

Connection



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October 2019

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What's new

We want to hear from you!

Our annual Provider Satisfaction Survey is currently underway. It is important for us to hear what we are doing well and where we can improve. We use the results from these surveys to help direct administrative and operational improvements and strengthen our provider partnerships.

Participants are randomly selected and mailed or emailed the survey which is administered by SPH Analytics. 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 300 respondents to return their survey before November 1, 2019 will receive a \$15.00 Amazon gift card.

We value your input, and look forward to hearing your feedback! ■

New program for Medical Benefit Drug Management

Effective January 1, 2020, Fallon Health will transition to Magellan Rx Management for medical pharmacy benefit prior authorizations and post-service pre-payment claims edits. These include edits concerning eligible diagnoses, maximum dosage/units, duration and frequency.



Prior authorization requests can be submitted through Magellan’s electronic portal and in many cases will get an immediate response. Verbal and facsimile requests will also be accepted. Medical necessity coverage criteria, approved by both the Fallon Health Pharmacy and Therapeutics Committee and Magellan Rx’s National Pharmacy and Therapeutics Committee, will be available online.

In preparation for the new program, Magellan will hold a series of 30-minute webinars for providers. The schedule is as follows:

- Wednesday, December 11, 8 a.m.
- Wednesday, December 11, 12 noon
- Tuesday, December 17, 8 a.m.
- Tuesday, December 17, 12 noon
- Thursday, December 19, 8 a.m.
- Thursday, December 19, 12 noon

To register for a webinar, please email the following details **for each attendee** to MRxWebinar@MagellanHealth.com:

- Webinar date and time (Copy and paste one option from the dates and times above.)
- Physician name and/or name of group or hospital
- Tax ID number
- Practice address
- Email and phone contact information

Once you register, you’ll receive an email confirmation with instructions on accessing the webinar.

All program materials will be available on the Fallon website, including the formulary indicating which drugs require prior authorization. We will also post a recorded version of the webinar for you to watch at your convenience. Please contact your Provider Relations Representative with any questions. ■

Product spotlight

Relaunch of Fallon’s Medicare Advantage plans

Effective January 1, 2020, Fallon will be introducing new Medicare Advantage plans. Formerly called Fallon Senior Plan™, the new plans will be called Fallon Medicare Plus™ and Fallon Medicare Plus™ Central.

Fallon Medicare Plus will have a network of providers located across the state. Members can see any doctor and get care at any hospital or facility that is currently in the Fallon Senior Plan network, with the addition of Reliant Medical Group.

Fallon Medicare Plus Central is a limited network available only to residents of Worcester County. Providers in this network include:

- Reliant Medical Group
- Heywood Hospitals and providers
- St. Vincent Hospital
- Select Steward Health Care providers

At Fallon, we understand that Medicare can be confusing. That's why we simplified our plan options. Within both of our Medicare networks are three new plans—Orange, Green and Blue. These plans include medical coverage, Part D prescription drug coverage and rich benefits—like the Benefit Bank. The Benefit Bank is a card that can be used to pay for fitness memberships, dental care and/or eyewear. Members can use the card for one item or service, or a combination. Benefit Bank amounts vary by plan.

For more information, call your Provider Relations Representative or click:

[Fallon Medicare Plus](#)

[Fallon Medicare Plus Central](#) ■

Clinical Integration

Fallon Health's Clinical Integration Department has two programs that can be beneficial to the health of your patients: Disease Management and Complex Case Management.

Disease Management Program empowers your patients

The 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 and heart failure. The program 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, navigators and social care managers 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. ■

Quit to Win

Quit to Win provides free individual telephonic coaching to all Fallon members who wish to quit smoking. Our Quit to Win text message support program (free to all Fallon members) is more popular than ever! Call us at 1-508-368-9540 or 1-888-807-2908, or email quittowin@fallonhealth.org.

Did you know that Nicotine Replacement Therapy (NRT) generic products are free under the Affordable Care Act? Your patients will need a prescription from their primary care provider to receive free NRT from network pharmacies.

**Medicare Advantage beneficiaries are excluded. ■*

NaviCare® – Model of Care training

The main objective of our NaviCare product is to assist members in functioning at the safest level in the most appropriate setting, utilizing both Medicare and Medicaid covered benefits and services. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. NaviCare services every county in Massachusetts, with the exception of Nantucket and Dukes.

