CONNECTION

Important information for Fallon Health physicians and providers

March 2016

In this issue

Let's connect

Ensuring a safe transition of care for NaviCare members

Transitions of care occur when patients move from one care setting to another or from one care team to another. These are particularly dangerous times for patients, especially those who are elderly, functionally impaired, or have a significant chronic disease burden. This is a good description of the NaviCare population. NaviCare is a voluntary program in association with MassHealth/EOHHS and CMS. About 67 percent of NaviCare members are nursing home eligible, living in the community, and another 15-18 percent are in long-term care.

At Fallon Health, we are taking a proactive approach toward ensuring that care transitions for our NaviCare members are as safe as possible. Partnering with care teams in hospitals, skilled nursing facilities, community care agencies, and primary care providers, our Nurse Case Managers and Navigators are focusing on this important work.

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We actively track our members when they are admitted to acute care hospitals or skilled nursing facilities, follow their course, and then complete a structured transition of care assessment when our members return home from another care setting. Our Nurse Case Managers and Navigators ensure appropriate follow-up for medical care by confirming appointments and arranging for transportation when needed. Our Nurse Case Managers assess changes in medication, adherence to changes, differences in functional status, need for different in-home services, changes in support systems and goals of care. They communicate concerns to primary care providers. All of these elements are crucial to making the care transition as safe as possible.

Our goal is to complete the transition of care assessment for all members discharged to their home from a hospital or skilled nursing facility, and reconcile medications as part of that assessment. We are tracking our progress, and achieving greater than 90 percent rates of completion. Our objectives are to reduce the rate and risk of readmission, meet our members' changing complex care needs, and help them stay as healthy as possible. ■

Teach patients how to manage their asthma

Asthma affects more than 22 million individuals in the United States. Asthma care involves regular follow-up to maintain control. Achieving and maintaining asthma control requires appropriate medication, addressing environmental factors, helping patients learn self-management skills, and monitoring to assess control and adjust therapy.

The Massachusetts Asthma Action Partnership's mission is to reduce asthma health disparities and improve the quality of life for all people with asthma. Click below to see the **Strategic Plan for Asthma in Massachusetts 2015–2020.** Scroll down to "Downloadables" and click your choice of document.

massclearinghouse.ehs.state.ma.us/ASTHMA/AS931.html. ■

Obesity screening and counseling

More than 78 million adults and 12 million children and adolescents in the United States are obese. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death.

Body mass index (BMI) is a useful tool in assessing overweight problems. Screen for obesity at least annually using the CDC's growth and BMI charts as a guide at cdc.gov/healthyweight/assessing/bmi/index.html.

You can use the BMI Calculators. The Adult BMI Calculator is for your patients who are age 20 and over. ■

Improve opportunities to identify and treat chlamydia

Each year in the United States, there are more than one million new chlamydia infections. Most chlamydia infections are found in female adolescents and young women.

There are many factors that contribute to the high number of infections. Most women infected with chlamydia do not experience symptoms, which minimizes the chances they will seek care. Therefore, it's important

to annually test all young women under age 25 who are sexually active and women over age 25 if they are at increased risk for chlamydial infection.

Consider urine-based screening for women when a pelvic examination is not performed. The Massachusetts Health Quality Partners (MHQP) preventive screening recommendations for chlamydia can be found at fallonhealth.org/providers/medical-management/health-care-guidelines. ■

Quality focus

Clinical Practice Guideline update

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

- 2016 Massachusetts Health Quality Partners Adult Preventive Care Guidelines
- 2016 Massachusetts Health Quality Partners Pediatric Preventive Care Guidelines
- 2016 Massachusetts Health Quality Partners Perinatal Care Guidelines

These guidelines were developed by a collaborative group of Massachusetts healthcare organizations. Our Clinical Practice Guidelines are available at fallonhealth.org/providers/medical-management/health-care-guidelines. For a paper copy, please contact Robin Byrne at 1-508-368-9103. ■

Doing business with us

New address for claims submissions

Effective January 1, 2016, Fallon Health has a new P.O. Box for all paper claim submissions, adjustments, and appeals for all lines of business, including, but not limited to, Commercial, PPO, NaviCare, Fallon Senior Plan and non-contracted chiropractors. (Note: PPO no longer has a separate address.)

