Connection

Important information for Fallon Health physicians and providers April 2021

Fallon Health Announces Predominant Focus on Medicare and Medicaid Programs

Today, Fallon Health announced it will focus predominantly on offering government-sponsored health insurance programs such as Medicare and Medicaid. Beginning April 1, 2021, our organization will shift away from most commercial products in order to focus on programs that serve older adults and lower-income individuals.

Continuing along a strategic path that is unique among independent health plans in Massachusetts, Fallon has set its sights on becoming the leading provider of government programs in the region. Consistent with our history and mission of *making our communities healthy*, this focus will leverage our brand, expertise and experience to provide integrated and coordinated care, coverage and services to high-needs individuals.

fallonhealth

In the April 2021 issue:

Products Fallon will focus on include Medicare Advantage, Senior Care Options (SCO) Program, MassHealth Accountable Care Organization (ACO) Partnership Plans, Program of All-Inclusive Care for the Elderly (PACE) and a limited number of products on the Massachusetts Health Connector, including ConnectorCare. Fallon also intends to develop new products to address the diverse, changing and unique needs of populations it currently serves and hopes to serve in the future.

Fallon has been committed to government-sponsored programs from its start in 1977. It was the first health plan in Massachusetts to cover Medicaid recipients (in 1979), one of the first health plans in America to have a Medicare risk product (in 1980), and the first health plan in the state to operate a Program of All-Inclusive Care for the Elderly (in 1995).

While this will be a change in the relationship between Fallon and our contracted providers and vendors, we are excited about the new opportunities this will afford us as we focus on the growth of our membership in government programs.

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

Covid-19 updates

COVID-19 vaccine update

People who live, work, or study in Massachusetts can preregister for a COVID-19 vaccine appointment at a mass vaccination location: Gillette Stadium, Reggie Lewis Center, Hynes Convention Center, DoubleTree Hotel-Danvers, Eastfield Mall-Springfield, Natick Mall, former Circuit City-Dartmouth. Currently, these Phase 1 and Phase 2 groups can get the vaccine:

1. Individuals age 60+
2. Individuals with 2+ certain medical conditions. Certain medical conditions are those conditions that may increase your risk of severe illness from the virus that causes COVID-19. Examples include cancer, COPD, heart conditions and obesity. For the full list of applicable conditions, please visit this *site*.
3. Health care workers
4. Long term care settings residents and staff
5. First responders
6. Congregate care settings residents and staff
7. Educators, child care workers and school staff
8. Low income and affordable senior housing residents and staff
9. Other workers, including:
    - Restaurant or café workers
    - Food, meatpacking, beverage, agriculture, consumer goods, retail, or food service workers
    - Grocery and convenience store workers
    - Food pantry workers or volunteers

- Medical supply chain workers
- Vaccine development workers
- Transit/transportation workers
- Public works, water, wastewater, or utility workers
- Sanitation workers
- Public health workers
- Court system worker (judges, prosecutors, defense attorneys, clerks), other than court officers who are listed under first responders
- Funeral directors and funeral workers

These Phase 2 and Phase 3 groups will be eligible next:

- Effective 4/5/21: Individuals age 55 and older
- Effective 4/5/21: Individuals with one certain medical condition
- Effective 4/19/21: Individuals age 16 and older

Your patients can visit *mass.gov/covid-19-vaccine* to find vaccination locations near them. Patients who are unable to register for an appointment online can also dial the Massachusetts COVID-19 vaccine hotline at 2-1-1, Monday through Friday from 8:30 a.m. to 5 p.m., and a representative can help schedule an appointment. ■

Billing for COVID-19 vaccines

For Fallon Medicare Care Plus, Fallon Medicare Care Plus Central, NaviCare SNP, and Summit ElderCare

- Providers should bill the appropriate CMS Medicare Administrative Contractor directly for the administration of the vaccine https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List
- CMS has provided this tool kit for assistance https://www.cms.gov/files/document/COVID-19-toolkit-issuers-MA-plans.pdf

For Fallon 365 Care, Berkshire Fallon Health Collaborative, Wellforce Care Plan, NaviCare SCO

- Providers should submit a claim to Fallon Health for the vaccine administration with an accompanying claim line for the vaccine with an SL modifier and a charge of $0.00

For Commercial members

- Providers should submit a claim to Fallon Health for the vaccine administration

