Connection

Important information for Fallon Health physicians and providers March 2017

What's new

Provider survey

Results from the recent provider survey are in. Thank you to all who participated.

2016 Overall Satisfaction Summary Rate Score	
Fallon Health	**75.58%**
BCBSMA	85.71%
Harvard	80.72%
Tufts	73.33%

Overall Satisfaction and Loyalty Summary Rate Score			
2016	84.84%	**2013**	78.17
2015	78.73	**2012**	85.76
2014	84.35	**2011**	80.60

The overall satisfaction and loyalty score is the average of the following questions:

Would you recommend Fallon Health to other physicians' practices?
Please rate your overall satisfaction with Fallon Health.
Would you recommend Fallon Health to other patients?

Please be advised when making comparisons to trend data prior to 2016, the current scale for the overall satisfaction question is from "Completely satisfied" to "Completely dissatisfied." The previous years' overall satisfaction scores were from "Very satisfied" to "Very dissatisfied."

Please contact your Provider Representative if you have any questions.

In this issue

Doing business with us

Prior authorization will be required for Enbrel and Humira

Effective April 1, 2017*, two specialty medications, Enbrel and Humira, will require prior authorization for all of our Commercial and Medicaid members. Please note: this does not include members who are enrolled in a Medicare plan. This is being done to ensure the drugs are medically necessary and being used appropriately. The quantity limits currently associated with these products will remain in effect.

Patients currently taking these medications will be able to continue, provided the prescriber submits documentation of the diagnosis being treated, and there has been stabilization or improvement in the disease being treated.

Criteria for use are currently being developed and will be available soon. Please visit our *Provider PA* site for the latest criteria and PA forms.

**You may have received provider notification regarding this change in February.* ■

Please keep your practice information current

Changes happen in your practice, and we want your patients to have access to the most current information in the *Provider Directory* hard copy and on our website's electronic provider directory via the "Find a doctor" tool.

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
- Any other change that impacts your availability to patients ■

Reminder: Claims submissions address

Fallon Health has a Post Office Box for all paper claim submissions, adjustments and appeals for all lines of business. These include, but are not limited to, Commercial, PPO, NaviCare, Fallon Senior Plan and non-contracted chiropractors.

The 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.* ■

Commercial prior authorization (PA) reminder

The Massachusetts Standard Form for Medication Prior Authorization Requests is the only prior authorization form that is accepted for Commercial plan members. This is a state-wide requirement. Since each health plan still maintains distinct PA criteria, we want to remind you to review the criteria posted on our website prior to completing the PA form, and provide all relevant data for each part of the criteria.

If there is no specific field for the data on the PA form, please use the "Additional information pertinent to this request" field. Incomplete forms or forms that do not address all parts of the criteria may result in a denial. ■

Quality focus

NaviCare Clinical Practice Initiatives

Those of you who are in our NaviCare network have the convenience of viewing the updated Clinical Practice Initiatives for 2017 from the provider section of our website, and can easily print PDF versions of each topic. You'll find the most current version of the following initiatives here:

- Abuse and neglect
- Alcohol abuse prevention and treatment
- Care for older adults
- Chronic obstructive pulmonary disease
- Dementia
- Depression
- Diabetes
- Heart failure
- Medication management
- Osteoporosis
- Preventive screening for adults

While on our site, please take a few minutes to browse our various tools and resources that can help you stay informed and interact with us more smoothly. If you have any questions, please contact your Provider Relations Representative for assistance at 1-866-275-3247, option 4. ■

Clinical Practice Guidelines update

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

American Diabetes Association Standards of Medical Care in Diabetes-2017

The ADA position statement provides key clinical practice recommendations. Position statements are issued on scientific or medical issues related to diabetes. ■

Product spotlight

NaviCare Model of Care

When a person enrolls in NaviCare, they are matched with a team of experts, called a Care Team, which is dedicated to helping them meet their health goals. The Care Team works together to create a care plan based on the needs and health records of each member. The team reviews this plan together regularly, to make any adjustments based on how the member is responding to the treatment and services.

By having a shared record of the member's complete and up-to-date health information and by meeting and deciding treatment plans regularly, the Care Team is able to make the best decisions about continued and preventative care.

