophrenia or bipolar disorder are at high risk of developing diabetes, among other serious illnesses. The risk of developing diabetes is further increased if they are prescribed an antipsychotic.

Antipsychotics can cause significant weight gain and changes in a person's metabolism.

According to the HEDIS® measure, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, people 18-64 years of age with schizophrenia or bipolar disorder should have a diabetes screening each year. Screening may lead to earlier identification and treatment in patients taking these types of medications. ■

Coding corner

Coding updates

****Correction from the March 2016 *Connection*****

Effective May 2, 2016, the following codes have been changed from *not separately reimbursed* to *being covered with no plan prior authorization.*

Code	Description
A4265	Paraffin per pound
A4310	Insertion tray w/o drn bag and w/o cath
A4311	Insertion tray w/o bag, 2-way latex
A4314	Insertion tray with bag, 2-way latex
A4322	Irrigation syringe bulb/piston each
A4326	Male ext cath clct chamb any type
A4338	Indwll cath, 2-way latex w/ coat each
A4344	Indwll cath foley, 2-way silcon each
A4346	Indwll cath, foley 3-way cont irrig
A4351	Intermit urin cath, straight tip each
A4352	Intermit urin cath, coude tip each
A4354	Insertion tray w/ drn bag, w/o cath
A4356	Ext urethral clamp/comprs device each
A4357	Bedside drn bag day/night w/wo tube each
A4358	Urinary leg bag, vinyl w/wo tube each
A4361	Ostomy faceplate each
A4362	Skn barrier, solid 4x4/equivalent, each
A4364	Adhes liquid/equal any type, ounce.
A4367	Ostomy belt, each
A4397	Irrigation supply, sleeve, each
A4398	Ostomy irrigation supply, bag, each
A4399	Ostomy irrigation supply, cone/cath w/wo brush
A4402	Lubricant per ounce
A4404	Ostomy ring, each
A4455	Adhesive remover/solvent per ounce
A5051	Ost pouch clos, w/barrier attached, each
A5052	Ost pouch clos, w/o barrier attach each
A5053	Ostomy pouch clos, use faceplate each
A5054	Ost pouch clos, barrier with flnge each
A5055	Stoma cap
A5061	Ost pouch drnable, with barr attch, each
A5062	Ost pouch drnabl, w/o barr attch, each
A5063	Ost pouch drnable, barr w/flnge, each
A5071	Ost pouch urin, with barrier attch, each
A5072	Ost pouch urin, w/o barr attch, each
A5073	Ost pouch urin, barrier w/ flnge, each

Code	Description
A5081	Continent devc, plug continent stoma
A5082	Continent devc, cath continent stoma
A5093	Ostomy accessory, convex insert
A5105	Urin suspensory leg bag w/ and w/o tube each
A5112	Urinary drainage bag leg or abdomen latex, each
A5113	Leg strap, latex replacement only – set
A5114	Leg strap, foam/fabric repl – set
A5121	Skn barrier, solid 6x6/equivalent, each
A5122	Skn barrier, solid 8x8/equivalent, each
A5126	Adhes/non-adhes, disk/foam pad
A5131	Applinc clnr incont and ost appln – 16 oz.
A4335	Incontinence supply, miscellaneous – unlisted

Effective July 1, 2016, the following codes *are covered and require plan prior authorization.*

Code	Description
C9476	Injection, daratumumab, 10 mg
C9477	Injection, elotuzumab, 1 mg
C9478	Injection, sebelipase alfa, 1 mg
C9480	Injection, trabectedin, 0.1 mg

Effective November 1, 2016, code S8032 will be *deny vendor liable* for all lines of business. Instead of using S8032, providers should use code G0297 (LDCT for lung cancer screen).

Code	Description
G0297	LDCT lung cancer screening

Effective July 1, 2016, the following code *is covered and require plan prior authorization.* (Please note that the code below was originally active from 1/1/2000 to 12/31/15. CMS has decided to reactive this code effective July 1, 2016.)

