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Important information for Fallon Health physicians and providers

April 2019

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What's new

Provider Satisfaction Survey

Thank you to all who took the time to provide valuable feedback in our recent Provider Relations Survey. We received helpful insights into what is working well and areas that could use improvement. You will be hearing more from us as we analyze the results.

All respondents were entered into a drawing for three iPad Minis. The winners are:

Michael Nancollas, M.D.
at Berkshire Hand to Shoulder Center, LLC

Natalia Yurovetsky, M.D.
at Hallmark Health Medical Associates

Linda Teasdale
at the Hurowitz Medical Group

We welcome your feedback at any time. Please email ASKFCHP@fallonhealth.org or contact your Provider Relations Representative. ■

Fallon partners with Vital Decisions

Fallon recognizes that many people who are having a serious health issue have a hard time sorting out what kind of health care they want and expressing their wishes to loved ones. We have partnered with Vital Decisions, a company that specializes in helping people who have serious health problems, become more effective communicators and advocates for themselves. Through the Living Well Program, Vital Decisions Specialists are trained and experienced in listening

and coaching to help patients clarify their goals and communicate what's important to them to their family and caregivers. Fallon is offering these services to NaviCare® and Fallon Senior Plan™ members. The services are free.

If your patient opts into the program, a Vital Decisions Specialist will call him or her to see how they're doing. The two will set up a schedule for future calls—usually about three to five—to discuss your patient's wishes and formalize an advanced care plan. The specialists will also work with caregivers if that is preferred.

Vital Decisions Specialists do not provide medical advice of any kind or have access to your patients' medical records. The only medical information they get is from your patient or their caregiver, as long as the caregiver has provided Fallon with the proper personal representative authorization (PRA) documentation (PRA form, health care proxy or verbal permission over the phone).

If you have any questions about the program, contact your Provider Relations Representative. ■

Introducing new plan designs as of April 1

Effective April 1, 2019, upon anniversary, Fallon Health will be introducing four new Direct Care and Select Care plan designs to the commercial merged market. Fallon Health's new plan designs offer additional deductibles levels to choose from: Deductible 2500 Low, Deductible 3000 Low, Deductible 4000 Low and Deductible 5000 Low. Please contact your Provider Relations Representative for additional details or questions. ■

New Group Insurance Commission (GIC) tiers

Effective July 1, 2019, the tiers in the GIC Direct Care and Select Care commercial products are changing. These Administrative Services Only (ASO) products are created by the GIC and administered by Fallon Health. Providers are identified in three tiers with copayments of $30, $60 and $75 accordingly.

Patients who utilize the services of an ambulatory service center, rather than an outpatient department, for eye and GI procedures, will pay a copayment of $150 rather than $250. All other outpatient surgery services, regardless of place or service, are subject to the $250 copayment. Deductibles may apply. To learn more about the GIC tiering methodology, please click *here*. To obtain a provider specific tier, please go *here*. ■

NaviCare® – Model of Care training

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

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

Transportation to medical appointments is covered, along with 90 round-trip supplemental rides to health-related services, such as the pharmacy, gym or support groups, within a 30-mile radius of the member's home.

Requirements of the Primary Care Provider and roles of the Care Team are outlined below. The member centric care plan is sent to the Primary Care Provider by the Navigator, and feedback is welcome. Providers can communicate with the Care Team by calling 1-877-700-6996. Advantages for members and providers include care coordination by the Care Team at the time of member care transition and the support we provide.

Navigator

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

Nurse case manager or Advanced Practitioner

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

Primary Care Provider

- Provides overall clinical direction
- Provides primary medical services including acute and preventive care
- Orders prescriptions, supplies, equipment and home services
- Documents and complies with advance directives about the patient's wishes for future treatment and health care decisions
- Receives patient's care plan and provides input when needed

Geriatric support service coordinator employed by local Aging Service Access Points (ASAP) (if patient is living in own home)

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

Behavioral health case manager (as needed)

- Identifies and coordinates services to support patients' emotional health and well-being
- Supports 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

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

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

Clinical pharmacist (as needed)

- Visits patients after care transitions to perform a medication reconciliation and teach them proper medication use ■

Smoking cessation

Do you have patients who would like to quit using tobacco products? The Quit to Win (QTW) program at Fallon can help by providing support in conjunction with the smoking cessation medications that you might prescribe.