Here is what the Care Team looks like:

Navigator

- Organizes benefits and services
- Advocates for patients so they receive the care they need
- Helps patients make medical appointments and arranges transportation

Nurse Case Manager or Advanced Practitioner

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

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

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

Primary Care Provider

- Contributes to and approves the individualized plan of care for the patient at time of program enrollment and ongoing
- 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

Behavioral Health Case Manager (as needed)

- Coordinates services to address mental health and substance use disorder needs
- Coordinates with the team and mental health and substance use providers

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

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

Visit navicare.org for more information. ■

Medication Therapy Management program

Fallon Health offers a free Medication Therapy Management program for eligible Medicare patients. Eligibility requirements are as follows:

- Enrolled in a Medicare Part D plan
- Taking at least eight prescriptions
- Have three or more chronic conditions (Qualifying chronic conditions include: high blood pressure, high cholesterol, diabetes, heart failure, COPD and depression)
- Spending an annual amount of $3,919 or more on prescriptions

An integral part of this program is the Comprehensive Medication Review, given by our partner, Clinical Support Services. Eligible patients will receive a welcome letter in the mail which includes instructions to call CSS to set up a review.

A review is beneficial because it can identify potential drug interactions, identify ways to simplify the patient's drug regimen, offer solutions to reduce side effects and identify less expensive alternatives.

This is a one-time call which usually takes 20 minutes or less. The patient can have a member of their family on the phone, or, with the patient's permission, the family member can provide CSS with information on their medications. After the review is completed, CSS will send a written summary with recommendations to both the patient and physician. The medication review is not intended to interfere with the care you already provide to your patient.

If your patient is eligible for this program and has not completed a review, we will send you a notice asking for your assistance. **If you receive one of these notices, please reach out to your patient to explain the importance of this program and recommend that they participate.** We thank you for your assistance in serving our Medicare patients. ■

Coding corner

Coding updates

Effective January 1, 2017, the follow code is *considered experimental/investigational and requires plan prior authorization:*

Code	Description
C1842	Retinal prosthesis, includes all internal and external components

Effective May 1, 2017, the following codes *will be covered with prior authorization:*

Code	Description
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)
J0888	Injection, epoetin beta, 1 microgram, (for non ESRD use)

Effective January 1, 2017, the following code is *not separately reimbursed:*

Code	Description
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit (list separately in addition to primary service)

Effective January 1, 2017, the following pharmacy codes *require plan prior authorization:*

Code	Description
J2182	Injection, mepolizumab, 1 mg
J2786	Injection, reslizumab, 1 mg
J2840	Injection, sebelipase alfa, 1 mg
J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg
J8670	Rolapitant, oral, 1 mg
J9304	Injection, bendamustine hcl (bendeka), 1 mg
J9145	Injection, daratumumab, 10 mg
J9176	Injection, elotuzumab, 1 mg
J9295	Injection, necitumumab, 1 mg
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
J9352	Injection, trabectedin, 0.1 mg

Effective January 1, 2017, the following codes *require plan prior authorization:*

Code	Description
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure.)
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure.)
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure.)
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed
43285	Removal of esophageal sphincter augmentation device
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure.)
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator
0468T	Removal of chest wall respiratory sensor electrode or electrode array
81327	SEPT9 (Septin9) (e.g., colorectal cancer) methylation analysis
81413	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A

Code	Description
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
81439	Inherited cardiomyopathy (e.g., hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN
87483	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (e.g., neisseria meningitidis, streptococcus pneumoniae, listeria, haemophilus influenzae, E. coli, streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpes virus 6, cytomegalovirus, varicella zoster virus, cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

Effective January 1, 2017, the following codes are *not covered for all lines of business:*

Code	Description
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family.
97170	Athletic training evaluation, moderate complexity, requiring these components: a medical history and physical activity profile with 1-2 comorbidities that affect physical activity; an examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97171	Athletic training evaluation, high complexity, requiring these components: a medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; a comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; clinical presentation with unstable and unpredictable characteristics; and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97172	Re-evaluation of athletic training established plan of care requiring these components: an assessment of patient's current functional status when there is a documented change; and a revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.