  Administration CPT Codes*:
  - 0001A (IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 1ST Dose - Pfizer)
  - 0002A (IMM ADMN SARSCOV2 30MCG/0.3ML DIL RECON 2ND Dose - Pfizer)
  - 0011A (IMM ADMN SARSCOV2 100 MCG/0.5 ML 1ST Dose - Moderna)
  - 0012A (IMM ADMN SARSCOV2 100 MCG/0.5 ML 2ND Dose - Moderna)
  - 0031A (ADM SARSCOV2 VAC AD26 05ML – Janssen)

Vaccine CPT Codes*:

- 91300 (SARSCOV2 Vaccine DIL RECON 30 MCG/0.3 ML IM USE - Pfizer)
- 91301 (SARSCOV2 Vaccine 100 MCG/0.5 ML IM USE - Moderna)
- 91303 (SARSCOV2 VAC AD26 05ML IM – Janssen)

**Additional codes will become available as Emergency Use Authorization is granted* ■

Billing for COVID-19 tests

When billing for COVID-19 Testing, please use the most appropriate ICD-10 Codes. Testing must be medically necessary to be covered.

For contact with and (suspected) exposure to COVID-19 Use ICD 10 Diagnosis Code **Z20.822**

During the COVID-19 pandemic, a screening code generally is not appropriate, therefore Z11.52 should be used infrequently.

Effective June 1, 2021

For testing for asymptomatic patients prior to a planned outpatient procedure or inpatient admission, use ICD 10 Diagnosis Codes Z01.818 or Z01.812 as the primary diagnosis codes and Z20.822 as a secondary diagnosis

Covid-19 Test Claims billed using ICD-10 Diagnosis Code **Z11.59 will be denied for commercial plan members**. ■

What's new

Medicare Medication Therapy Management Program – MDLink™

Fallon Health, in partnership with our Medication Therapy Management (MTM) vendor, CSS Health, would like to remind you of a program to improve our Fallon Medicare Plus, Fallon Medicare Plus Central and NaviCare HMO members' engagement in the CMS Comprehensive Medication Review (CMR).

Program Overview

MDLink provides a referral coordination service that uses physicians' recommendations to engage patients in care activities.

To employ the MDLink program to engage patients in a Comprehensive Medication Review (CMR), CSS utilizes the automated functionality in its software to identify all members who have been identified as eligible for the MTM program, but who have not previously participated in a comprehensive medication review.

For each member identified, a physician recommendation is faxed to the primary prescriber. The recommendation includes these details:

- The patient's eligibility for a medication therapy management review due to meeting the CMS submission criteria

- A short description of the MTM review and its benefits
- A request for the prescriber to refer their patient to the plan's MTM program

Prescribers who do not respond to the program are re-faxed a referral request (monthly referrals).

Prescribers respond to referral requests by signing the referral and faxing it to the plan specific secure fax server. CSS coordinates referral requests by printing the prescriber's signed referral, attaching a cover letter, and mailing the referral to the patient.

CSS allows three (3) days for mail delivery and contacts the patient to discuss their physician's referral. If the patient can be engaged in a MTM interaction a CMR is completed and fulfilled as required by CMS. ■

MassHealth preferred diabetic testing supplies

Effective 1/1/2021, MassHealth added Diabetic Testing Supplies to the Partial Unified Formulary. The new preferred diabetic testing supplies for Fallon's ACO plans—Fallon 365 Care, Berkshire Fallon Health Collaborative and Wellforce Care Plan—are FreeStyle and Precision Xtra. Any member who has a prior authorization for a non-preferred product will be able to continue getting that product through their current prior authorization.

Please remind your patients that they can obtain a FreeStyle or Precision Xtra glucose meter at network pharmacies by providing the pharmacy with the following information:

RxBIN: 610020

Group #: 99992432

ID#: ERXMASSHEAL

Or by calling Abbott Diabetes Care at 1-866-224-8892 with Offer Code A35AB110.
FreeStyle can also be ordered by signing up at ChooseFreeStyle.com with Offer Code A35AB110.

Test strip quantities over 5 strips per day and other brand meters and test strips require prior authorization. ■

The new MyFallon member portal makes it easier for your patients to manage their Fallon plan

We've updated Fallon's secure member portal—MyFallon—to give your patients convenient, easy-to-use tools that will help them better manage their Fallon plan. Available 24 hours a day, 7 days a week on mobile or desktop, the new MyFallon gives members the ability to:

- See their copayment and/or coinsurance for common services
- Track deductibles and out-of-pocket maximums
- Check authorization status
- Log into many of Fallon's online tools with a single username and password

The new MyFallon also improves tools that were already available to your patients, including:

- Claims lookup
- Viewing benefit documents, claims statements and letters
- Temporary ID card/ordering ID card
- Changing PCP
- Changing address ■

Product spotlight

NaviCare® – Model of Care training

The main philosophy behind our NaviCare product is to assist our 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, except Nantucket and Dukes.