Every member has a customized plan of care developed by their Care Team. Benefits include, but are not limited to, in-home supportive services such as homemakers, the Personal Care Attendant (PCA) Program, Adult Day Health Care, Group Adult and Adult Foster Care.

Transportation to medical appointments is covered along with 90 round-trip supplemental rides to health-related services, such as the pharmacy, gym, support groups, family gatherings, church/places of worship and the grocery store—within a 30-mile radius of the member's home.

In 2020, transportation to medical appointments will be covered and the number of rides will be unlimited. Members will again receive the same types of supplemental rides. Supplemental transportation will be limited to 140 one-way trips per year, within a 30-mile radius of the member's home.

Requirements of the PCP and roles of the Care Team are outlined below. The navigator shares the member-centric care plan with the PCP, who provides input as needed. If you have a patient with NaviCare, you can communicate with the Care Team by calling 1-877-700-6996. Advantages of NaviCare that impact both members and providers include care coordination by the Care Team at the time of member care transition and the support we provide.

Navigator

- Educates patients about benefits and services
- Educates patients about, and obtains their approval for, their care plan
- Assists in developing patient's care plan
- Helps patients make medical appointments and access services
- Informs Care Team when patient has a care transition

Nurse Case Manager or Advanced Practitioner

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

Primary Care Provider

- 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
- Receives patient's care plan and provides input when needed

Geriatric Support Service Coordinator employed by local ASAP (if patient is living in own home)

- Evaluates need for services to help patients remain at home and coordinates those services
- Helps patients with MassHealth paperwork
- Connects patients with helpful resources

Behavioral Health Case Manager (as needed)

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

Facility liaison

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

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

Clinical pharmacist (as needed)

- Visits patients after care transition to perform a medication reconciliation and teaches them proper medication use ■



PCP referral change effective January 1, 2020

Effective January 1, 2020, PCP referrals for Medicare and NaviCare members only must be submitted to Fallon for referrals made outside of the PCP's provider group, also referred to as a Health Care Option (HCO).*

No changes are being made to the current referral processes for our Commercial members or Medicaid ACO members at this time.

PCP referrals can be submitted via our tool, ProAuth. ProAuth can also be used to submit prior authorization requests to the plan. You may request access to ProAuth prior to January 1, and may use it for prior authorizations immediately.

To request ProAuth, complete the [ProAuth enrollment form](#) and send it to askfchp@fallonhealth.org.

We will be reaching out to impacted providers prior to January 1. If you have not been contacted but wish to set up a training session, or if you have any questions about this change, please contact your Provider Relations Representative at 1-866-275-3247, prompt 4.

Please note: If a specialist claim is received from outside of the member's PCP provider group for a date of service post January 1, 2020, and a PCP referral was not submitted, **the claim will be denied.**

** Some specialties are exempt from this requirement. These include obstetrics and gynecology, routine eye exams, behavioral health and podiatry. Exempt specialties also include emergency and urgent care services. Physical, occupational and speech therapy (when not provided as part of home health services), as well as chiropractic services are also exempt, however a prescription is necessary. In addition, for Medicare members, kidney dialysis services outside of the area on a temporary basis, routine dental services, flu shots, pneumonia vaccinations, one supplemental routine eye exam and Medicare covered preventive services are exempt. For members in NaviCare SCO, routine women's health services, flu shots and pneumonia vaccinations are exempt. ■*

Provider Directory reminder

Please be advised that Fallon Health and Beacon Health Options, our partner in behavioral health, are obligated by state law to provide members with accurate Provider Directory information. Providers are required to notify Fallon and Beacon about any inaccurate information in the Provider Directories so that appropriate corrections may be made. Please check the directory regularly and [update](#) it when necessary. ■

CAQH DirectAssure

In the fourth quarter, we expect to begin implementing CAQH (Council for Affordable Quality Healthcare®) DirectAssure, initially with a small group of providers. DirectAssure works with the CAQH ProView® system to enable providers to submit professional and practice information and share it with multiple health plans, streamlining the data submission process. Once we begin using DirectAssure, it will be important that you respond to the emails and screen prompts from CAQH seeking validation of your practice data every 90 days.