Effective January 1, 2017, the following codes are *deny vendor liable for all lines of business:*

Code	Description
A4467	Belt, strap, sleeve, garment, or covering, any type
A9286	Hygienic item or device, disposable or non-disposable, any type, each
G9687	Hospice services provided to patient any time during the measurement period
G9688	Patients using hospice services any time during the measurement period
G9689	Patient admitted for performance of elective carotid intervention
G9690	Patient receiving hospice services any time during the measurement period
G9691	Patient had hospice services any time during the measurement period
G9692	Hospice services received by patient any time during the measurement period
G9693	Patient use of hospice services any time during the measurement period
G9694	Hospice services utilized by patient any time during the measurement period
G9695	Long-acting inhaled bronchodilator prescribed
G9696	Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator
G9697	Documentation of patient reason(s) for not prescribing a long-acting inhaled bronchodilator
G9698	Documentation of system reason(s) for not prescribing a long-acting inhaled bronchodilator
G9699	Long-acting inhaled bronchodilator not prescribed, reason not otherwise specified
G9701	Children who are taking antibiotics in the 30 days prior to the date of the encounter during which the diagnosis was established
G9702	Patients who use hospice services any time during the measurement period
G9703	Children who are taking antibiotics in the 30 days prior to the diagnosis of pharyngitis
G9704	AJCC breast cancer stage i: t1 mic or t1a documented
G9705	AJCC breast cancer stage i: t1b (tumor > 0.5 cm but <= 1 cm in greatest dimension) documented
G9706	Low (or very low) risk of recurrence, prostate cancer
G9707	Patient received hospice services any time during the measurement period
G9708	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy
G9709	Hospice services used by patient any time during the measurement period
G9710	Patient was provided hospice services any time during the measurement period
G9711	Patients with a diagnosis or past history of total colectomy or colorectal cancer

Code	Description
G9712	Documentation of medical reason(s) for prescribing or dispensing antibiotic (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/ asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis
G9713	Patients who use hospice services any time during the measurement period
G9714	Patient is using hospice services any time during the measurement period
G9715	Patients who use hospice services any time during the measurement period
G9716	BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason
G9717	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required
G9718	Hospice services for patient provided any time during the measurement period
G9719	Patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair
G9720	Hospice services for patient occurred any time during the measurement period
G9721	Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair
G9723	Hospice services for patient received any time during the measurement period
G9725	Patients who use hospice services any time during the measurement period
G9726	Patient refused to participate
G9727	Patient unable to complete the foto knee intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9728	Patient refused to participate
G9729	Patient unable to complete the foto hip intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9730	Patient refused to participate
G9731	Patient unable to complete the foto foot or ankle intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9732	Patient refused to participate

Code	Description
G9733	Patient unable to complete the foto lumbar intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9734	Patient refused to participate
G9735	Patient unable to complete the foto shoulder intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9736	Patient refused to participate
G9737	Patient unable to complete the foto elbow, wrist or hand intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9738	Patient refused to participate
G9739	Patient unable to complete the foto general orthopedic intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
G9740	Hospice services given to patient any time during the measurement period
G9741	Patients who use hospice services any time during the measurement period
G9742	Psychiatric symptoms assessed
G9743	Psychiatric symptoms not assessed, reason not otherwise specified
G9744	Patient not eligible due to active diagnosis of hypertension.
G9745	Documented reason for not screening or recommending a follow-up for high blood pressure
G9746	Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery).
G9747	Patient is undergoing palliative dialysis with a catheter.
G9748	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant.
G9749	Patient is undergoing palliative dialysis with a catheter.
G9750	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant.
G9751	Patient died at any time during the 24-month measurement period.
G9752	Emergency surgery
G9753	Documentation of medical reason for not conducting a search for dicom format images for prior patient CT imaging studies completed at non-affiliated external healthcare facilities, or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., trauma, acute myocardial infarction, stroke, aortic aneurysm where time is of the essence)
G9754	A finding of an incidental pulmonary nodule

Code	Description
G9755	Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has a known malignancy that can metastasize, other medical reason(s)
G9756	Surgical procedures that included the use of silicone oil
G9757	Surgical procedures that included the use of silicone oil
G9758	Patient in hospice and in terminal phase
G9759	History of preoperative posterior capsule rupture
G9760	Patients who use hospice services any time during the measurement period
G9761	Patients who use hospice services any time during the measurement period
G9762	Patient had at least three HPV vaccines on or between the patient's 9th and 13th birthdays
G9763	Patient did not have at least three HPV vaccines on or between the patient's 9th and 13th birthdays
G9764	Patient has been treated with an oral systemic or biologic medication for psoriasis.
G9765	Documentation that the patient declined therapy change, has documented contraindications, or has not been treated with an oral systemic or biologic for at least six consecutive months (e.g., experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by PGA, BSA, PASI, DLQI
G9766	Patients who are transferred from one institution to another with a known diagnosis of CVA for endovascular stroke treatment
G9767	Hospitalized patients with newly diagnosed CVA considered for endovascular stroke treatment
G9768	Patients who utilize hospice services any time during the measurement period
G9769	Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months.
G9770	Peripheral nerve block (PNB)
G9771	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
G9772	Documentation of one of the following medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., emergency cases, intentional hypothermia, etc.)
G9773	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
G9774	Patients who have had a hysterectomy
G9775	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively
G9776	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)