The old P.O. Box will remain active during the transition period, which will end April 1, 2016. However, we encourage providers to start using the new address now in order to avoid delays in claim processing. Member ID cards will be updated with the new claims address as members' policies renew. The only change for providers is the new P.O. Box. The fax numbers are the same.

The new P.O. Box is:

Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908

When shipping paper claims that *are not deliverable* to a P.O. Box (via FedEx/overnight/air, etc.), please send to the following street address:

Fallon Health Claims
Smart Data Solutions*
2401 Pilot Knob Road, Suite 140
Mendota Heights, MN 55120

**Smart Data Solutions (SDS) is Fallon Health's vendor for paper claims. SDS keys the claims into an electronic claims file (HIPAA 837) for processing at Fallon Health.* ■

Provider documentation basics

The purpose of complete and accurate patient record documentation is to foster quality and continuity of care of a patient. It creates a means of communication between providers and health plans about the health status, treatment, planning, and delivery of care of the patient. Accuracy and specificity is key in documentation.

Here are some helpful tips for building a good foundation to documentation.

- Avoid coding from a superbill. A superbill does not allow providers to see all diagnosis options that are available. It is generally a limited and generic list and lacks a lot of specified codes.
- Do not code from a problem list. Problems should be brought forward and listed as active problems. Avoid copy and paste. This may create errors in documentation.
- Try not to use unspecified codes. This is important with ICD-10 implementation.
- Make sure to code any condition that the providers are monitoring, evaluating, assessing or treating. Don't just code the primary reason for which the patient is being seen.
- Be sure to code for signs and symptoms for which the patient is being seen at the time of the visit even if no definitive diagnosis has been determined.
- Make sure to assess and document chronic conditions annually. This is a requirement for Medicare and Medicaid services in risk adjustment. Commonly under-coded chronic conditions are COPD, chronic heart failure and angina pectoris.
- Never code a "history of" as current. The condition must be active, meet the M.E.A.T criteria (monitored, evaluated, assessed, or treated) and may not have resolved. Cancer and stroke are common documentation mistakes.
- Don't make assumptions when documenting manifestations and complications. Document the causal relationship which links the cause to the manifestation. This will provide a clear connection. Diabetes is a diagnosis that is frequently lacking linkage in documentation. ■

Update to genetic testing prior authorization requests

Effective May 1, 2016, all requests for genetic testing must come directly from the ordering provider. These requests must include all recent clinical information such as the most recent physical examination, lab work and any other support. Failure to provide this information will result in a denial of the request. ■

Coding Corner

Cost-sharing removed from colonoscopy pathology services

In accordance with the clarification issued by the Department of Labor regarding compliance with the Affordable Care Act, Fallon Health has removed cost-sharing from pathology services associated with routine screening colonoscopies **effective January 1, 2016.** In order to allow these claims to process properly, the pathologist should bill this service under CPT code 88305. In addition, a corresponding ICD-10 code from the following list must accompany the billing of 88305:

D12.0	Benign neoplasm of cecum
D12.1	Benign neoplasm of appendix
D12.2	Benign neoplasm of ascending colon
D12.3	Benign neoplasm of transverse colon
D12.4	Benign neoplasm of descending colon
D12.5	Benign neoplasm of sigmoid colon
D12.6	Benign neoplasm of colon, unspecified
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
K62.0	Anal polyp
K62.1	Rectal polyp
K63.5	Polyp of colon
Z12.11	Encounter for screening for malignant neoplasm of colon

Failure to submit a claim with the proper CPT and ICD-10 combination may result in cost-sharing for the member. This change only applies to routine screening colonoscopies. Cost-sharing may still apply to any other pathology performed related to other colonoscopies. ■

New DVL codes

Effective January 1, 2016 the following codes *are considered denied vendor liable for all lines of business:*