Every NaviCare member has a customized plan of care developed by their Care Team. The care plan contains details about the member's goals and the benefits that are part of their care plan. Benefits may 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. Each member's care plan is unique to meet their needs.

Additional NaviCare benefits that are available to all members include:

- Unlimited transportation to medical appointments
- 140 one-way trips per calendar year to places like the grocery store, gym, and to attend religious services within a 30-mile radius of the member's home. Transportation may be arranged 4 days in advance by calling our Transportation Vendor CTS at 1-833-824-9440. The member/caregiver can arrange transportation and Fallon's Navigators are also available to assist. **New in 2021:** Members' caregivers can qualify for mileage reimbursement for covered trips.
- Up to $400 per year in fitness reimbursements to a qualified fitness facility and/or health tracker and a free SilverSneakers™ gym membership.
- $480 per year on the Save Now card, to purchase certain health-related items like fish oil, contact lens solution, cold/allergy medications, probiotics, incontinence products and more.
- The ability to earn up to $100 annually with the Fallon Healthy Food program for completing healthy activities such as:
    - Welcome to Medicare/Annual physical or qualified wellness visits
    - Preventive vaccines such as annual flu vaccine, Tdap, pneumococcal vaccine and the Shingles vaccine

The Healthy Food Card can be used by members to purchase healthy food items at participating retailers, including: canned vegetables, beans, rice and pastas, fresh vegetables and fruits, frozen and fresh meat, fish and poultry,

NaviCare members have their own Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as a coordinated care plan to reference and other Care Team members to communicate with to have the best information possible for each NaviCare patient.

Care Team members and their roles include:

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

Primary Care Provider (PCP)

- 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 Aging Service Access Points (ASAPs) *(if patient is living in own home)*

- Evaluates need for services to help patients remain at home and coordinates those services
- Helps patients with 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 your patients through transition to older adulthood
- Helps connect patients with their Care Team and patients' mental health providers and substance-use counselors, if present

Clinical pharmacist *(as needed)*

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

PCPs are welcome to provide input to their patient's care plan at any time by contacting the NaviCare Enrollee Service Line at 1-877-700-6996 or by speaking directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you are interested in having a Navigator and/or Nurse Case Manager embedded in your practice, please contact us at the above phone number.

To refer a patient to NaviCare or learn more about eligibility criteria, contact us at the NaviCare Marketing Line at 1-877-255-7108. ■

NaviCare Model of Care Successes

The NaviCare Model of Care continues to be successful even during the COVID-19 pandemic and Fallon continues to work with our members to address the social determinants of health needs.

Members are receiving telephonic support from their Navigators and Care Teams, who are working collaboratively with the Aging Service Access Point Geriatric Support Service Coordinators and contracted providers including Long Term Care Facilities. Our team is providing in-home services to those in need by adhering to safety protocols, and members are accessing their plan benefits. ■

Doing business with us

Directory update

Fallon Health is committed to ensuring we have the most accurate information in our provider directories as we continue working with HealthCare Administrative Solutions, Inc. (HCAS) to add more and more Fallon network providers to DirectAssure® by CAQH.

CAQH is engaging providers to review and maintain up-to-date provider directory information via email. Your prompt attention to these emails, reviewing your information and attesting to the data, is of the utmost importance to ensure that your patients have access to accurate provider demographic information when care is needed.

For more information about DirectAssure, please visit *HCAS*. For questions specific to Fallon's implementation, please contact your provider relations representative or email *askfchp@fallonhealth.org*.

Encrypted Email

When Fallon sends an email to a provider that includes Protected Health Information, the email will be encrypted. Recipients will need either Outlook 2019 or Office 365 installed on their machine, or must use Outlook Web Access (OWA), to open these emails. If you are using OWA, your IT department will need to make sure security policies are not blocking Outlook from opening the OWA link, and that you have the ability to download attachments. ■

Be specific when coding claims

ICD-10 was officially implemented on October 1, 2015. One of the goals of moving to ICD-10 was to enable and encourage reporting diagnoses with a higher level of specificity. Fallon Health expects

claims to contain specific codes to support the clinical indication for the procedures or services being rendered. ICD-10 has provided so many new codes to increase specificity that reporting unspecified codes could raise red flags, cause reviews of your documentation and/or keep your claims from being reimbursed.

