

CONNECTION

Important information for Fallon Health physicians and providers

May 2016

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What's new

Emergency care utilization initiative

It's important to Fallon Health that people get the right care in the right place at the right time. With this in mind, inappropriate use of the Emergency Department (ED) has a significant impact on the cost and quality of care, according to the New England Healthcare Institute.

In a data-driven and quality-focused initiative to reduce unnecessary ED visits, Fallon has created best practice information for our members. Our messages include:

- When it is appropriate to go to the ED
- When to go to another facility, such as urgent care or primary care provider's office
- Access to [Nurse Connect](#), a free 24-hour resource of nurses and health coaches



How can you help? We are distributing best practices information to our members. You are welcome to share these best practices with your patients. If medical care is needed right away and your patients can't get in to see you, this [guide](#) will help them decide their best and most convenient option for care.

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

CDC releases guideline for prescribing opioids for chronic pain

"More than 40 Americans die each day from prescription opioid overdoses, we must act now. Overprescribing opioids—largely for chronic pain—is a key driver of America's drug-overdose epidemic. The guideline will give physicians and patients the information they need to make more informed decisions about treatment."

Tom Frieden, MD, MPH - Director of the Centers for Disease Control and Prevention

There is an epidemic of opioid overdose deaths in the United States. In 2014, a record 28,647 people died from prescription opioids and heroin overdoses. The CDC has recently issued new recommendations for prescribing opioid medications for chronic pain, excluding cancer, palliative and end-of-life care.

The guideline provides recommendations for primary care providers, who account for prescribing nearly half of all opioid prescriptions, on the use of opioids in treating chronic pain in adults. Prescription opioids have serious risks, primarily addiction after prolonged use. The goals of the new guideline are to:

- improve the safety of prescribing and reduce the harm that can happen with opioids, particularly use disorder and overdose.
- strongly suggest that providers review patient history of controlled substance prescriptions using the state prescription drug monitoring program to see if the patient is already receiving opioid dosages.
- encourage the use of alternate treatments, such as non-opioid medications and physical therapy
- help physicians determine when and if they should prescribe opioids for chronic pain
- offer information on medication selection, dosage, duration and when and how to reassess progress, and discontinue medication
- stress that providers should always use caution when prescribing opioids and monitor patients closely.

For more information:

[2016 CDC Guideline for prescribing opioids for chronic pain](#)

[2016 CDC Checklist for prescribing opioids for chronic pain](#)

[Massachusetts list of SAMHSA providers](#) (prescribers of Suboxone)

You may also visit Beacon Health Options at beaconhealthoptions.com. ■

Governor Baker signs opioid bill

About 100 people in Massachusetts die each month from drug overdoses. Massachusetts has taken serious measures to curtail opioid use. Governor Charlie Baker signed a new law on March 14, the first law in the country, to limit opioid prescriptions to a 7-day supply for adults who are taking them for the first time. Other provisions of the law include:

- a requirement that information on opiate use and misuse be disseminated at annual head injury safety programs for high school athletes
- requirements for doctors to check the Prescription Monitoring Program (PMP) database before writing a prescription for a Schedule 2 or Schedule 3 narcotic
- continuing education requirements for prescribers, ranging from training on effective pain management to the risks of abuse and addiction associated with opioid medications

The governor said the bill is “the most comprehensive measure in the country to combat opioid addiction.” ■

New Commercial formulary tool

Fallon now has a new online Commercial formulary tool, which is much like the Medicare Formulary search tool. It is available for our three Commercial/Connector formularies: the Commercial 3 Tier, Commercial 4 Tier, and Hybrid 4 Tier. Members and providers can search by entering the full name or first few letters of a drug name, or they can search by drug category. The results page will bring up all strengths for the chosen drug or all products in the drug category. It will also indicate utilization management information such as prior authorization (PA), quantity limit, and applicable notes. Users can click on the PA indicator to see the criteria for that drug.

Also, if a member finds a drug name and wants to see what other drugs are available in that particular drug class, they can click on the drug class name, and all drugs that fall under that class will be listed. For example, if a member is prescribed a brand drug, and they want to know if there are any generics in the class that could be used instead, they simply click on the drug class name, and all drugs in that class appear. They can then print the page and bring it to discuss with their provider.