Code	Description
0396T	Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure.)
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure.)
0398T	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder, including stereotactic navigation and frame placement when performed
0399T	Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics) (List separately in addition to code for primary procedure.)
0400T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions
0401T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; six or more lesions
0402T	Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
0403T	Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
0405T	Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time
0406T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant
0407T	Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only

Code	Description
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiac contractility modulation system
0419T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromata
0420T	Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromata
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (Vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed.)
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
0423T	Secretory type II phospholipase A2 (sPLA2-IIA)
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only

Code	Description
0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only
0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study

Effective January 1, 2016 the following HCPCS codes *are considered denied vendor liable for all lines of business:*

Code	Description
G9673	Intend to report the cardiovascular prevention measures group
G9674	Patients with clinical ascvd diagnosis
G9675	Patients who have ever had a fasting or direct laboratory result of ldl-c = 190 mg/dl
G9676	Patients aged 40 to 75 years at the beginning of the measurement period with type 1 or type 2 diabetes and with an ldl-c result of 70-189 mg/dl recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period
G9677	All quality actions for the applicable measures in the cardiovascular prevention measures group have been performed for this patient. ■

New codes requiring prior authorization

Effective January 1, 2016 the following CPT codes *require plan prior authorization:*

Code	Description
54438	Replantation, penis, complete amputation including urethral repair
81162	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (e.g., acute myeloid leukemia), gene analysis, full gene sequence
81219	CALR (calreticulin) (e.g., myeloproliferative disorders), gene analysis, common variants in exon 9
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (e.g., exons 8, 11, 13, 17, 18)
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., mastocytosis), gene analysis, D816 variant(s)
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis; additional variant(s) (e.g., codon 61, codon 146)
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (e.g., colorectal carcinoma), gene analysis, variants in exon 2 (e.g., codons 12 and 13) and exon 3 (e.g., codon 61)
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (e.g., gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (e.g., exons 12, 18)
81412	Ashkenazi Jewish associated disorders (e.g., Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 14 genes, including ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11, and TP53
81433	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11
81434	Hereditary retinal disorders (e.g., retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A

Code	Description
81437	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL
81438	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL
81442	Noonan spectrum disorders (e.g., Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure.)
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (e.g., benign or suspicious)
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score

Code	Description
74712	Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
74713	Magnetic resonance (e.g., proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure.)

Effective January 1, 2016, the following dental codes *are covered and require plan prior authorization:*

Code	Description
D0521	Extraoral posterior image
D1354	Interim caries med app
D4283	Auto tissue graft addl tooth
D4285	Non-auto graft addl tooth
D5221	Immed max part denture resin
D5222	Immed man part denture resin
D5223	Immed max part dent metal
D5224	Immed mand part dent metal
D7881	Occ orthotic device adjust
D8681	Removable retainer adjust
D9223	General anesthesia each 15m
D9243	IV sedation each 15m

Effective January 1, 2016 the following HCPCS codes *are covered and require plan prior authorization:*

Code	Description
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
C2645	Brachytherapy planar source, palladium-103, per square millimeter

Code	Description
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each
G0297*	Low dose ct scan (ldct) for lung cancer screening
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
J0202	Injection, alemtuzumab, 1 mg
J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immuneglobulin
J1833	Injection, isavuconazonium, 1 mg
J2407	Injection, oritavancin, 10 mg
J2502	Injection, pasireotide long acting, 1 mg
J2547	Injection, peramivir, 1 mg
J2860	Injection, siltuximab, 10 mg
J3090	Injection, tedizolid phosphate, 1 mg
J3380	Injection, vedolizumab, 1 mg
J7188	Injection, factor viii (antihemophilic factor, recombinant), (obizur), per iu
J7205	Injection, factor viii fc fusion protein (recombinant), per iu
J7313	Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension
J7999	Compounded drug, not otherwise classified
J8655	Netupitant 300 mg and palonosetron 0.5 mg

Code	Description
J9032	Injection, belinostat, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9271	Injection, pembrolizumab, 1 mg
J9299	Injection, nivolumab, 1 mg
J9308	Injection, ramucirumab, 5 mg
Q4161	Bio-connekt wound matrix, per square centimeter
Q4162	Amniopro flow, bioskin flow, biorenew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc
Q4163	Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter
Q4164	Helicoll, per square centimeter
Q4165	Keramatrix, per square centimeter
Q9980	Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg

**Per CMS2015 Retroactive Code. This code was previously expired by CMS, but was published in the CMS 2016 Alpha-Numeric HCPCS file as a reused code with a retroactive effective date of 2/5/2015. The effective date in KnowledgeSource will be listed as 2/5/2015. Therefore, this code will not show up as a new code for 1/1/2016 when searching in KnowledgeSource.*

Effective January 1, 2016 the following codes *are considered experimental and investigational and will require plan prior authorization:*

Code	Description
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
0395T	High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed

Effective May 1, 2016 the following code *will be covered with plan prior authorization:*

Code	Description
31513	Injection into vocal cord ■

Codes not covered

Effective January 1, 2016 the following dental codes *are not covered:*

Code	Description
D9932	Clean and inspect rem dent max
D9933	Clean and inspect rem dent man
D9934	Clean rem part denture max
D9935	Clean rem part denture mand
D9943	Occlusal guard adjustment

Effective January 1, 2016 the following code *is not covered:*

Code	Description
90625	Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use ■

Codes not separately reimbursed

Effective May 1, 2016 the following codes *will no longer be separately reimbursed:*

Code	Description
15850	Removal of sutures under anesthesia (other than local), same surgeon
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure.)
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure.)
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure.)
36000	Introduction of needle or intracatheter, vein
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

Code	Description
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
92352	Fitting of spectacle prosthesis for aphakia; monofocal
92353	Fitting of spectacle prosthesis for aphakia; multifocal
92354	Fitting of spectacle mounted low vision aid; single element system
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus test
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus test
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure.)
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure.)
92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure.)
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure.)
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure.)

Code	Description
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure.)
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure.)
93740	Temperature gradient studies
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan
94150	Vital capacity, total (separate procedure)
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
97010	Application of a modality to one or more areas; hot or cold packs
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99053	Service(s) provided between 10 p.m. and 8 a.m. at 24-hour facility, in addition to basic service

Code	Description
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
99071	Educational supplies, such as books, tapes and pamphlets, for the patient's education at cost to physician or other qualified health care professional
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable), educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
99090	Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable), requiring a minimum of 30 minutes of time
99288	Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plan
99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plan
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy
99364	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Code	Description
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, 15-29 min.
99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment, 15-29 min.
99379	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment, 15-29 min.
99380	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment, 30+ min.
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
99485	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

Code	Description
99486	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure.)
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
99489	Complex chronic care coordination services; each additional 30 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.)
A4212	Noncoring needle or stylet w/wo catheter
A4262	Temporary absorbable lacrimal duct implant, each
A4263	Perm long-term nondissolvable lacrimal duct implant, each
A4265	Paraffin, per pound
A4300	Implantable access catheter external access
A4301	Implantable access total catheter port/reservoir
A4305	Disposable drug deliv system flow rate 50 ml/> per hour
A4306	Disposable drug deliv system flow rate <50 ml per hour
A4310	Insertion tray w/o drain bag and w/o catheter
A4311	Insertion tray w/o drain bag w/catheter 2-way latex
A4312	Insertion tray w/o drain bag w/catheter 2-way silicone
A4313	Insertion tray w/o drain bag w/catheter 3-way continuous irrigation
A4314	Insertion tray w/drain bag w/catheter 2-way latex w/coating
A4315	Insertion tray w/drain bag w/catheter 2-way all silicone
A4322	Irrigation syringe bulb or piston, each
A4326	Male external catheter w/integral collection chamber any type, each
A4327	Fe external urinary collection device; metal cup, each
A4328	Fe external urinary collection device; pouch, each