Code	Description
S3854	Gene expression profiling panel for use in the management of breast cancer treatment

Effective July 1, 2016, the following codes are *deny vendor liable* for all lines of business:

Code	Description
S0311	Comprehensive management and care coordination for advanced illness, per calendar month
0437T	Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure.)
0438T	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure.)
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral

Effective April 5, 2016, the following code *is covered and requires plan prior authorization.* CMS implanted this code on July 1, 2016 but retro-dated it back to an April 5, 2016 effective date. When submitting code Q5102, modifier ZB (Pfizer/hospira) should be applied.

Code	Description
Q5102	Injection, infliximab biosimilar

Effective November 1, 2016, the following codes will be set up as *deny vendor liable* for all lines of business.

Code	Description
0205T	Intravascular catheter-based coronary vessel or graft spectroscopy (e.g., infrared) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation, and report, each vessel (List separately in addition to code for primary procedure.)
0206T	Computerized database analysis of multiple cycles of digitized cardiac electrical data from two or more ECG leads, including transmission to a remote center, application of multiple nonlinear mathematical transformations, with coronary artery obstruction severity assessment
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral
0208T	Pure tone audiometry (threshold), automated (includes use of computer-assisted device), air only
0209T	Pure tone audiometry (threshold), automated (includes use of computer-assisted device), air and bone
0210T	Speech audiometry threshold, automated (includes use of computer-assisted device)
0211T	Speech audiometry threshold, automated (includes use of computer-assisted device), with speech recognition
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated (includes use of computer-assisted device)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic, single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic, second level (List separately in addition to code for primary procedure.)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic, third and any additional level(s) (List separately in addition to code for primary procedure.)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral, single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral, second (List separately in addition to code for primary procedure.)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral, third and any additional level(s) (List separately in addition to code for primary procedure.)

Code	Description
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level, cervical
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level, thoracic
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level, lumbar
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure.)

Effective November 1, 2016, the following codes will be set up as *deny vendor liable* for all lines of business with no plan prior authorization.

Code	Description
0545F	Plan for follow-up care for major depressive disorder, documented (MDD ADOL)
0575F	HIV RNA control plan of care, documented (HIV)
1180F	All specified thromboembolic risk factors assessed (AFIB)
1200F	Seizure type(s) and current seizure frequency(ies) documented (EPI)
1205F	Etiology of epilepsy or epilepsy syndrome(s) reviewed and documented (EPI)
1220F	Patient screened for depression (SUD)
2060F	Patient interviewed directly on or before date of diagnosis of major depressive disorder (MDD ADOL)
3008F	Body Mass Index (BMI), documented (PV)
3015F	Cervical cancer screening results documented and reviewed (PV)
3038F	Pulmonary function test performed within 12 months prior to surgery (Lung/Esop Cx)
3250F	Specimen site other than anatomic location of primary tumor (PATH)
3293F	ABO and Rh blood typing documented as performed (Pre-Cr)
3294F	Group B Streptococcus (GBS) screening documented as performed during week 35-37 gestation (Pre-Cr)
3321F	AJCC cancer stage 0 or 1A Melanoma, documented (ML)
3322F	Melanoma greater than AJCC Stage 0 or IA (ML)
3323F	Clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery (Lung/Esop Cx)
3324F	MRI or CT scan ordered, reviewed or requested (EPI)
3328F	Performance status documented and reviewed within 2 weeks prior to surgery (Lung/Esop Cx)
3370F	AJCC breast cancer stage 0, documented (ONC)
3372F	AJCC breast cancer stage I: T1mic, T1a or T1b (tumor size <= 1 cm), documented (ONC)