In the meantime, please continue to cooperate with our staff during our outreach phone calls seeking to validate your information. We greatly appreciate your help in providing our members updated and accurate information about your practice. ■

Formularies and PA criteria reminder

Fallon Health formularies and prior authorization criteria are available on our [website](#). Prior authorizations can be submitted electronically on our website, via phone or via fax. ■

Home health agency services prior authorization change for NaviCare

Fallon will require prior authorization for home health agency services for NaviCare members beginning January 1, 2020.

In accordance with 130 CMS 403.00, a home health agency is defined as a public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c).

Home health services requiring prior authorization from the plan include:

- Nursing
- Home health aide
- Physical, occupational and speech/language therapy
- Medication administration

Please note, coordinating procedure codes will be required on claim submission as of January 1, 2020 in order to receive payment on a claim. If a provider does not include a procedure code after January 1, 2020, the claim will be denied and the provider will need to resubmit a corrected claim in order to obtain payment on authorized services. Please refer to 130 CMR 403.000, Subchapter 6 for a list of procedure codes. ■

Medical drugs payment policy and National Drug Code (NDC) billing update

Post-service pre-payment claims edits will be listed under our Drug and Biologicals Payment Policy on our website beginning October 1, 2019. This payment policy will also require that all providers for all lines of business submit an NDC, the quantity and a unit of measure with the claim. If an NDC is not submitted with the claim on or after January 1, 2020, the claim will be denied. This requirement will apply to unspecified codes including A9699, J3490, J3590, J7599, J7699, J7799, J7999, J8498, J8499, J8597, J8999, J9999 and C9399. Please note: this update is in addition to current NDC billing requirements for MassHealth and Navicare. ■

Medical benefit prior authorization changes

Effective November 1, 2019 for Commercial patients, and effective January 1, 2020 for Medicare patients, the following medical benefit drugs will require prior authorization: Abraxana, Akynzeo IV, Alimta, Aloxi, Avastin, Erbitux, Fulphila, Fusilev, Herceptin and Herceptin Hylecta, Khapzory, Margibo, Neulasta, Onivyde, Sustol, Udenyca, Evenity and Spravato.

Effective January 1, 2020, 85 medical benefit drugs will no longer require prior authorization. Please refer to our formulary on our website for these changes. An additional 47 medications will no longer require prior authorization, but will be subject to our payment policy. ■

Medical benefit biosimilar formulary changes

Fallon will be focusing on preferred biosimilar therapies when appropriate for your patients. Biosimilars currently approved by the FDA needed to demonstrate they are “highly similar” to the reference product, including producing the same clinical results as the reference products. They

also needed to show that the risk of alternating between the reference products and the biosimilar products is not greater than the risk of maintaining the patient on the reference products.

At this time, there are 24 FDA-approved biosimilar products, but only seven currently on the market: Inflectra, Renflexis, Zarxio, Nivestym, Retacrit, Udenyca and Fulphila. Three new oncology biosimilars coming to market soon are Mvasi, Kanjinti and Rituximab biosimilar.

Effective January 1, 2020, Fallon's preferred biosimilars will be Zarxio, Retacrit, Rituximab biosimilar, Mvasi, Kanjinti and Udenyca for your current patients new to therapy.

Inflectra will be the preferred therapy for all patients currently receiving Remicade and any patients new to therapy. Remicade coverage will require failure of both Inflectra and Renflexis. Medical criteria updates will be posted on the Fallon website. Product information on biosimilars can be found on the FDA [website](#). ■

Medicare adherence management

Patient non-adherence to drug therapy has been shown to be a major driver of unnecessary health care costs. It is estimated that non-adherence to medication therapy costs the American health care system more than \$100 billion annually, with some estimates as much as \$500 billion annually, factoring in both direct and indirect costs.

It is important to understand that non-adherence is multifactorial. Numerous barriers and challenges exist, such as patient indifference, culture, medication out-of-pocket costs, adverse effects (both real and perceived), personal beliefs, health literacy, polypharmacy, transportation, physical limitation and memory problems. Your patients may be impacted by several of these factors. It is important to personalize their care plan, as there is no one-size-fits-all strategy to improving medication adherence.