The new listing shows brand names in upper case and generic names in lower case italics. There is also a legend on the listing that describes the different indicators and notes used in the listing. The formulary tool may be found here: fallonhealth.org/members/Pharmacy/online-drug-formulary.aspx ■

eviCore program will expand to Fallon NaviCare members

Effective July 1, 2016, we will expand our eviCore program for high-tech, outpatient radiology to our NaviCare membership. eviCore has partnered with Fallon Health to administer a program for specialty radiology management for most of our other product lines since January, 2010.

The program applies to outpatient MRI/MRA, CT/CTA, nuclear cardiac imaging (NCM) and PET imaging studies. The process to obtain prior authorization for specialty radiology services for NaviCare members will be identical to the process for all other Fallon lines of business.

To request an authorization number:

Online: myportal.medsolutions.com

Phone: 1-888-693-3211, 8 a.m. to 9 p.m.

Please have patient demographic information, including health plan member ID, date of birth and the patient's current diagnosis.

Fax: 1-888-693-3210

Fax forms are available at myportal.medsolutions.com or by calling their Customer Service Department at 1-888-693-3211. When faxing prior authorization forms, please ensure that the case number is included on the fax reference page.

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

Let's connect

Postpartum Depression

Perinatal depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the “baby blues,” postpartum depression and postpartum psychosis.

Symptoms of depression

People with depression do not all experience the same symptoms. The severity, frequency, and length of symptoms are different for each person.

Symptoms of depression include:

- Lasting sad, anxious or empty mood
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness or helplessness
- Feelings of irritability or restlessness
- Loss of interest in hobbies and activities
- Loss of energy
- Problems concentrating, recalling details and making decisions
- Difficulty falling asleep or sleeping too much
- Overeating or loss of appetite
- Thoughts of suicide or suicide attempts
- Aches or pains that do not get better with treatment

Symptoms of postpartum depression

The symptoms of postpartum depression are similar to symptoms for depression, but may also include:

- Crying more often than usual
- Feelings of anger
- Withdrawing from loved ones
- Feeling numb or disconnected from the baby
- Worrying about hurting the baby
- Feeling guilty about not being a good mother or doubting one's ability to care for the baby

Treatment

Depression is treatable. Talk to your patients who have recently given birth. If you think they may be depressed, encourage them to seek help. See [cdc.gov/reproductivehealth/Depression/Treatments.htm](https://www.cdc.gov/reproductivehealth/Depression/Treatments.htm) to learn about seeking treatment for depression.

Experiences that may put some women at a higher risk for depression include:

- Difficulty getting pregnant
- Being a mother to multiples, like twins, or triplets
- Losing a baby
- Being a teen mother
- Preterm (before 37 weeks) labor and delivery
- Having a baby with a birth defect or disability
- Pregnancy and birth complications
- Having a baby or infant hospitalized

Depression can also occur among women with a healthy pregnancy and birth. Your patients who have recently given birth should have a checkup within 21 to 56 days after the birth. Fallon has a [flyer](#) which has information about postpartum blues, postpartum depression and the importance of a postpartum doctor's visit. If you'd like a supply of these flyers, speak with your Provider Relations Representative.

Dr. Price-Stevens appointed to Commission on Postpartum Depression

Dr. Lisa Price-Stevens, M.D., Fallon's Vice President of Medical Affairs, was recently appointed by Governor Charles Baker to the Massachusetts Special Legislative Commission on Postpartum Depression.

The Commission brings together health care providers, including obstetricians, gynecologists, pediatricians, and primary care providers, with non-profits and health insurance carriers. The goal is to develop a culture of awareness, de-stigmatization and screening for perinatal depression.

Fallon wants people to know that postpartum depression is treatable, and early detection is critical. We're eager to engage and collaborate in efforts toward improving the access and care for women who are affected.

"It's an honor to represent Fallon on the Governor's Commission on Postpartum Depression," said Dr. Price-Stevens. "This is a very important initiative, and we look forward to collaborating with all stakeholders."

What is the Massachusetts Legislative Commission on Postpartum Depression?