Code	Description
3374F	AJCC breast cancer stage I: T1c (tumor size > 1 cm to 2 cm), documented (ONC)
3376F	AJCC breast cancer stage II, documented (ONC)
3378F	AJCC breast cancer stage III, documented (ONC)
3380F	AJCC breast cancer stage IV, documented (ONC)
3382F	AJCC colon cancer, stage 0, documented (ONC)
3384F	AJCC colon cancer, stage I, documented (ONC)
3386F	AJCC colon cancer, stage II, documented (ONC)
3388F	AJCC colon cancer, stage III, documented (ONC)
3390F	AJCC colon cancer, stage IV, documented (ONC)
3500F	CD4+ cell count or CD4+ cell percentage documented as performed (HIV)
3502F	HIV RNA viral load below limits of quantification (HIV)
3503F	HIV RNA viral load not below limits of quantification (HIV)
3510F	Documentation that tuberculosis (TB) screening test performed and results interpreted (HIV) (IBD)
3511F	Chlamydia and gonorrhea screenings documented as performed (HIV)
3512F	Syphilis screening documented as performed (HIV)
3513F	Hepatitis B screening documented as performed (HIV)
3514F	Hepatitis C screening documented as performed (HIV)
3515F	Patient has documented immunity to Hepatitis C (HIV)
3550F	Low risk for thromboembolism (AFIB)
3551F	Intermediate risk for thromboembolism (AFIB)
3552F	High risk for thromboembolism (AFIB)
3555F	Patient had International Normalized Ratio (INR) measurement performed (AFIB)
3570F	Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (e.g., X-ray, MRI, CT) corresponding to the same anatomical region in question (NUC_MED)
3572F	Patient considered to be potentially at risk for fracture in a weight-bearing site (NUC_MED)
3573F	Patient not considered to be potentially at risk for fracture in a weight-bearing site (NUC_MED)
3650F	Electroencephalogram (EEG) ordered, reviewed or requested (EPI)
4004F	Patient screened for tobacco use AND received tobacco cessation (intervention, counseling, pharmacotherapy, or both) if identified as a tobacco user (PV, CAD)
4063F	Antidepressant pharmacotherapy considered and not prescribed (MDD ADOL)
4148F	Hepatitis A vaccine injection administered or previously received (HEP-C)
4149F	Hepatitis B vaccine injection administered or previously received (HEP-C, HIV) (IBD)
4255F	Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record (CRIT) (Peri2)

Code	Description
4256F	Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record (CRIT) (Peri2)
4270F	Patient receiving potent antiretroviral therapy for 6 months or longer (HIV)
4271F	Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy (HIV)
4274F	Influenza immunization administered or previously received (HIV) (P-ESRD)
4290F	Patient screened for injection drug use (HIV)
4293F	Patient screened for high-risk sexual behavior (HIV)
4300F	Patient receiving warfarin therapy for nonvalvular atrial fibrillation or atrial flutter (AFIB)
4330F	Counseling about epilepsy specific safety issues provided to patient (or caregiver) (EPI)
4340F	Counseling for women of childbearing potential with epilepsy (EPI)
5200F	Consideration of referral for a neurological evaluation of appropriateness for surgical therapy for intractable epilepsy within the past 3 years (EPI)
6070F	Patient queried and counseled about anti-epileptic drug (AED) side effects (EPI)

Effective November 1, 2016, the following codes will be set up as *not separately reimbursed.*

Code	Description
C1780	Lens, intraocular (new technology)
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

On July 1, 2016, CMS implemented modifier ZA (Novartis/Sandoz), but retro-dated it back to a **January 1, 2016 effective date**. When submitting code Q5101, modifier ZA (Novartis/Sandoz) should be applied. Code Q5101 does not require plan prior authorization.

Code	Description
Q5101	INJ filgrastim G-CSF Biosim ■

Balloon sinuplasty for treatment of chronic sinusitis

Effective November 1, 2016, Fallon Health will *cover balloon sinuplasty for treatment of chronic sinusitis for all lines of business with approved prior authorization* (see codes below). Balloon sinuplasty utilizes a small balloon-like device which is inflated in order to push sinus tissue and/or bones to allow a larger airway passage and assist with mucus drainage. This procedure can be done as a stand-alone procedure or in conjunction with a functional endoscopic sinus surgery (FESS) procedure.