The QTW program utilizes teaching materials modeled after the tobacco cessation program at the Center for Tobacco Treatment Research & Training Center, UMass Medical School. During these sessions, motivational interviewing techniques, along with an individualized quit plan, are used to guide your patient through the quitting process.

The program consists of approximately eight weekly telephonic coaching sessions, facilitated by a professional quit coach. Text message support is also available.

Please refer members by calling 1-888-807-2908, email QuitToWin@fallonhealth.org or fax 1-508-798-8394. ■

Important changes regarding claims with Zelis™ edits

Please note, contrary to what we reported in our January 2019 article, medical records will not be required for corrected claims submitted to Zelis over $100.00.

As a reminder, Fallon Health began using an integrated claims editing tool offered by Zelis in 2018 to further evaluate claims for adherence to industry-recognized edits and guidelines, and to ensure compliance with payment policies and standard coding practices.

Beginning March 1, 2019, providers will find a message on the Remittance Advice Summary (RAS) and the Electronic Remittance Advice (835 file) indicating an edit was applied by Zelis.

- Questions related to an edit should be directed to Zelis at 1-866-489-9444.
- Zelis corrected claims and/or appeals should be sent to Zelis at the following address:

  Zelis Claims Integrity, Inc.
  2 Crossroads Drive
  Bedminster, NJ 07921
  Attn: Appeals Department
  Fax: 1-855-787-2677

Zelis appeals require:

- A completed *Request for Claim Review Form* explaining the reason for the dispute, including contact information and a fax number
- A copy of the original claim billed
- A copy of the RAS including the denial
- All pertinent medical records and or reports necessary for reconsideration of the claim

Zelis corrected claims require:

- A completed request for claim review form
- A new claim
- Must be sent within 120 days of the original RAS.
- Cannot be sent electronically. ■

Serious Reportable Event reporting reminder

Massachusetts requires hospitals and ambulatory surgery centers to report Serious Reportable Events (SRE) which are defined as incidents involving death or serious harm to a patient resulting from a lapse or error.

These events must be reported to the Massachusetts Department of Public Health (DPH), the patient/family and the insurer within seven days of the incident with a follow-up report within 30 days.
To comply with these requirements, please forward the seven and 30 day report as follows:

- Secure emails can be sent to kathleen.bien@fallonhealth.org and jessica.scafidi@fallonhealth.org
- Faxes can be sent to the attention of Kathy Bien/Jessica Scafidi at 1-508-368-9902.

If there are any questions regarding this process, please reach out to your provider relations representative. ■

New Medicare opioid edits and programs for 2019

There are several new opioid safety edits and programs that have been introduced for the 2019 Medicare Part D plan year. This will impact all Fallon Medicare members: Senior Plan™, NaviCare, Summit ElderCare® PACE, and Fallon Health Weinberg–PACE. These programs went into effect on January 1, 2019.

The criteria used to identify members potentially at risk or for the point of sale pharmacy edits are not intended as prescribing limits. They are used to identify members that may be at risk for opioid overuse. The edits are not a substitute for your professional judgment and do not mean that you cannot prescribe over these limits. You need to attest that the identified medications and doses are intended and medically necessary for the member.

Please be aware that network pharmacies, Fallon Pharmacy Department, our Medication Therapy Management Program (MTMP) vendor (Clinical Support Services (CSS)), and/or our Opioid Drug Management vendor and Pharmacy Benefit Manager (PBM) (CVS Caremark, Enhanced Safety and Monitoring Solutions) may reach out to you for your assistance in resolving these safety edits and opioid management cases.

Please assist us in meeting the expectation that prescribers respond to pharmacy outreach related to opioid safety alerts in a timely manner, including educating their on-call staff. Some of these issues can be completed directly with the retail pharmacy by attesting that the medications and doses are intended and medically necessary for the member.