This commission was established in 2010 by Governor Duval Patrick in order to study and report on research and policy initiatives on postpartum depression, and make recommendations to address postpartum depression. Some of its activities include:

- Collaborating with the Department of Public Health to announce postpartum depression screening reporting requirements
- Helping to develop MCPAP for Moms, a part of the MCPAP program focusing on maternal behavioral health
- Funding PPD Community Health Center pilot programs across Massachusetts
- Promoting postpartum depression screening coverage in pediatric settings
- Postpartum Depression Awareness Day at the State House ■

Easier access to NRT

A provision of the Affordable Care Act may have removed one more barrier for the smoker who is contemplating another quit attempt. Now Fallon commercial plans cover all FDA-approved tobacco cessation medications (nicotine and non-nicotine). Fallon Mass Health already covers all cessation medications for two quit attempts per year.

With easier access to NRT, other cessation medications and no out-of-pocket costs (if the prescription is filled at a network pharmacy), we hope to see more quit attempts and more patient inquiries about quitting. Requiring a prescription for an OTC medication will likely facilitate more conversations about quitting. Free cessation medications and more provider-patient conversations about quitting sounds like a win-win scenario for quitters. The final element that could help your patient stop using tobacco is the Quit to Win (QTW) program!

QTW continues to provide free individual telephonic coaching to all Fallon members. The QTW text message support program, free to all Fallon members, is more popular than ever. Please let us know how QTW can enhance your provider experience and better serve our members in your care. Call us at 1-508-368-9540 or 1-888-807-2908, or email us at quittowin@fallonhealth.org ■

Supporting healthier lives in 2016

Fallon is committed to providing opportunities that support healthier lives in our community. Our programs and services are created to educate and guide individuals in all areas of wellness.

The Fallon Information Center, at the White City Shopping Center in Shrewsbury, Mass., is offering a variety of educational workshops to help people get and stay healthy in 2016. These classes and workshops are free and open to the community.

Please share our [calendar of events](#) found on fallonhealth.org, or encourage patients to call the Information Center at 1-866-209-5073 (TRS 711):

Monday, Tuesday, Thursday

8:30 a.m.–5:00 p.m.

Wednesday

8:30 a.m.–7:00 p.m.

Friday

8:30 a.m.–3:00 p.m.

Saturday

9:00 a.m.–1:00 p.m.

Here are some of the courses available:

- **Quit to Win stop-smoking program:** This eight-week program gives individuals the tools to become tobacco-free!
- **Sleeping Better:** Learn tips and techniques for getting a better night's sleep.
- **The Smart Kitchen:** Learn food safety tips, how to save time in the kitchen, how to eat healthy on a budget, and how to turn leftovers into a healthy meal or snack.
- **Healthy Lunches for Adults:** Learn how to turn your mid-day meal into a healthy, satisfying, and nutritious lunch.
- **Stress Management Program:** A four-week, thought-provoking workshop to learn how to reduce stress. ■

New address for claims submissions

Effective January 1, 2016, Fallon Health has a new P.O. Box for all paper claim submissions, Claims Adjustment forms, adjustments, and appeals for all lines of business, including, but not limited to, Commercial, PPO, NaviCare®, Fallon Senior Plan™ and non-contracted chiropractors. (Note: PPO does not have a separate address anymore.)

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

The new P.O. Box is:
Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908

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

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

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

Quality focus

Measuring blood pressure

Blood pressure determination continues to be one of the most important measurements in clinical medicine. The diagnosis and management of hypertension is dependent on an accurate blood pressure measurement. With all the expectations in health care, sometimes it is the simple things that get lost – such as repeating, reviewing and documenting all blood pressure readings. **Here are some simple reminders for measuring blood pressure:**

- The cuff bladder should be centered over the brachial artery. The cuff should fit appropriately, as cuffs that are either too loose or too tight will affect blood pressure readings.
- Check to see if the patient had waited quietly for about five minutes before the first reading. If not, have the patient do so before repeating the screening. If yes, then a one – to – two minutes rest between readings is sufficient.
- Record **all** readings and note which arm was used.