Fallon's Pharmacy Department continually evaluates tools to help reduce barriers for your patients to take their medications. Some discussion points you may want to have with your patients regarding our benefits include:

- 90-day supplies offered at retail pharmacies and CVS mail order for many traditional chronic medications
- For Fallon Medicare Plus™ (formerly Fallon Senior Plan™) members only:
 - 90-day mail order supplies discounted to the cost of two copayments rather than three
 - Reduced copayments at preferred network pharmacies
- Multi-dose packaging: Available through CVS as well as certain network pharmacies
- Home delivery of medications offered by many local pharmacies (Pharmacy may charge for this service.)
- Syncing multiple medications to be filled at once, reducing the amount of trips your patient takes to the pharmacy
- Electronic pill dispensers that provide visual and auditory cues for members to take their medications

Please instruct your patients to call Fallon's Customer Service Department at the number on the back of their member ID card, or speak with their pharmacy to take advantage of these offerings. ■

Primary care exclusivity not applicable to MassHealth Fee-For-Service (FFS), OneCare, SCO, or PACE members

Primary care providers who contract with ACOs may continue to provide services to MassHealth FFS, OneCare, SCO and PACE members regardless of their contracts with ACOs. Please see the [All Provider Bulletin 279](#) for more information. ■

Clinical Trials Payment Policy

The Clinical Trials Payment Policy has been revised, effective December 1, 2019. Effective for dates of service on or after December 1, 2019, claims must adhere to the following:

- **All claims for clinical trial-related services** must include the National Clinical Trials Identifier and diagnosis code Z00.6.
- **Inpatient and outpatient facility claims** must include condition code 30.
- **Professional claims and outpatient facility claims** must include modifiers Q1 and Q0 as appropriate.
- **Claims for services related to CMS-Approved Category A and B Investigative Device Exemption (IDE) studies** must include the IDE number assigned to the study by CMS.

Effective for dates of service on or after December 1, 2019, claims for clinical-trial related services with missing or invalid information will be returned as unable to process. ■

For ACO home health providers: Medication Administration Visits (MAV) codes

Our claims system has been adjusted and is now accepting Medication Administration Visits (MAV) codes T1502 and T1503. Effective August 14, 2019, providers may start submitting claims for these service codes.

These MAV codes require prior authorization. Previously denied claims due to “not a covered benefit” are being processed retroactively to March 1, 2018.

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

Commercial PPO Behavioral Health claims

Beginning January 1, 2020, both in-state and out-of- state Commercial PPO Behavioral Health claims should be submitted directly to Beacon Health Options. The address is:

Beacon Health Options
Claims Department
PO Box 1850
Hicksville, NY 11802-1850

You may sign up to submit electronically by emailing e-supportservices@beaconhealthoptions.com. ■

Quality focus

Medication reconciliation, post discharge

What a medication reconciliation measures: the percentage of patients 18 years and older who were discharged and had their medications reconciled within 30 days from the date of discharge from a hospital or skilled nursing facility. It is not a medication review. Rather, it reconciles the most recent outpatient medications list with the medications that were prescribed at discharge.

Who can conduct it: primary care physicians, nurse practitioners, physician assistants, registered nurses and clinical pharmacists.

Who is eligible: Medicare members who are discharged from an acute or non-acute facility. Every time patients are discharged, they are eligible.

Best practices:

- Schedule appointments with primary care teams within the first seven days of discharge, or as soon as you are aware of discharge.
- Review discharge instructions and medications with patients, and make sure they understand and are able to follow them.
- Reconcile patients' discharged medications to their outpatient medications.

How to close the gap in care: Once a medication reconciliation is complete, record it in one of these two ways:

1. On the claim encounter with one of the following CPT codes (No other documentation is required.):
 - **CPTII code - 1111F** Discharge medications reconciled with the current medication list in outpatient medical record
 - **Transition of care code - 99495** Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
 - **Transition of care code - 99496** Transitional care management services with high medical decision complexity (face-to-face visit within seven days of discharge)
2. In the medical record and include a dated progress note stating, "Hospital (or skilled nursing facility) discharge medications were reconciled with the current outpatient medications" and a signed and dated current medication list. ■

Cultural Competency

In 2017, Fallon created an internal council of 25 employees to help understand the growing diversity of our members, employees and providers. The Council for Cultural Competence seeks to establish a respectful environment within our organization, and to develop programs that will achieve and support this objective. Throughout the year, the Council holds events and offers virtual education sessions that help inform our employees about equity, diversity and inclusion within our business and community. Some examples of the topics that the Council as covered include:

- Delivering culturally competent care to the elderly
- Healthy ethnic cuisine in the workplace
- Transgender health services
- Healthcare for diverse populations

We also offer translation services for over 15 different languages to better serve the needs of our members; Spanish, Chinese, Vietnamese and many more languages are offered through this service. Several of our employees are multilingual as well. In the last year, 15 percent of our new hires have indicated they are multilingual. ■

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

Fallon's Clinical Quality Improvement Committee endorses and approves evidence based Clinical Practice Guidelines. Please visit [here](#) for guideline updates. For a paper copy, please contact Robin Byrne at 1-508-368-9103. ■

CMS star ratings

Striving for a 5-Star rating from CMS is among our quality benchmarks as an organization.

What is "Satisfaction" in the 5-Star measures?

Satisfaction measures our members' experience, with us and with their provider.

How is member satisfaction measured?

For the purpose of the CMS star ratings, member satisfaction is calculated by the results of the Consumer Assessment of Healthcare Providers or Systems (CAHPS). This is a 68-question survey focusing on the experience our members have as patients.

The survey is mailed every year in February to a random sampling of about 1,000 of our members who are selected by CMS. We at Fallon don't know who receives the survey. Typically, 30-40 percent of people who receive it complete it.

The survey is provided in English. It is also available in Spanish for those NaviCare members who may need it. Some of the questions indicate:

- How well the member feels they are treated by Fallon's Customer Service
- How quickly the member is able to get an appointment with his or her doctor
- How much a member pays for prescriptions
- How a member feels about their health coverage
- If a member feels they aren't receiving the care needed
- How easy it is to get a needed prescription drug

Some examples of questions in past surveys and how answers impact our rating:

Q: In the last six months, how often was it easy to get the care, tests, treatment you needed?

Answer choices: Never, Sometimes, Usually, Always

A "Usually" or "Always" answer positively impacts the rating, while a "Never" or "Sometimes" answer would not.

Q: In the last six months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?

Answer choices: Never, Sometimes, Usually, Always

A "Usually" or "Always" answer will positively impact the rating, while a "Never" or "Sometimes" answer would not.

Q: *Have you had a flu shot since July 1, 2017?*

Answer choices: Yes, No, Don't Know

A "Yes" answer would positively impact the rating, while a "No" or "Don't know" answer would not.

In what areas do we excel and where do we need help?

Historically, we have done well in the CAHPS survey, even though there are varying factors that make scores unpredictable from year to year.

Typically, we score well in these two areas:

- Overall Quality of Healthcare
- Customer Service

And, we tend to see lower scores in these areas:

- Getting Needed Care
- Rating of Health Plan

Because the CAHPS survey measures members' perception of us and of their health care, it takes creativity and forward-thinking to improve scores.

What impacts our score?

Historically, Fallon Health performs well in the CAHPS survey. But it's important to note that our score is also impacted by the overall health of our member population and how well other health plans perform in the survey. If all of our members provided the same survey responses for two years in a row, but a competitor got higher scores than the previous year, then our overall score would drop and the competitor's score would improve.

Using our CAHPS score

Even though there are a fair amount of unknowns in the scores, we have discovered that we can make some correlations between member experience and our scores.

For instance, if a member has low copays but is taking many prescriptions, he or she may feel that the cost of health care is too high, and we may get a bad score.

We take our CAHPS scores as feedback and based on them, have made changes to our services to improve our members' experience with us. Some of the changes we've made include:

- Lowering the cost of 90-day mail-order prescriptions for Medicare members
- Removing prior authorizations for many medical services
- Sending reminders to members about the care and coverage available to them as plan members
- Working with providers to give members more access to care ■

Compliance

Fraud, waste and abuse

At Fallon, we work hard to prevent and deter fraud, waste and abuse (FWA). FWA hurts everyone. In addition to higher premiums and increased out-of-pocket costs, FWA compromises health and safety, which can result in harm to patients, and undermines the public's confidence in the healthcare system.

Fallon is partnering with Cotiviti Inc. for a FWA solution effective January 1, 2020. Cotiviti is a leader in combating FWA. Cotiviti's integrated solution combines data analysis, decisions and insights with rules and algorithms to create a dynamic FWA solution.