Codes that are "unspecified" or "NOS" (not otherwise specified) are assigned when information in the medical record is missing or the clinical information isn't sufficient to assign a more specific code. These codes signify that neither the diagnostic statement nor the documentation provides enough information to assign a more specific diagnosis code. For categories without unspecified codes, the "other specified" code may represent both "other" and unspecified. These should be used in limited circumstances. However, when a procedure code is billed with a NOS ICD-10 code, it may not provide enough information on the claim to support the indication for a procedure. Each encounter's diagnoses should be coded to the level of certainty known for that encounter.

"Unspecified" codes have acceptable and necessary uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition(s), there are instances when either signs/symptoms or unspecified codes are the best choices for accurately depicting the patient's diagnoses during the encounter. If a definitive diagnosis has not been established, then the symptoms and signs that are present could be reported. A symptom code may be appropriate when a more definitive diagnosis is not documented, especially in situations where diagnostic tests, such as labs and radiologic studies, are needed to make a definitive diagnosis.

Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter. The type of encounter, (initial, subsequent, or sequelae, designated by the characters "A," "D," and "S" respectively), should also be included when applicable. Many ICD-10 codes require a fourth, fifth, sixth, or seventh character in order to be valid. Many of these characters can be found in the tabular list. A code is invalid if it doesn't include the full number of characters required. A three-character code is used only if the category is not further subdivided into four-, five-, six-, or seven-character codes. Always check for applicable seventh characters for that category.

A placeholder character ("X") is used as part of an alphanumeric code to allow for future expansion and as a placeholder for empty characters in a code that requires a seventh character but has no fourth, fifth, or sixth character. Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query the provider for clarification. Borderline conditions are not the same as uncertain diagnoses. Assign the code that most completely describes the condition that existed at the time of the visit so long as it affect patient care, treatment, and management. Review the tabular instructional notations in the ICD-10-CM book to determine the highest level of specificity for a given code. They will also indicate if additional codes are required. If laterality applies, include it, whether it is a fifth or sixth digit in an ICD-10 code. If an ICD-10 code is followed by a dash (-) and an additional character icon, then more characters are required. If laterality applies and no bilateral code is provided, then assign separate codes for both the left and right side. It is essential that laterality be coded when it applies to a diagnosis.

For an injury, the specific cause of the injury may be available in the record. The external cause would be reported as a secondary diagnosis with the injury code sequenced first. Most codes in Chapter

20 require a 7th character to identify the type of encounter. Again, the specificity must be consistent and the 7th character assigned to the external cause code should match the 7th character of the code assigned for the associated injury or condition for the encounter. We should also code to the greatest level of specificity when it comes to CPT procedure codes. An "unlisted" CPT code should only be reported if a specific code for that procedure does not exist. Fallon requires prior authorization for any unlisted CPT code utilized. It is also important to apply laterality if it is applicable. It is important to query the provider to capture the highest level of specificity initially and ensure the documentation supports the final codes reported with the appropriate and accurate code assignment.

The ICD-10-CM code set greatly expands the number of codes available in order to capture specificity and granularity. Using unspecified codes should be a last option. ■

Important reminders

Health Outcomes Survey (HOS) and telehealth wellness visits

HOS surveys are sent to a random sample of members each year to evaluate physical and mental health status and other health-related topics, and all managed care organizations with Medicare contracts participate. Primary Care Physician (PCP) interactions with patients during scheduled wellness visits have a direct impact on the rating of HOS measures and outcomes.

The goal of the Medicare HOS is to gather valid, reliable, and clinically meaningful health status data from the Medicare Advantage (MA) program to use in star ratings, quality improvement activities, program oversight, public reporting, and to improve health.

Telehealth and HOS

As a result of the COVID-19 pandemic, telehealth has played a much larger role in how patients receive care. While a bit different than a traditional in-person setting, performing wellness visits via telehealth allows care teams to proactively engage patients, help them avoid risky health behaviors, and identify and meet care needs before they become acute enough to require the patient to access an in-person healthcare setting, such as urgent care or the emergency department

During telehealth appointments—whenever possible—Fallon believes that it is important for providers to find ways to incorporate and address the relevant HOS survey topics on the Provider Tip Sheet, which will positively impact quality scores and ultimately improve patient outcomes.