Code	Description
A4330	Perianal fecal collection pouch w/adhesive, each
A4335	Incontinence supply; miscellaneous
A4338	Indwelling catheter; foley type two-way latex w/coating, each
A4340	Indwelling catheter; specialty type, each
A4344	Indwelling catheter; foley type two-way all silicone, each
A4346	Indwelling catheter; foley type 3-way continuous irrigation, each
A4351	Intermittent urinary catheter; straight tip w/wo coating, each
A4352	Intermittent urinary catheter; coude tip, each
A4354	Insertion tray w/drain bag but without catheter
A4355	Irrigation tubing continuous bladder irrigation 3-way catheter, each
A4356	External urethral clamp/compression device, each
A4357	Bedside drain bag day/night w/wo anti-reflux device, each
A4358	Urinary leg bag; vinyl w/wo tube, each
A4361	Ostomy faceplate, each
A4362	Skin barrier; solid four or equivalent, each
A4364	Adhesive liquid or equal any type per ounce
A4367	Ostomy belt, each
A4397	Irrigation supply; sleeve, each
A4398	Ostomy irrigation supply; bag, each
A4399	Ostomy irrigation supply; cone/catheter, with or without brush
A4402	Lubricant per ounce
A4404	Ostomy ring, each
A4455	Adhesive remover or solvent per ounce
A4465	Nonelastic binder for extremity
A4470	Gravlee jet washer

Code	Description
A4480	Vabra aspirator
A4557	Lead wires per pair
A4649	Surgical supply; miscellaneous
A5051	Ostomy pouch closed; with barrier attached, each
A5052	Ostomy pouch closed; without barrier attached, each
A5053	Ostomy pouch closed; for use on faceplate, each
A5054	Ostomy pouch closed; use barrier w/flange, each
A5055	Stoma cap
A5061	Ostomy pouch drainable; w/barrier attached, each
A5062	Ostomy pouch drainable; without barrier attch, each
A5063	Ostomy pouch drainable; use barrier w/flange, each
A5071	Ostomy pouch urinary; with barrier attached, each
A5072	Ostomy pouch urinary; without barrier attached, each
A5073	Ostomy pouch urinary; use barrier w/flange, each
A5081	Continent device; plug for continent stoma
A5082	Continent device; catheter for continent stoma
A5093	Ostomy accessory; convex insert
A5102	Bedside drain bottle w/wo tubing rigid/expandable, each
A5105	Urinary suspensory with leg bag w/wo tube, each
A5112	Urinary drainage bag, leg or abdomen, latex, w/wo tube, with straps, each
A5113	Leg strap; latex replacement only per set
A5114	Leg strap; foam/fabric replacement only per set
A5121	Skin barrier; solid 6 x 6 or equivalent, each
A5122	Skin barrier; solid 8 x 8 or equivalent, each
A5126	Adhesive or non-adhesive; disk or foam pad

Code	Description
A5131	Applinc clnr incont and ostomy applincs per 16 oz.
A6154	Wound pouch, each
A6196	Alginate/other fiber gelling dressing wound pad 16 sq/<, each
A6197	Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. inch but less than or equal to 48 sq. inch, each dressing
A6198	Alginate/other fiber gelling dressing wound pad > 48 sq., each
A6199	Alginate/other fiber gelling dressing wound fil-6 in.
A6203	Composite dressing pad size 16 sq./less w/adhesive border, each
A6204	Composite dressing, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6205	Composite dress pad size > 48 sq. w/adhesive border, each
A6206	Contact layer 16 sq. in. or less, each dressing
A6207	Contact layer > 16 sq. but </equal 48 sq., each dressing
A6208	Contact layer more than 48 sq. in., each dressing
A6209	Foam dressing pad size 16 sq./< w/o adhesive border, each
A6210	Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6211	Foam dressing pad size > 48 sq. w/o adhesive border, each
A6212	Foam dressing pad size 16 sq./less w/adhesive border, each
A6213	Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6214	Foam dressing pad size > 48 sq. w/adhesive border, each
A6215	Foam dressing wound filler per gram
A6216	Gauze, nonimpregnated, nonsterile 16 sq./< w/o adhesive, each
A6217	Gauze, nonimpregnated, nonsterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6218	Gauze, nonimpregnated, nonsterile > 48 sq. w/o adhesive, each
A6219	Gauze, nonimpregnated, 16 sq./less w/adhesive border, each