We will continue to share updates as we get closer to 2020. ■

Coding corner

Medicare billing reminders

Duplicate diagnosis codes and diagnosis pointers:

CMS has recommended that providers stop billing the same ICD-10 Diagnosis codes and diagnosis code pointers referenced more than once a claim. According to General Coding Guidelines,

"12. Reporting Same Diagnosis Code More Than Once: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code."

In addition, according to the HIPPA Technical Report Version 3 Guide on 837 Professional claims, providers should bill distinct diagnosis pointers to differentiate among multiple diagnosis codes on a claim.

Claims that have diagnosis codes entered more than once or have the same pointers listed more than once (for example, 1, 1, or 2, 2) on a claim will be denied.

Highest level of specificity

Per Medicare Claims Processing Manual on 1500 claims, all physician and non-physician specialties must submit ICD-10-CM diagnosis codes to the highest level of specificity using the fourth, fifth and in some cases up to the seventh characters were applicable.

Codes with three characters are included as the heading of a category of codes that may be further subdivided by the use of the fourth to the seventh characters which provide greater detail. The Diagnosis codes are considered invalid if they have not been coded to the full number of characters required for the code.

Use of External Cause of Morbidity codes (V00 – Y99)

External Cause of Morbidity Diagnosis codes are used to identify the cause of injuries which is supplemental to the actual injury itself. Thus, External Cause of Morbidity codes are never to be recorded as a principal diagnosis (first-listed) or sole diagnosis code on a professional claim. If these diagnosis codes are billed as the first-listed or sole diagnosis code on a claim, the claim will deny.

For more information on official guidelines for coding and reporting please go to:

[cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf](https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf) ■

IMRT billing

The Office of the Inspector General recently audited Medicare Payer claims for Intensity Modulated Radiation Therapy (IMRT) for possible incorrect billing practices. In accordance with their findings, we would like to remind providers that CPT code 77301 (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) is considered a bundled code that includes multiple aspects of the IMRT planning and treatment. As such, the following codes should not be billed within the treatment time frame and will be denied when billed as being part of a bundled service: 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370. ■

Coding updates

Effective December 1, 2019, the following codes *will be set up as covered and will require plan prior authorization for Medicaid and Navicare*:

Code	Description
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (e.g., glioma), common variants (e.g., R132H, R132C)
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (e.g., glioma), common variants (e.g., R140W, R172M)
81508	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score

Effective July 1, 2019, the following codes *will be covered and will require plan prior authorization*:

Code	Description
C9047	Injection, caplacizumab-yhdp, 1 mg
C9048	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
C9049	Injection, tagraxofusp-erzs, 10 mcg
C9050	Injection, emapalumab-lzsg, 1 mg
C9051	Injection, omadacycline, 1 mg
C9052	Injection, ravulizumab-cwvz, 10 mg

Effective December 1, 2019, the following codes *will be covered and will require plan prior authorization*:

Code	Description
37760	Ligation of perforator veins, subfascial, radical (linton type), including skin graft, when performed, open,1 leg
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg

Effective December 1, 2019, the following codes *will deny vendor liable*:

Code	Description
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) ■

Payment policies

New policies – effective December 1, 2019:

- **Podiatry** ■

Revised policies – effective December 1, 2019:

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

- **Aging Service Access Points (ASAP)** – Updated reimbursement section and coding table.
- **Ambulatory Surgery (Professional)** – Clarified billing section.
- **Clinical Trials** – Added requirement to include National Clinical Trial (NCT) indicator to the claim. Clarified policy, definitions, reimbursement and billing sections.
- **Group Adult Foster Care** – Added language regarding room and board payment responsibility.
- **Home Health** – Updated policy for new MassHealth coverage, updated reimbursement section.
- **Member Liability** – Updated member financial liability waiver.
- **Modifiers** – Updated modifier tables.
- **Non-Covered Services** – Updated code list and financial liability waiver.
- **Personal Care Assistant** – Updated policy section, clarified definitions and reimbursement.
- **Physical and Occupational Therapy** – Updated coverage of codes 97545/97546.
- **Skilled Nursing Facility** – Added NaviCare Pre-admission screening requirements. ■

Annual review

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

- *Ambulatory Surgery (Facility)*
- *Autism*
- *Nurse Practitioner*
- *Observation Status*
- *Palliative Care Consultation*
- *Physician Assistant*
- *Sleep Management Services* ■

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

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