Provider Tip Sheet	
Measures	**Recommendations**
Improving or maintaining physical health: Percentage of patients whose physical health was the same or better than expected after two years.	• Routinely assess patients' pain and functional status using standardized tools. • Provide interventions to improve physical health, such as disease management, pain management and referrals to physical therapy or case management, as indicated. • Practice self-management support strategies, including goal setting, action planning, problem solving, and follow-up to help patients take an active role in improving their health.

Improving or maintaining mental health: Percentage of patients whose mental health was the same or better than expected after two years.	• Routinely assess whether emotional problems (depression, anxiety, addiction) negatively affect your patient's daily or social activities. • Refer patients to behavioral health services or manage depression treatment as indicated. • Refer patients to web-based programs that provide a range of evidence-based mental health self-care resources. • Integrate motivational interviewing to improve treatment engagement and mental and physical health outcomes.
Monitoring physical activity: Percentage of patients who discussed exercise with their doctor or other healthcare provider and were advised to start, increase or maintain their physical activity within the year.	• Routinely assess patient's current physical activity level. • Discuss health benefits and advise patients to start, maintain or increase physical activity as appropriate for their individual health status. • Develop physical activity plans with patients that match their abilities • Encourage participation in fitness and exercise programs as appropriate. Gym membership may be a benefit of their health plan or encourage use of local community resources. • Refer patients with limited mobility to physical therapy to learn safe and effective exercises.
Reducing risk of falling: Percentage of patients with falls, walking or balance problems who discussed these topics with their providers and received treatment within the year.	• Routinely assess fall risks by asking patients about falls, gait and balance problems and document discussion for patients. • Provide fall prevention interventions, such as promoting regular exercise and strengthening and balance activities (tai chi, yoga), performing regular medication review to evaluate for medications that increase fall risk, promoting regular eye exams, and providing educational materials about fall prevention. • Promote home safety, such as recommending removal of throw rugs and clutter to reduce tripping, installing handrails on stairways and grab bars in the bathrooms, use of non-slip mats in the tub or shower, use of nightlights to keep halls and bathrooms well lit, and keeping frequently used items within easy reach.
Improving bladder control: Percentage of patients with urinary incontinence who discussed the problem and treatment options with their healthcare providers.	• Routinely assess problems with urinary incontinence (UI) in the last six months and document discussion for patients. • Evaluate the severity of the condition, the impact of UI on patient's quality of life, and involve them in decisions about treatment options for behavioral (such as bladder training and pelvic muscle rehabilitation), pharmacological and surgical therapies. ■

Fully-insured health plan coverage of 12-month supply of contraceptives

Please be advised, Massachusetts law permits individuals with fully-insured commercial health plan coverage to fill a 12-month supply of prescription contraceptives.

Coverage under Chapter 120 of the Acts of 2017, An Act Relative to Advancing Contraceptive Coverage and Economic Security in Our State, provides that coverage shall be required for:

> *"Prescription contraceptives intended to last (A) for not more than a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (B) for not more than a 12-month period for any subsequent dispensing of the same*

prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in a plan or policy under this chapter at the time the prescription contraceptive was first dispensed: provided, however, that the insured may not fill more than one 12-month prescription in a single dispensing per plan year."

If your patients have any questions, please have them contact Fallon Health. ■

NaviCare provider directory updates

All contracted NaviCare providers should continue to notify Fallon Health of all changes with specialties, special skills, languages spoken and completion of cultural competence training. As with all changes, updates will be completed timely and accurately for displaying in the directory or website. ■

Quality focus

Clinical practice guideline update

Our Clinical Practice Guidelines are available *here*.

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

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

- Asthma Care Quick Reference: Diagnosing and Managing Asthma
- National Heart Lung, and Blood Institute (NHLBI) National Asthma Education and Prevention Program Expert Panel Report (EPR-3)
- Global Initiative for Chronic Obstructive Pulmonary Disease (GOLD) 2020 Global Strategy for Prevention, Diagnosis and Management of COPD
- Heart Failure Guideline-2017 ACCF/AHA Guideline for the Management of Heart Failure
- High Cholesterol-ACC/AHA Updated Cholesterol Guidelines-2018
- High Blood Pressure-2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JNC 8)
- Massachusetts Health Quality Partners 2021 Pediatric and Adult Preventive Care Guidelines
- Centers for Disease Control and Prevention Recommended Child and Adolescent Immunization Schedule for ages 18 years and younger
- Centers for Disease Control and Prevention Recommended Child and Adult Immunization Schedule
- Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain-United States, 2016
- 2021 Standards of Medical Care in Diabetes ■

Helping providers discover non-adherence in their patients

Over 50% of diabetes patients do not tell their provider that they are not taking their medications.[1] A large majority don't even fill the prescriptions that are handed to them. With the advent of ePrescribing, providers send the prescription directly to the pharmacy, but this still doesn't mean it gets picked up by the patient. Often it takes a catastrophic event and hospitalization before the prescriber becomes aware of a problem.