Source: Massachusetts Department of Public Health, A Clinician's Guide to Improving the Accuracy of Blood Pressure Measurement in Community and Work Settings. ■

Clinical Practice Guideline update

Our [Clinical Practice Guidelines](#) are available online. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

Recent updates:

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

- American Diabetes Association Standards of Medical Care in Diabetes-2016: These standards have been revised by the American Diabetes Association's multidisciplinary Professional Practice Committee, incorporating new evidence. The recommendations include screening, diagnostic, and therapeutic actions that are known or believed to favorably affect health outcomes of patients with diabetes.
- The 2016 Adult Immunization Schedules and Birth-18 Years Immunization Schedules were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) ■

Coding corner

PPD screening initiative

Reporting specifications for S3005

There is currently no reimbursement for these codes. However, we ask that you submit them so we can keep track of screenings and documentation.

Perinatal depression screening during a woman's prenatal and postpartum visits (perinatal care providers)

1. Limit to two units for female members age 12-55 per 12-month period.
2. Use modifiers U1 or U2 with the HCPCS code (Table 1).
3. No referral required.

Postpartum depression screening during infant, well-child or episodic visits (pediatric providers)

1. Limit to one unit for members age 0 to six months (male or female).
2. Use modifiers U3 or U4 with the HCPCS code (Table 1).
3. Be sure there is no conflict with EPSDT BH screening (96110) or other services rendered during pediatric visits. Allow pediatric providers to bill for S3005 code on same date of service as 96110.
4. No referral required.

Amended medical records: Provider Audit, Medical Record Review and Fraud, Waste and Abuse (FWA)

We have updated our policy on Medical Record Addendums as addressed in the [Provider Manual](#), the [Provider Audit Payment Policy](#) and the [Fraud, Waste and Abuse Payment Policy](#).

Amended medical records will not be permitted once an audit notification is received. All corrections of medical records must be made within 30 days following consultation or discharge.

Amended medical records fall into three primary categories:

1. Late entry (Provides information originally omitted from the original entry.)
2. Addendum (Provides information not available at the time of the original entry.)
3. Correction

When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records.

For paper medical records:

- A thin pen line should be drawn through the incorrect entry to make sure that the inaccurate information is still legible.
- The provider must state the reason for the error, document the correct information, and sign and date the correction.
- The original entry must not be obliterated or otherwise altered by blacking out with marker, using white out, writing over an entry, or by other means.

For electronic records:

- You may make an entry any time up to 30 days following consultation or discharge from care.
- Use either "Amendment of original documentation" or "Correction of original documentation" as a title.
- Include the reason the change is being made, documentation of who is making the change and what the corrected documentation should say.

Documentation should only include acceptable standard abbreviations and symbols as identified in *Jablonski's Dictionary of Medical Acronyms & Abbreviations* or *Dorland's Dictionary of Medical Acronyms & Abbreviations*. The use of unofficial symbols is prohibited without proper medical record substantiation and context. The table below gives some guidance for medical record documentation as recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The Joint Commission’s “Do Not Use” list is part of their Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating the introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official “Do Not Use” List ¹		
Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for <ul style="list-style-type: none"> • “0” (zero), • the number “4” (four) • or “cc” 	Write “unit”
IU (International Unit)	Mistaken for <ul style="list-style-type: none"> • IV (intravenous) or • the number 10 (ten) 	Write “International Unit”
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for <ul style="list-style-type: none"> • each other • Period after Q mistaken for “l” • the “O” mistaken for “l” 	Write “daily” Write “every other day”
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write “morphine sulfate”
MSO₄ and MgSO₄	Confused for one another	Write “magnesium sulfate”

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A “trailing zero” may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

jointcommission.org/standards_information/npsgs.aspx ■

Commonly under-coded medical conditions

Specificity and accuracy are critical when documenting for diagnosis coding. Hospital and physician claims are the primary sources of data that drive a number of clinical metrics and regulatory reporting requirements such as HEDIS, P4P and data submissions to state and federal agencies. Under-coded medical conditions can result in understated claim payments, diminished capitation amounts and inaccurate risk adjusted payments. Here are some commonly under-coded medical conditions:

COPD - The word "chronic" is essential to include in the category of chronic obstructive pulmonary disease. The documentation should specify the condition (for example, chronic obstructive bronchitis, emphysema or asthma). Please document acute/chronic respiratory failure or hypoxemia, if applicable. If a patient requires oxygen, please state the reason for the oxygen. A relationship between the two may not be assumed.