Code	Description
G9778	Patients who have a diagnosis of pregnancy
G9779	Patients who are breastfeeding
G9780	Patients who have a diagnosis of rhabdomyolysis
G9781	Documentation of medical reason(s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who are receiving palliative care, patients with active liver disease or hepatic disease or insufficiency, and patients with end stage renal disease)
G9782	History of or active diagnosis of familial or pure hypercholesterolemia
G9783	Documentation of patients with diabetes who have a most recent fasting or direct LDL-C laboratory test result < 70 mg/dl and are not taking statin therapy
G9784	Pathologists/dermatopathologists providing a second opinion on a biopsy
G9785	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) sent from the pathologist/dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist
G9786	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) was not sent from the pathologist/dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist
G9787	Patient alive as of the last day of the measurement year
G9788	Most recent blood pressure is less than or equal to 140/90 mm Hg
G9789	Blood pressure recorded during inpatient stays, emergency room visits, urgent care visits, and patient self-reported blood pressure (home and health fair results)
G9790	Most recent blood pressure is greater than 140/90 mm hg, or blood pressure not documented
G9791	Most recent tobacco status is tobacco free
G9792	Most recent tobacco status is not tobacco free
G9793	Patient is currently on a daily aspirin or other antiplatelet
G9794	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed or intra-cranial bleed or documentation of active anticoagulant use during the measurement period
G9795	Patient is not currently on a daily aspirin or other antiplatelet
G9796	Patient is currently on a statin therapy
G9797	Patient is not on a statin therapy
G9798	Discharge(s) for AMI between July 1 of the year prior measurement year to June 30 of the measurement period
G9799	Patients with a medication dispensing event indicator of a history of asthma any time during the patient's history through the end of the measure period

Code	Description
G9800	Patients who are identified as having an intolerance or allergy to beta-blocker therapy
G9801	Hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis
G9802	Patients who use hospice services any time during the measurement period
G9803	Patient prescribed a 180-day course of treatment with beta-blockers post discharge for AMI.
G9804	Patient was not prescribed a 180-day course of treatment with beta-blockers post discharge for AMI.
G9805	Patients who use hospice services any time during the measurement period
G9806	Patients who received cervical cytology or an HPV test
G9807	Patients who did not receive cervical cytology or an HPV test
G9808	Any patients who had no asthma controller medications dispensed during the measurement year
G9809	Patients who use hospice services any time during the measurement period
G9810	Patient achieved a PDC of at least 75% for their asthma controller medication
G9811	Patient did not achieve a PDC of at least 75% for their asthma controller medication
G9812	Patient died, including all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure
G9813	Patient did not die within 30 days of the procedure or during the index hospitalization
G9814	Death occurring during hospitalization
G9815	Death did not occur during hospitalization
G9816	Death occurring 30 days post procedure
G9817	Death did not occur 30 days post procedure
G9818	Documentation of sexual activity
G9819	Patients who use hospice services any time during the measurement period
G9820	Documentation of a chlamydia screening test with proper follow-up
G9821	No documentation of a chlamydia screening test with proper follow-up
G9822	Women who had an endometrial ablation procedure during the year prior to the index date (exclusive of the index date)
G9823	Endometrial sampling or hysteroscopy with biopsy and results documented
G9824	Endometrial sampling or hysteroscopy with biopsy and results not documented
G9825	HER-2/neu negative or undocumented/unknown
G9826	Patient transferred to practice after initiation of chemotherapy
G9827	Her2-targeted therapies not administered during the initial course of treatment
G9828	Her2-targeted therapies administered during the initial course of treatment
G9829	Breast adjuvant chemotherapy administered