If you need to submit a coverage determination or an exception request, please call 1-866-239-4707 or Fax 1-855-633-7673.

Below is a summary of the new programs:

Point of Sale (POS) Opioid safety edits

CMS requires certain prospective safety edits beginning in 2019. These edits will occur when the member is filling the prescription at the pharmacy. These edits require resolution. The pharmacist may override some of the edits with appropriate codes, may need to consult with the provider, and may need to inform the provider that a prior authorization is required. Since these are safety edits, they will still apply during a member's transition period, meaning, the claims will still reject with the edits and require resolution.

Buprenorphine for medication-assisted treatment (MAT) is not included in the safety edits. Hospice/ palliative care, active cancer-related pain, and long-term care (LTC) members are excluded from the safety edits. Members have coverage determination and appeal rights under this program.

The edits that we will be utilizing include:

- Soft edit for concurrent opioid and benzodiazepine use – pharmacy can override
- Soft edit for duplicative long-acting (LA) opioid therapy – pharmacy can override
- Care coordination edit at 90 morphine milligram equivalents (MME) and 4 prescribers – pharmacy can override only after consultation with the prescriber, documentation of the discussion, and if the prescriber confirms intent (the opioids and/or day supply is intended and medically necessary for the member), using an override code that indicates the prescriber has been consulted.
- Hard edit for a seven-day supply limit for initial opioid fills (opioid naïve) with a 90-day look-back. This will require a prior authorization be submitted. Provider needs to attest that the opioids and/or day supply is intended and medically necessary for the member. Member is considered opioid naïve if there are no opioid claims in the past 90 days.

Medication Therapy Management Program (MTMP) (Not applicable to Summit ElderCare® PACE and Fallon Health Weinberg PACE)

We are also including special eligibility criteria in our MTMP. In addition to traditional MTMP eligibility, members are eligible if they have high opioid usage, defined as:

- Opioid pharmacy claims equal to or greater than 90 MME
- Three or more opioid prescribers and three or more opioid dispensing pharmacies

Comprehensive Addiction and Recovery Act of 2016 (CARA) – Drug Management Program

This is a new comprehensive opioid management program required under the Comprehensive Addiction and Recovery Act of 2016 (CARA). This is a retrospective drug utilization review (DUR) program to identify members at risk for frequently abused drugs and conduct case management. Frequently abused drugs are defined by CMS as opioids and benzodiazepines. Buprenorphine for medication-assisted treatment (MAT) is not included in the 90 MME accumulations.

The program excludes members with active cancer pain, palliative/hospice care, and in LTC. Dual/Low Income Subsidy (LIS) members are limited in ability to change plans to avoid intervention once identified as at-risk.

Criteria for identification into the program includes any of the below:

- Members with opioid pharmacy claims equal to or greater than 90 MME and three or more opioid prescribers and three or more opioid dispensing pharmacies
- Members with opioid pharmacy claims equal to or greater than 90 MME and five or more opioid prescribers
- Members with any MME level and seven or more opioid prescribers or seven or more opioid dispensing pharmacies
- Additional potentiator drugs – beneficiaries receiving gabapentinoids and benzodiazepines

The program includes case management and clinical outreach to providers to determine if the member is at risk for opioid overutilization, notifications to the member, potential lock-in restrictions to specific provider(s), pharmacy(ies), and/or to certain drugs. Members have coverage determination and appeal rights under this program. ■

Validating your practice information

Changes happen in your practice, and we want your patients to have access to the most current information in our *Provider Directory* and "Find a doctor" tool. Please use the tool on our website to update your practice information. It's quick and easy. Just go to the Find a doctor page, check out your information, then fill out the online form on the new Update your practice information page. Please be sure to hit the submit button at the bottom. Updates will be made within 30 days if there are no questions about the information you have provided.