Code	Description
A6220	Gauze, nonimpregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6221	Gauze nonimpregnated > 48 sq. w/adhesive border, each
A6222	Gauze impregnated not h2o nl saline/hydrogel 16 sq./<
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6224	Gauze, impregnated not h2o nl saline/hydrogel > 48 sq.
A6234	Hydrocolloid dressing 16 sq./less w/o adhesive border, each
A6235	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6236	Hydrocolloid dressing > 48 sq. w/o adhesive border, each
A6237	Hydrocolloid dressing 16 sq./less w/adhesive border, each
A6238	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6239	Hydrocolloid dressing > 48 sq. w/adhesive border, each
A6240	Hydrocolloid dressing wound filler paste-fl ounce
A6241	Hydrocolloid dressing wound filler dry form-gm
A6242	Hydrogel dressing pad size 16 sq./< w/o adhesive border, each
A6243	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6244	Hydrogel dressing pad size > 48 sq. w/o adhesive border, each
A6245	Hydrogel dressing pad size 16 sq./< w/adhesive border, each
A6246	Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6247	Hydrogel dressing pad size > 48 sq. w/adhesive border, each
A6248	Hydrogel dressing, wound filler, gel, per fl oz.
A6251	Specialty absorptive dress 16 sq./< w/o adhesive border, each
A6252	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing

Code	Description
A6253	Specialty absorptive dressing > 48 sq. w/o adhesive border, each
A6254	Specialty absorptive dressing 16 sq./< w/adhesive border, each
A6255	Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6256	Specialty absorptive dress > 48 sq. w/adhesive border, each
A6257	Transparent film 16 sq. in. or less, each dressing
A6258	Transparent film > 16 sq. but </equal 48 sq., each dressing
A6259	Transparent film > 48 sq. in., each dressing
A6261	Wound filler, gel/paste, per fl oz., not otherwise specified
A6262	Wound filler, dry form, per gram, not otherwise specified
A6266	Gauze impregnated not H2O saline/zinc paste linr yd
A6402	Gauze, nonimpregnated, sterile, 16 sq./< w/o adhesive border
A6403	Gauze, nonimpregnated, sterile, pad size more than 16 sq. in., less than or equal to 48 sq. in., without adhesive border, each dressing
A6404	Gauze, nonimpregnated, sterile, > 48 sq. without adhesive border
Q3031	Collagen skin test
R0076	Transportation of portable EKG to facility/location per pt
V2520	Contact lens hydrophilic spherical per lens ■

Payment policy updates

Payment policies this issue

Revised policies– effective May 1, 2016

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

- ***Ambulatory Surgery – Professional–*** Added POS 19
- ***Clinical Trials–*** Updated "qualified clinical trial" definition to include life-threatening conditions or diseases
- ***Fraud, Waste, & Abuse–*** Updated Definitions section
- ***Gastroenterology–*** Updated Billing/coding guidelines section to reflect removal of cost-share from pathology services associated with routine screening colonoscopies
- ***Laboratory and Pathology–*** Updated Reimbursement and Billing/coding guidelines to reflect removal of cost-share from pathology services associated with routine screening colonoscopies and to replace deleted laboratory codes
- ***Medical Supplies–*** Updated Appendix A to indicate need for modifier with code A5120
- ***Neonatal Intensive Care Services–*** Replaced deleted codes
- ***Non-Covered Services–*** Updated the table at the end of the policy
- ***Provider Audit–*** Updated Policy section
- ***Transportation–*** Extended the period of time providers have to verify coverage and obtain prior authorization for non-emergency services to three weeks (15 business days)
- ***Vaccine–*** Updated Definition section and Addendums A and B

Annual review

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

- ***Adult Day Health***
- ***Adult Foster Care***
- ***Aging Service Access Points (ASAP)***
- ***Ambulatory Surgery – Facility***
- ***Assistant Surgeon***
- ***Autism***
- ***Cardiology***
- ***Claims Auditing Software***
- ***Code Review***
- ***Coding Analysis*** ■

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