Code	Description
G9830	Her-2/neu positive
G9831	AJCC stage at breast cancer diagnosis = ii or iii
G9832	AJCC stage at breast cancer diagnosis = i (Ia or Ib) and t-stage at breast cancer diagnosis does not equal = t1, t1a, t1b
G9833	Patient transfer to practice after initiation of chemotherapy
G9834	Patient has metastatic disease at diagnosis
G9835	Trastuzumab administered within 12 months of diagnosis
G9836	Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation not complete)
G9837	Trastuzumab not administered within 12 months of diagnosis
G9838	Patient has metastatic disease at diagnosis
G9839	Anti-EGFR monoclonal antibody therapy
G9840	Kras gene mutation testing performed before initiation of anti-EGFR moab
G9841	Kras gene mutation testing not performed before initiation of anti-EGFR moab
G9842	Patient has metastatic disease at diagnosis
G9843	Kras gene mutation
G9844	Patient did not receive anti-EGFR monoclonal antibody therapy
G9845	Patient received anti-EGFR monoclonal antibody therapy
G9846	Patients who died from cancer
G9847	Patient received chemotherapy in the last 14 days of life
G9848	Patient did not receive chemotherapy in the last 14 days of life
G9849	Patients who died from cancer
G9850	Patient had more than one emergency department visit in the last 30 days of life
G9851	Patient had one or less emergency department visits in the last 30 days of life
G9852	Patients who died from cancer
G9853	Patient admitted to the ICU in the last 30 days of life
G9854	Patient was not admitted to the ICU in the last 30 days of life
G9855	Patients who died from cancer
G9856	Patient was not admitted to hospice
G9857	Patient admitted to hospice
G9858	Patient enrolled in hospice
G9859	Patients who died from cancer
G9860	Patient spent less than three days in hospice care

Code	Description
G9861	Patient spent greater than or equal to three days in hospice care
G9862	Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is = 66 years old, or life expectancy < 10 years old, other medical reasons)
G9700	Patients who use hospice services any time during the measurement period
G9724	Patients who had documentation of use of anticoagulant medications overlapping the measurement year
G9722	Documented history of renal failure or baseline serum creatinine = 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation the cr has been or is 4.0 or higher
G9777	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

Effective January 1, 2017, the following code is *not a covered benefit for all lines of business:*

Code	Description
A9285	Inversion/eversion correction device

Effective January 1, 2017, the following codes are *deny vendor liable for all lines of business:*

Code	Description
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure.)
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal

Code	Description
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device
0462T	Programming device evaluation (in person) with iterative adjustment of the implantable mechano-electrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day
0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

Effective January 1, 2017, the following codes are *not separately reimbursed:*

Code	Description
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service.)
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service.)

Effective January 1, 2017, the following codes *require plan prior authorization:*

Code	Description
A4553	Non-disposable underpads, all sizes
A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie
A9588	Fluciclovine f-18, diagnostic, 1 millicurie
A9597	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
A9598	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified

Code	Description
G0502	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies
G0503	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms or other treatment goals and are prepared for discharge from active treatment
G0504	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure); (use G0504 in conjunction with G0502, G0503)
G0505	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home
G0507	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team
J2182	Injection, mepolizumab, 1 mg
J2786	Injection, reslizumab, 1 mg
J2840	Injection, sebelipase alfa, 1 mg
J7320	Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg

Code	Description
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg
J8670	Rolapitant, oral, 1 mg
J9034	Injection, bendamustine HCL (bendeka), 1 mg
J9145	Injection, daratumumab, 10 mg
J9176	Injection, elotuzumab, 1 mg
J9295	Injection, necitumumab, 1 mg
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
J9352	Injection, trabectedin, 0.1 mg
Q4166	Cytal, per square centimeter
Q4167	Truskin, per square centimeter
Q4168	Amnioband, 1 mg
Q4169	Artacent wound, per square centimeter
Q4170	Cygnus, per square centimeter
Q4171	Interfyl, 1 mg
Q4172	Puraply or puraply AM, per square centimeter
Q4173	Palingen or palingen xplus, per square centimeter
Q4175	Miroderm, per square centimeter
T1040	Medicaid certified community behavioral health clinic services, per diem
T1041	Medicaid certified community behavioral health clinic services, per month
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc

Effective March 1, 2017, the following codes will *require plan prior authorization:*

Code	Description
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle
27704	Removal of ankle implant ■

MCO non-covered services

Below are code lists for MCO non-covered services. These codes reflect the "wrap codes" recognized by the MassHealth system. If your patient accesses these services while enrolled in a plan, please know that these services, using these codes only, should be submitted directly to MassHealth for processing.