Code type	Code	Description
CPT	31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa
	31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)
	31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation) ■

Hip arthroscopy for femoroacetabular impingement

Effective November 1, 2016, Fallon Health will utilize *Interqual Criteria for Hip Arthroscopy for Femoroacetabular Impingement*. The criteria can be accessed via McKesson or upon request by contacting Fallon Health. ■

ICD-10-CM and ICD-10-PCS annual code update

The annual update of the ICD-10-CM diagnosis and ICD-10-PCS procedure codes is effective October 1, 2016. An ICD-10-CM diagnosis code is required on all paper and electronic claims billed to Fallon Health.

For a list of new and invalid ICD-10-CM and ICD-10-PCS codes, effective for dates of service on or after October 1, 2016, see *Connection* online. ■

Obesity in ICD 10

Obesity is a major problem in the United States and can be a very sensitive subject to address in the physician's office. Morbid obesity is defined as a Body Mass Index (BMI) of greater than 40 kg/m2. Obesity increases the risks of certain diseases such as diabetes, heart disease, stroke, arthritis, sleep apnea and some cancers.

BMI documentation can be from clinicians who are not the patient's provider; however an associated diagnosis such as morbid obesity verbiage must be documented in the patient's record by a physician to assign the morbid obesity code. Here are some obesity code examples:

- E66. – Obesity unspecified, NOS
- E66.01 – Morbid (severe) obesity due to excess calories
- E66.3 – Overweight
- Z68.41 – BMI 40.0-44.9 adult
- Z68.42 – BMI 45.0-49.9 adult
- Z68.43 – BMI 50.0-59.9 adult
- Z68.44 – BMI 60.0-69.9 adult
- Z68.45 – BMI 70 or greater, adult
- Z71.3 – Dietary or weight-loss counseling
  - Procedure code 0G0477: face-to-face behavioral counseling for obesity (RVU 0.45). The medical record note must include documentation about obesity counseling.

Documentation tips

Key words for your documentation should include: "obese", "underweight" or "BMI out of range". Consider using billing diagnoses and problem list entries, incorporating the patient's BMI range. Examples:

- BMI of 25.0 to 29.9 (E66.3)
- Overweight, pediatric, BMI 85-94.9 percentile (E66.3)
- BMI (Body Mass Index), pediatric, less than 5th percentile for age (Z68.51)

A follow-up plan should be documented and must be connected to the diagnosis in your documentation. Some examples that can be used in a follow-up plan include:

- Exercise or nutritional counseling
- Provision of weight management educational literature
- A referral to a nutritionist, dietician, physical therapist, exercise physiologist, bariatric center for surgery, mental health provider for behavioral changes. May also include a referral to an occupational therapist.
- Prescribing FDA approved weight-loss medication or dietary supplements
- Discussion of lifestyle changes, addressing barriers to changes and self-monitoring ■

Payment policy updates

New policies – effective November 1, 2016:

- ***Modifiers*** ■

Revised policies – effective November 1, 2016:

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

- ***Anesthesia*** – Added clarifying language regarding time units.
- ***Evaluation and Management*** – Updated the billing/coding guidelines section to clarify coverage of codes 99406-99407.
- ***Medical Supplies and Surgical Dressings*** – Updated codes in Appendix A. ■

Annual review

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

- ***Nurse Practitioner***
- ***Outpatient Drugs***
- ***Palliative Care Consultation***
- ***Physician Assistant***
- ***Physician Standby Services***
- ***Post-Operative Nasal Debridement***
- ***Preoperative Autologous Blood Donation*** ■

Connection is an online bimonthly publication for all Fallon Health ancillary and affiliated providers. The next copy deadline is **September 8** for our **November 2016** issue.

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