Diabetes with complications - This is the most commonly under-coded condition. Many physicians default to diabetes without complications because of how their EHR is set up. When selecting a diagnosis, consider the type and method of control, complication or manifestation. Remember to document and link the manifestation by using words such as "caused by," "due to," or "secondary to."

Angina – Distinguish between "angina" and "chest pain." The type of angina should be specified, if known. Angina that is controlled by medication should be documented as such.

CHF - Chronic heart failure has multiple cardiovascular conditions associated with it. Multiple codes can specify heart failure by type and acuity. This category also includes pulmonary hypertension and cardiomyopathies, which should be specified by type. Remember that X-rays, electrocardiograms and echocardiograms are not sufficient for the assignment of a diagnosis code. An interpretation with written documentation is necessary.

Just focusing on a few documentation improvements will help to assign patients the true severity of their illnesses, provide better patient care and will result in a more accurate forecasting of the cost of care. ■

Coding updates

Effective January 1, 2016 the following code will not be separately reimbursed.

Code	Description
S3005	Performance measurement, evaluation of patient self-assessment, depression

Effective June 30, 2016, the following codes will no longer be on the Fallon Health Auxiliary Fee Schedule.

Code	Description	Reason
99050	Services requested after posted office hours in addition to basic service	Not separately reimbursed (effective 5/1/16)
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	
99053	Services requested between 10 p.m. and 8 a.m. at 24-hour facility, in addition to basic service	
99056	Services provided at request of patient in a location other than physician's office which are normally provided in the office	
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	Code has a Medicare rate.
99377	Physician supervision of a hospice patient (patient not present) 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; 15-29 minutes	Not separately reimbursed (effective 5/1/16)

Code	Description	Reason
99379	Physician supervision of a nursing facility patient (patient not present) 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; 15-29 minutes	<p data-bbox="1198 638 1409 701">Not separately reimbursed</p> <p data-bbox="1198 722 1419 753"><i>(effective 5/1/16)</i></p>
99380	Physician supervision of a nursing facility patient (patient not present) 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	
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	<p data-bbox="1208 1346 1390 1377">Termed code</p>
D9220	General anesthesia - first 30 minutes	
D9221	General anesthesia - each additional 15 minutes	
D9241	IV sedation - first 30 minutes	
D9242	IV sedation - each additional 15 minutes	
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	<p data-bbox="1208 1598 1403 1661">Code has a Medicare rate.</p>

Effective July 1, 2016 the following code will be added to the Fallon Auxiliary Fee Schedule with a rate of \$13.00.

Code	Description
92251	Screening test, pure tone, air only

Effective January 1, 2016 the following codes will be added to the Fallon Auxiliary Fee Schedule.

Code	Description	Rate
D9223	General anesthesia each 15m	\$58.00
D9243	IV sedation each 15m	\$50.00 ■

● Payment policy updates

New policies– effective July 1, 2016

- *Ventricular Assist Devices*
- *Speech Therapy*

Revised policies, effective July 1, 2016

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

Durable Medical Equipment– Added clarifying language regarding rental periods and reasonable useful lifetimes. Added additional modifiers.

Evaluation & Management– Updated to address new codes and replace deleted codes throughout the policy. Also updated to indicate that 99050 and 99051 are no longer separately reimbursed.

Hospice– Added the requirement to report all diagnoses identified in the initial and comprehensive assessments on hospice claims.

Obstetrics/Gynecology– Updated to address IUD reimbursement.

Preventive Services– Added codes 99497 and 99498.

Special Services, Procedures and Reports– Updated the reimbursement section.

Annual review

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

- ***Counseling/Risk Factor Reduction Intervention Services***
- ***Dermatology***
- ***Diabetes Self-Management Education/Training***
- ***Emergency Department***
- ***Global Surgical***
- ***Home Health Care***
- ***Hospital Acquired Conditions*** ■

Connection is an online bimonthly publication for all Fallon Health ancillary and affiliated providers. The next copy deadline is **May 5** for our **July 2016** issue.

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