Should you submit a claim to us for these services, they will be denied with a message to bill MassHealth directly. This is consistent with the messaging you receive when you bill MassHealth for a service that is covered by plans.

MassHealth will update and release this list periodically.

Managed Care Organizations (MCO) MCO non-covered services for MassHealth Standard, Family Assistance and CommonHealth enrollees		
Service Type	**Code**	**Description**
Money Follows the Person (MFP) services	**T1016**	Case Management, each 15 minutes
	T2028	Specialized supply, not otherwise specified
	H2016	Comprehensive community support service
	T1999	Misc. therapeutic items and supplies
Waiver services	**H0045**	Respite care services, not in the home
	H0047	Alcohol and/or other drug abuse service
	H2023	Supported employment, per 15 minutes
	S5108	Supported home care training, client, per 15 min
	S9128	Speech therapy in the home per diem
	S9129	Occupational therapy in the home per diem
	S9131	PT in the home per diem
	T2029	Specialized med equipment, NOS, waiver
	T2038	Community transition, waiver, per service
	H0031	06/01/15 - 9/30/15 ABA services only
	H0032	06/01/15 - 9/30/15 ABA services only
	H2012	06/01/15 - 9/30/15 ABA services only
Adult day health	**S5102**	Day care services, adult
	S5100	Day care services, per 15 min
	T2003	Nonemergency transportation
	T1017	Targeted Case Management, 15 minutes each U
Adult foster care/ group adult foster care	**S5140**	Foster care, adult; per diem
	S5141	Adult foster care per month
	T1028	Assessment of home, physical, and family environment
	H0043	Support house per diem, GAFC

Managed Care Organizations (MCO) MCO non-covered services for MassHealth Standard, Family Assistance and CommonHealth enrollees		
Service Type	**Code**	**Description**
Chapter 766 home assessments and participation in team meetings	**X9170**	Home assessment
	X9172	Home assessment
Day habilitation	**H2014**	Skills training and development
	T2003	Nonemergency transportation
	T2018	Habilitation support employment, waiver
	T2019	Habilitation support employment, waiver added 2/17/16
Dental services		All D codes are paid fee for service as a wrap.
Family planning i. Family planning indicator on procedure file ii. Family planning indicator on diagnosis file (It should be the primary diagnosis assigned to that claim service line.) iii. Family planning indicator on HCFA-1500 set by provider/condition code A4 on UB04 iv. Family planning services provider type 21		
Private duty nursing/continuous skilled nursing services	**T1002**	RN services, up to 15 min
	T1003	LPN/LVN services up to 15 min
	T1000	Private duty/independent NSG
Personal care attendant	**99456**	Work related or medical disability exam by other than physician
	T2022	Case management per month
	T1023	Screening to determine appropriateness in a program
	T1019	Personal care services, per 15 min
	T1020	Personal care services, per diem
	S5120	Chore services, per 15 min
	S5125	Attendant care service, per 15 min
	S5130	Homemaker service, per 15 min
	S5135	Companion Care, adult, per 15 min
	S5165	Home modifications, per service
	S5170	Home delivered meals, per meal
	S5175	Laundry service, external, professional

Managed Care Organizations (MCO) MCO non-covered services for MassHealth Standard, Family Assistance and CommonHealth enrollees		
Service Type	**Code**	**Description**
Transportation services non-emergent	**A0100**	Nonemergency transportation, taxi
	A0110	Nonemergency transportation, bus
	A0120	Nonemergency transportation, mini-bus
	A0130	Nonemergency transportation, wheelchair van
	A0140	Nonemergency transportation and air travel
	A0425	Ground mileage
	A0426	Ambulance service, ALS, nonemergency
	A0428	Ambulance service, BLS, nonemergency
	A0434	Specialty care transport
	S0215	Nonemergency transportation, wheelchair van mileage
	T2001	Nonemergency transportation, wheelchair van, escort
	T2002	Nonemergency transportation, per diem
	T2003	Nonemergency transportation (also under day habilitation)
	T2004	Non-emergency transport, commercial carrier, multi
	T2005	N-ET; stretcher van
	rev code	540-549 ambulance services
Vision care non-medical component	**92340**	Fitting of spectacles
	92341	Fitting of spectacles
	92342	Fitting of spectacles
	92370	Repair and refitting of spectacles
	V2600	Hand held low vision aids
	V2610	Single lens spectacle
	V2615	Telescopic or other compound lens
	V2623	Prosthetic eye
	V2624	Polish/resurface ocular prosth
	V2625	Enlargement of ocular prosth
	V2626	Reduction of ocular prosth
	V2627	Scleral coer shield
	V2628	Fabrication and fitting
	V2629	Prosth eye service, NOC
	V2797	Vision supply, accessory and/or service
	V2799	Misc vision service, NOC
	V2020-V2499	Only billable by PT31 volume purchaser
	rev 276	Intraocular lens