Changes to the following can be made via the tool or through the Standardized Provider Information Change Form:

- Your ability to accept new patients
- Street address
- Phone number
- Specialty
- Hospital affiliations
- Panel status
- Languages spoken by you or your staff
- Product participation (Subject to the terms of your contract)
- Any other change that impacts your availability to patients

In addition to receiving your updates via our online tool or other means of notification, you will receive a call from one of our representatives periodically to ensure your information is correct. This verification aligns Fallon Health with requirements that have been set forth by the Centers for Medicare & Medicaid Services (CMS), the Massachusetts Division of Insurance (DOI) and the National Committee for Quality Assurance (NCQA)*. The regulations are designed to ensure health care consumers have current and accurate provider demographic information. If you have any questions, please contact your Provider Relations Representative.

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

5-Star rating from CMS

Striving for a 5-Star rating from CMS is among our quality benchmarks as an organization. We want you to know why getting a 5-Star rating from CMS is important.

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

Satisfaction measures our members' experience, or how happy our member is with us. The experiences measured include interactions between the member and Fallon, and the member and his or her providers.

How is member satisfaction measured?

For the purpose of the CMS 5-Star rating, member satisfaction is calculated by the results of the Consumer Assessment of Healthcare Providers or Systems (CAHPS). This is a 68-question survey focusing on the experience our members have as patients.

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

The survey is provided in both English and Spanish. Some of the questions indicate:

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

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

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

Typically, we score well in these two areas:

- Overall Quality of Healthcare
- Customer Service

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

- Getting Needed Care
- Rating of Health Plan

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

What do our CAHPS scores look like?

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

Using our CAHPS score

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

For instance, if a member is asked if he or she is offered preventive screenings by the doctor, and he or she responds negatively, we may get a lower score. Or if a member has low copayments, but is taking many prescriptions, he or she may feel that the cost of health care is too high and again we may get a bad score.

We take those scores as feedback and have, at times, made changes to our services to improve our members' experience with us.

What are we doing to improve our satisfaction score?

Our CAHPS scores are reviewed and analyzed every year so that we can look at ways to improve the member experience. Some things that we have done recently as a result of information gathered in the CAHPS survey include:

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

High-risk medication use in older adults

The NaviCare Clinical Team is working to lower the risk of adverse drug reactions by reducing the use of commonly prescribed high-risk medications for our NaviCare members. Adverse drug reactions due to polypharmacy and the use of high-risk medications are responsible for significant morbidity and mortality in older adults. We expect the results of this effort to be safer, more effective prescribing, leading to healthier outcomes.

NaviCare Nurse Case Managers will review pharmacy claims for repeat fills of targeted high-risk medications listed in Beers Criteria for potentially inappropriate medication use in older adults. These include zolpidem, amitriptyline, cyclobenzaprine, glyburide, meclizine, methocarbamol and paroxetine.

Nurse Case Managers will then educate members about the appropriate use of the high-risk medication(s), potential side effects, and possible alternative treatment options, providing them with educational materials they can bring to their primary care providers for discussion. The discussion that follows should help the member and their provider engage in shared decision making to determine if continuing a high-risk medication, prescribing a lower dose, an alternative medication, or discontinuing a medication may be the best course of action. ■

Osteoporosis management in older women

Our Health Promotions Department, in conjunction with a contracted vendor, Magellan Rx Management, is conducting provider outreach and doing in-home bone mineral density (BMD) screenings for identified female NaviCare and Fallon Senior Plan members between the ages of 67 and 85, and who have had a bone fracture within the past six months. BMD testing within six months for older individuals who have had a fracture is one of our HEDIS measures under the National Committee for Quality Assurance (NCQA).

This is a free and voluntary program offered by Fallon Health. The population is identified from a monthly claims file created by our quality data analyst. The BMD screening is a quick procedure which uses the heel of the foot and ultrasound technology to screen for osteoporosis. The member gets immediate results, along with education on osteoporosis and its risk factors. The results are also sent to the member's PCP, who can then determine if any further testing is needed or what treatment options may prevent future fractures. All members are advised to follow up with their PCPs at the time of screening.