How can providers improve adherence?

The first step is to identify potentially non-adherent patients. This is not as easy as it seems and there are various "checklists" and some simple tools to identify those patients that are least likely to take their medications as prescribed.

Many resources are available to educate providers and staff. A couple of resources found easily online include:

- **"Table 1: Suggested Checklist for Identifying Patients at High Risk for Medication Non-adherence",** from the journal, Clinical Diabetes which can be used to identify barriers for patients with non-adherence related to socio-demographic problems or other patient specific factors.
- **Another resource** which has been validated for providers is from Merck and Company, Inc.[2]
- **The Adherence Estimator®** is a fast and simple patient survey which stratifies patients into 3 categories, commitment, concern, or cost. This adherence tool only takes a couple of minutes. The patient's likelihood to be adherent is scored and this provides insight into why a patient may be or become non-adherent. This tool is available by request from Merck and Co, Inc. online, from a company representative or though their provider services portal. Other indicators that may identify potentially non-adherent patients include:
  - Patients that fail to show up to regularly scheduled appointments.
  - Patients that fail to show improvement in objective data despite adjustments in their medications.
  - Patients that fail to use up all of their refills or request refills after the previous script should be used up.
  - Pharmacy Fill history is incomplete, irregular, or inconsistent showing potential gaps where medications have not been refilled.

Ask open-ended questions to start the dialog, but keep adherence as the focal point of the discussion.

There are numerous reasons for non-adherence. The first step is to acknowledge that the problem of non-adherence is common and under recognized by health care providers. Prescribers should evaluate patients during each visit to try and identify possible barriers for the patient that do not take their medications as prescribed. Solutions should be tailored to meet the patient's individual needs. ■

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1 ncbi.nlm.nih.gov/pmc/articles/PMC5510928
Bussell JK, Cha E, Grant YE, Schwartz DD, Young LA. Ways Health Care Providers Can Promote Better Medication Adherence. Clin Diabetes. 2017;35(3):171-177. doi:10.2337/cd016-0029]

2 merckconnect.com

Coding corner

Telehealth preventive care and Modifier 95

Telehealth preventive care during the PHE

It is no surprise that in the last year routine preventive visits were often deferred by patients. Fallon Health, together with our providers, has been actively encouraging them to seek these services once again.

Preventive visits (99381- 99387, 99391-99387, G0438, G0439, G0420) are critical to ensuring the health and well-being of patients. During the COVID-19 State of Emergency, Fallon Health has been reimbursing plan providers for a preventive visit delivered via telehealth when a preventive visit is clinically appropriate for the member (i.e., the physical examination can be deferred) and the member has consented to the telehealth visit. Additional services such as developmental screening (CPT 96110), behavioral/emotional assessments (CPT 96127) and administration of patient/caregiver health risk assessments (CPT 96160, 96161) may be reported—in addition to a Preventive Medicine Service.

All telemedicine (telehealth) services require the same documentation as would be required if the service was provided in-person. When an Evaluation & Management (E/M) service is billed, documentation in the medical record must support the level of E/M billed. In addition, for all telemedicine (telehealth) services, providers must document whether the service was provided via telephone or live video, the location of the provider at the time the service was provided (distant site) and the location of the member at the time the service was provided (originating site). Medical records may be requested to ensure appropriate documentation of services rendered and accuracy of coding.

Documentation must include a plan for follow-up for any components of the preventive visit deferred due to telehealth. Claims for Preventive Medicine Services and any additional services reported in addition to the Preventive Medicine Service delivered via telehealth, must be submitted with Place of Service 02.

For those preventive visits delivered via telehealth, there are components of a Preventive Medicine Service that cannot be completed via telehealth. These components should be completed as soon as possible.