Managed Care Organizations (MCO) MCO non-covered services for MassHealth Standard, Family Assistance and CommonHealth enrollees		
Service Type	**Code**	**Description**
Keep teens healthy	**99401 SE**	Counseling/risk factor reduction intervention 15 M
	99404 SE	Counseling/risk factor reduction intervention 60 M
	99412 SE	Preventive counseling group
Intensive early intervention	**H2019 SE**	Mod SE for intensive early intervention. Member must be age 0-3, PT 29, and have diag F84-F849. All others MCO covered.
Miscellaneous	**99054**	Sunday/holiday service
Wrap fee for service if PT 58	**99509**	Home visit day life activity
Wrap fee for service if PT 58	**A0170**	Non-emergency transportation ancillary
Waiver services - only if rendered by PT 98	**T1004**	Supportive home care aide
	G0156	Home health aide
	G0154	Skilled nursing
	H0038	Peer support
	G0299	HHS/hospice of RN ea 15
	G0300	HHS/hospice of LPN ea 15

CarePlus CarePlus MCO non-covered services for MassHealth CarePlus enrollees		
Service Type	**Code**	**Description**
Dental services		All D codes are paid fee for service as a wrap.
Family planning i. Family planning indicator on procedure file ii. Family planning indicator on diagnosis file (It should be the primary diagnosis assigned to that claim service line.) iii. Family planning indicator on HCFA-1500 set by provider/condition code A4 on UB04 iv. Family planning services provider type 21		
Transportation services non-emergent	**A0100**	Nonemergency transportation, taxi
	A0110	Nonemergency transportation, bus
	A0120	Nonemergency transportation, mini-bus
	A0130	Nonemergency transportation, wheelchair van
	A0140	Nonemergency transportation and air travel
	A0425	Ground mileage
	A0426	Ambulance service, ALS, nonemergency
	A0428	Ambulance service, BLS, nonemergency
	A0434	Specialty care transport
	S0215	Nonemergency transportation, wheelchair van mileage
	T2001	Nonemergency transportation, wheelchair van, escort
	T2002	Nonemergency transportation, per diem
	T2003	Nonemergency transportation
	T2004	Non-emergency transport, commercial carrier, multi
	T2005	N-ET; stretcher van
	rev code	540-549 ambulance services
Vision care	**92340**	Fitting of spectacles
	92341	Fitting of spectacles
	92342	Fitting of spectacles
	92370	Repair and refitting of spectacles
	V2600	Hand held low vision aids
	V2610	Single lens spectacle
	V2615	Telescopic or other compound lens
	V2797	Vision supply, accessory and/or service
	V2799	Misc vision service, NOC
	V2020-V2499	Only billable by PT31 volume purchaser ■

Payment policy updates

New policy – effective May 1, 2017:

- ***Physical and Occupational Therapy*** ■

Revised policies – effective May 1, 2017:

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

- ***Anesthesia –*** Removed deleted codes.
- ***Cardiology –*** Removed deleted codes.
- ***Evaluation and Management –*** Removed deleted codes.
- ***Gastroenterology –*** Removed deleted codes.
- ***Inpatient Medical Review and Payment –*** Clarified language discussing routine and bedside nursing services.
- ***Laboratory and Pathology –*** Added new code G0659 and added molecular testing code requirement.
- ***Non-Covered Services –*** Revised the policy format and provided updated code listing.
- ***Outpatient Drugs –*** Updated JW modifier language to address CMS requirement.
- ***Telemedicine –*** Added new codes.
- ***Vaccine –*** Removed deleted code 90645. ■

Annual review

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

- ***Ambulatory Surgery – Facility***
- ***Ambulatory Surgery – Professional***
- ***Aging Service Access Points (ASAP)***
- ***Assistant Surgeon***
- ***Autism***
- ***Code Review***
- ***Neonatal Intensive Care Services*** ■

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

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