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

Colorectal cancer screening

Fallon Health has launched a free and voluntary colorectal cancer screening program for our Fallon Senior Plan and NaviCare members. Members who have not received colorectal cancer screening are identified from a claims file using current HEDIS technical specifications. Members can meet HEDIS requirements by having one of the following tests: a colonoscopy every ten years, a flexible sigmoidoscopy or CT colonography (virtual colonoscopy) every five years, a stool DNA test every three years (Cologuard®), or a fecal occult blood test yearly. Colorectal cancer screening is also a HEDIS measure per NCQA and a CMS 5-Star measure.

Our program uses a fecal occult blood test, the InSure® ONE™ kit, provided by Quest Diagnostics™, to screen for colorectal cancer and other sources of lower gastrointestinal bleeding. The InSure ONE is designed to be simpler and more user-friendly than other screenings specific for human hemoglobin. More importantly, the InSure ONE requires only one stool sample and does not require fecal handling, or dietary or medication restrictions.

Your patients can receive an InSure ONE kit from Fallon via mail with a provider order. Fallon Health will be reaching out to identified members' PCPs via fax to request a provider order for the InSure ONE kit. Results are interpreted by Quest Diagnostics and faxed to the member's PCP. Providers are encouraged to review the results with their patients.

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

Comprehensive diabetes care

Fallon Health will be reaching out to identified diabetic members' PCPs to provide them with gaps in care reports for their patient panels. The American Diabetes Association Standards of Medical Care in Diabetes sets forth recommendations regarding diabetic care, including annual hemoglobin A1c testing, attention for nephropathy (ACE Inhibitor or ARB therapy; or microalbuminuria testing annually), and an annual retinal eye exam. Comprehensive diabetes care is also a HEDIS measure per NCQA and a CMS 5-Star measure.

Additionally, Magellan Rx Management, a Fallon Health contracted vendor, is conducting outreach to Fallon Senior Plan and NaviCare members and their PCPs for those who are identified as being diabetic but do not have evidence of being prescribed a statin. The purpose of this outreach is to encourage PCPs to evaluate whether their patients may benefit from the addition of a statin to their current regimen. The outreach is conducted by licensed pharmacists and nurses and may occur via fax to providers or phone calls to both providers and identified members. Statin use in people with diabetes is also a CMS 5-Star measure.

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

Home health billing changes

Effective June 1, 2019, all NaviCare contracted home health care agencies will be required to submit appropriate CPT or HCPC codes in conjunction with revenue codes in order to comply with EOHHS regulations pertaining to the submission of patient encounters for outpatient services under the Senior Care Options contract Appendix O.

Per 130 CMR 403.000 Home Health Agency Manual Subchapter 6 those codes are:

Code	Description
G0151	Svc phys therap hh/hospice ea 15 min (per vist for mh only)
G0152	Svc occup therap hh/hospice ea 15 min (per visit for mh only)
G0153	Svc spch & lang path hh/hospice ea 15 min (per visit for mh)
G0154	Direct skill nurse services hh/hospice ea 15 min
G0155	Svc clin socl wrker hom hlth ea 15 min
G0156	Svc hom hlth aide hom ea 15 min
G0157	HHC pt assistant ea 15 min
G0158	HHC ot assistant ea 15 min
G0162	HHC rn e & m plan svs, 15 min
G0299	HHC/hospice of rn ea 15 min (per visit for medicaid only)
G0300	Dir sn srvs; rn hh/hospice ea 15 min (per visit for mh only)
G0493	RN care ea 15 min hh/hospice
G0494	LPN care ea 15 min hh/hospice

Any questions related to this change should be directed to Fallon Health Provider Relations Department by calling 1-866-275-3247 or by emailing askfchp@fallonhealth.org ■

MassHealth billing reminder

Billing Medicaid ACO members for covered services is **prohibited** as set forth in the plan/provider ACO contracts with EOHHS. Providers are expected to apply contractual and claims adjustments accordingly and not balance bill members for these services.

If the member is seeking non-covered services, as indicated in the non-covered services payment policy and the member *Evidence of Coverage*, the member must be told the services are non-covered prior to the service being rendered. Additionally, a waiver must be signed and dated by the member. This waiver must clearly indicate the specific non-covered service for which the member will be held liable.