When a Preventive Medicine Service has been delivered via telehealth and reimbursed by Fallon Health:

- For MassHealth ACO (Fallon 365 Care, Berkshire Fallon Health Collaborative and Wellforce Care Plan), NaviCare and Summit ElderCare members: Fallon Health will reimburse one in-person follow-up Evaluation & Management (E/M) Service to complete the components of the Preventive Medicine Service not performed on the day of the Preventive Medicine Service. The follow-up E/M Service can be billed with CPT code 99211, 99212 or 99213, depending on the complexity of the visit. Additional services, such as immunization administration and visual acuity screening, that are separately reimbursed with a Preventive Medicine Service, may be reported with the E/M Service.

- For commercial and Medicare Advantage plan members: Fallon Health will not reimburse an additional Preventive Medicine Service or E/M Service to complete the components of the Preventive Medicine Service that were not performed via telehealth. Additional services, such as immunization administration and visual acuity screening, that are separately reimbursed with a Preventive Medicine Service, will be separately reimbursed.
- The Plan does not reimburse Medicare HCPCS codes G0438, G0439 or G0402 when billed on the same date of service as an annual preventive medicine code due to the overlap in service inclusion in these codes.

Modifier 95

In the last year, provider offices have quickly developed the capacity to render telehealth services, particularly synchronized audio and video. Modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system) is used, in addition to POS 2, to report this type of telehealth visit.

Modifier 95 may be appended per Appendix P of the Current Procedural Terminology (CPT®) Manual.

Appendix P codes for 2021 include:

90791-792, 90832-838, 90845-847, 90863, 90951-961, 92227-228, 93228-229, 93268, 93270-272, 96040, 96116, 97802-804, 98960-962, 99202-205, 99212-215, 99231-233, 99241-245, 99251-255, 99307-310, 99354-355, 99406-409, 99417, 99495-496.

These codes are identified in CPT 2021 with the symbol.

This additional claims data assists the plan in identifying provider offices who have developed this capacity and can be used in the formulation of post-PHE policies.

The complete Telemedicine policy may be accessed here: *http://www.fchp.org/providers/criteria-policies-guidelines/payment-policies.aspx*

Coding updates

Effective January 1, 2021, the following codes *will require plan prior authorization:*

Code	Description
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis

Code	Description
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis
81278	IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10
81347	SF3B1 (splicing factor [3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)
81348	SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, P95H, P95L)
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant
81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, S34F, S34Y, Q157R, Q157P)
81360	ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2
81513	Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis
81514	Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)

Code	Description
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])
82077	Alcohol (ethanol); any specimen except urine and breath, immunoassay (eg, IA, EIA, ELISA, RIA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation

Effective January 1, 2021, the following code will be *deny vendor liable excluding: All Medicare HMO-PSP/NAVICARE/PACE/FHW PACE:*

Code	Description
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Effective January 1, 2021, the following codes will *deny vendor liable for all lines of business:*

Code	Description
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed
0621T	Trabeculostomy ab interno by laser
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
0623T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report
0624T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography
0626T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)

Code	Description
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed
76145	Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report

The following codes are **effective February 9, 2021:**

Code	Description
M0245	Intravenous infusion,bamlanivimab and etesevimab, includes infusion and post administration monitoring—will be set up as deny vendor liable excluding: Commercial and Medicaid (which means we will only pay for Comm and MH) with NO PA and no costshare
Q0245	Injection, bamlanivimab and etesevimab, 2100mg—will be set up as deny vendor liable for all lines of business.

Effective March 1, 2021, the following code will be *deny vendor liable for all lines of business:*

Code	Description
91303	SARSCOV2 VAC AD26 .5 ML IM

Effective March 1, 2021, the following code will be *deny vendor liable excluding Commercial and Medicaid:*

Code	Description
0031A	ADM SARSCOV2 VAC AD26 .5 ML

Effective April 1, 2021, the following codes *will require plan prior authorization:*

Code	Description
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue

0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens
0247U	Obstetrics (preterm birth), insulin-like growth factor-binding protein 4 (IBP4), sex hormone-binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth

Effective April 1, 2021, the following codes *will not be a covered benefit for all lines of business:*

Code	Description
G2020	Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the sip component of the pcf model (do not bill with chronic care management codes)
G2172	All inclusive payment for services related to highly coordinated and integrated opioid use disorder (oud) treatment services furnished for the demonstration project

Effective April 1, 2021, the following codes *will require plan prior authorization:*