You may refer to the Non-covered services payment policy here. ■

Adult foster care accreditation requirements

Pursuant to the Adult Foster Care Bulletin 14 issued in March 2018, as of June 30, 2019 all adult foster care providers will be required to provide evidence of accreditation to MassHealth as required in 130 CMR 408.404(A)(11). Accreditation must be obtained by a nationally recognized accreditation organization determined acceptable by MassHealth, including the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF). Below is the timeline for accreditation milestones as outlined in this bulletin:

- By December 31, 2018, the AFC provider must have submitted documentation to the LTSS Provider Portal at masshealthltss.com demonstrating that they have scheduled an onsite survey date with the accrediting body.
- By February 1, 2019, the AFC provider must have submitted documentation to the LTSS Provider Portal that they have performed an initial gap analysis and received a report from the accrediting organization that reflects process gaps necessary to achieve accreditation.
- By June 30, 2019, the AFC provider must submit a copy of the final report and determination to the LTSS Provider Portal. The final report and determination will serve as evidence of accreditation for purposes of 130 CMR 408.404(A)(11).

AFC providers should contact the MassHealth LTSS Provider Services Center with questions or concerns related to this requirement:

Phone: Toll-free 1-844-368-5184

Email: support@masshealthltss.com

Portal: MassHealthLTSS.com

Mail: MassHealth LTSS, PO Box 159108, Boston, MA 02215 ■

Coding updates

Effective July 1, 2019, the following codes *will be added to the Fallon Health Auxiliary fee schedule.*

Code	Description	Rate
77387	Guidance for localization of target volume of delivery of radiation treatment, includes intrafraction tracking, when performed	$319.20

Effective June 1, 2019, the following code will be set up as *not a covered benefit for all lines of business:*

Code	Description
T4545	Incontinence product, disposable, penile wrap, each

Effective July 1, 2019, the following code will be *removed from the fee schedule, as the code is considered not separately reimbursed:*

Code	Description
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 plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more ■

Effective June 1, 2019, the following code will be *considered experimental and investigational*, and *will require plan prior authorization.*

Code	Description
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral

Effective January 1, 2019, the following codes will be set up *as deny vendor liable for all lines of business*. Per MLN MM11163, the implementation date is April, 2019, and the codes are *retro dated back to January 1, 2019*.

Code	Description
G2001	Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2002	Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2003	Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2004	Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2005	Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2006	Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2007	Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2008	Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2009	Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)

Code	Description
G2013	Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2014	Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility, and no more than 9 times.)
G2015	Comprehensive (60 minutes) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.)

Effective June 1, 2019, the following codes will be set up as *deny vendor liable for all lines of business:*

Code	Description
G0076	Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0077	Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0078	Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0079	Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0080	Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0081	Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0082	Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0083	Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)

Code	Description
G0084	Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0085	Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0086	Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)
G0087	Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) ■

Payment policy updates

Revised policies – effective June 1, 2019:

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

- ***Adult Foster Care*** **–** Clarified Alternative Placement reimbursement and coding.
- ***Drugs and Biologicals*** **–** Updated Exhibit A for clarifying prior authorization requirements and removing termed codes.
- ***Durable Medical Equipment*** **–** Updated policy section to clarify we defer to CMS rules. Removed authorization requirement for DME repair.
- ***Early Intervention*** **–** Updated coding.
- ***Evaluation and Management*** **–** Clarified policy section regarding CMS documentation requirements.
- ***OBGYN*** **–** Added code J7296 to IUD table, clarified billing guidelines.
- ***Home Health*** **–** Clarified coding and added NaviCare billing specifics to the Billing/coding section.
- ***Non-Covered Services*** **–** Updated coding.
- ***Vaccines*** **–** Moved code 90739 from non-covered to covered, effective November 1, 2018. ■

Annual Review

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

- ***Anesthesia***
- ***Cardiology Services***
- ***Claims Auditing Software***
- ***Code Review***
- ***Coding Analysis***
- ***Inpatient Medical Review***
- ***Masshealth Preventable Conditions***
- ***Neonatal Intensive Care Services***
- ***Serious Reportable Events*** ■

Retired policy

- ***Fraud, Waste and Abuse*** ■

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