Code	Description
C9776	Intraoperative near-infrared fluorescence imaging of major extra-hepatic bile duct(s) (e.g., cystic duct, common bile duct and common hepatic duct) with intravenous administration of indocyanine green (icg) (list separately in addition to code for primary procedure)
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition to code for primary procedure)
K1015	Foot, adductus positioning device, adjustable
K1016	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve
K1017	Monthly supplies for use of device coded at k1016
K1018	External upper limb tremor stimulator of the peripheral nerves of the wrist
K1019	Monthly supplies for use of device coded at k1018
K1020	Non-invasive vagus nerve stimulator Stent, non-coronary, temporary, with delivery system (propel)

Effective April 15, 2021, the following medical benefit drugs *will be added to the formulary and require prior authorization.* Correct NDCs and unspecified HCPCS codes *must be submitted for billing and authorization.* When a specified HCPCS code is available for the drug, it can be submitted with NDC instead for billing and authorization.

Unspecified HCPCS code(s)	NDC(s)	Brand name
J3490	71336-1002-01	Oxlumo
J9999	73042-0201-01	Danyelza
J9999	74527-0022-02 74527-0022-03	Margenza
J3590	55513-0224-01 55513-0326-01	Riabni

Effective June 1, 2021, the following code is not covered for commercial and Medicare Advantage plans. Claims will deny vendor liable.

Code	Description
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation

Effective July 1, 2021, the following code *will be removed* from the Fallon Health auxiliary fee schedule and the Fallon Health Weinberg auxiliary fee schedule because the code is no longer active as of 2/31/2020.

Code	Description
D7960	Frenulectomy

Effective July 1, 2021, the following codes *will be added* to the Fallon Health auxiliary fee scheduled and the Fallon Health Weinberg auxiliary fee schedule with the following rates.

Code	Description	Rate
D7961	Buccal/labial frenectomy (frenulectomy)	$212.00
D7962	Lingual frenectomy (frenulectomy)	$212.00 ■

Payment policies

Revised policies – effective June 1, 2021:

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

- **Drugs and Biologicals** – Added information about NDC-HCPCS validation for MassHealth ACO and NaviCare members; clarified billing requirements for 340B drugs.
- **Clinical Trials** – Corrected definition of an approved clinical trial.

- **Vision Services** – Updated diagnosis codes for routine eye exams; clarified medical vs. routine eye exam billing; added information about billing for presbyopia-correcting and astigmatism-correcting intraocular lenses.
- **Obstetrics and Gynecology** – Clarified reimbursement for E & M services billed with global delivery; clarified reimbursement for contraceptive implants. ■

Annual Review

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

- **Timely Filing**
- **Palliative Care Consults**
- **Coding Analysis** ■

Medicaid ACOs, NaviCare and Summit ElderCare: NDC and HCPCS match requirement for physician-administered drugs

Beginning 07/01/2021, all National Drug Codes (NDCs) submitted on physician-administered drugs must match the Healthcare Common Procedure System (HCPCS) being billed for and include accurate NDC information (unit of measure and quantity). This requirement applies to all provider claims paid for individual drugs that can be identified using Level II HCPCS with dates of service on or after 07/01/2021.

As of 7/1/2021, applicable ACO and NaviCare claims will be denied if submitted without a valid NDC and if the NDC does not match the HCPCS code. The following scenarios are excluded from this requirement:

- Inpatient claims
- Any claims with Dates of service prior to 07/01/2020
- BEACON (Behavioral Health Claims)
- ASHN – Chiropractic Services
- EyeMed ASO routine eye exam claims
- Radiopharmaceuticals
- Contrast media
- Vaccines/immunizations
- Devices
- Summit ElderCare and Fallon Health Weinberg PACE claims

Additionally,

- For MassHealth ACO, NaviCare SCO and **PACE Medicaid-only and Private Pay** plan members, outpatient hospitals billing for physician-administered drugs are required to report modifier UD on the same claim line as the drug HCPCS code to identify a 340B-acquired drug.
- For NaviCare HMO SNP and **PACE Dual and Medicare-only** plan members, outpatient hospitals billing for physician-administered drugs are required to report modifier JG or TB, as appropriate, on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. ■

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

Send information to:

Provider Relations
Fallon Health
10 Chestnut St.
Worcester, MA 01608

or

Email your Provider Relations representative

Richard Burke
President and CEO

Dr. Carolyn Langer
Senior Vice President and Chief Medical Officer

Susan Keser
Vice President, Network Development and Management

Kathy Bien
Director, Provider Relations

fallonhealth.org/providers

Questions?

1-866-275-3247

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