

# Connection



Important information for Fallon Health physicians and providers

November 2017

## What's new

### New telephone options for Spanish- and Vietnamese-speaking NaviCare® members

When Spanish and Vietnamese NaviCare members and prospective members call Fallon, they will now be directed to an employee who speaks their language.

Before this enhancement, Spanish-speaking callers had to navigate English instructions, speak to an English-speaking Fallon employee, and wait to be transferred to one of our Spanish-speaking Senior Care Enrollee Representatives. Vietnamese-speaking callers had to navigate our phone system in English and wait for an employee to connect them to a vendor who could translate the conversation.

We now have new answering options. Callers who speak Spanish hear instructions in Spanish and are sent directly to someone who speaks Spanish. For callers who speak Vietnamese, we have Vietnamese instructions and a Vietnamese-speaking Senior Care Enrollee Representative.

Offering these caller options has enhanced our ability to meet our diverse members' needs. ■

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# Product spotlight

## Summit ElderCare – a PACE program offered by Fallon Health

Summit ElderCare is a Program of All-Inclusive Care for the Elderly (PACE) that provides medical care, insurance and social support for people who are age 55 and older, and who qualify for nursing home care. The program allows participants to stay in their homes and have social ties to their communities while providing them with the coordinated medical attention that they need, often resulting in less frequent emergency room visits and hospitalizations. We have more than 20 years of experience, and we have six centers in Massachusetts.

At Fallon, we believe in teamwork. The Summit Model of Care includes medical care, in-home services, social support, health insurance and transportation.

Our in-home services include medication management, personal care, nursing visits and even light housekeeping, meal preparation and grocery shopping.

Our participants receive support from social workers and our staff who lead activities that are recreational, educational, therapeutic and fun. Specialized care and dedicated activity areas for participants with Alzheimer's disease, dementia and other cognitive impairments are also available.

### **Some important things to note about Summit ElderCare:**

- The program is available to any person who is 55 years and older, lives in the service area, meets the Medicaid nursing facility clinical eligibility criteria and is able to live safely at home as determined by the Summit ElderCare interdisciplinary team.
- All care must be from providers who have a contract with Summit ElderCare—except emergency care.
- Participants receive most medical care and services at a Summit ElderCare PACE center, where medical, nursing, rehabilitation and personal care needs are coordinated.
- Summit ElderCare PACE facilities are located in Charlton, Leominster, Lowell and Springfield—and in two locations in Worcester.
- Out-of-network care requires prior authorization.
- Participants receive 100% coverage for hospitalization and all medically necessary prescription drugs, as authorized by the interdisciplinary team.

Summit ElderCare participants also receive 24-hour telephone access to a member of their geriatric care team; in-home assistance with personal care needs, such as bathing and dressing; transportation, if needed, to and from medical appointments; and physical, occupational, recreational and other therapies.

To learn more about Summit ElderCare, call 1-800-698-7566 (TRS 711), Monday–Friday, 8 a.m. to 5 p.m. ■

## Summit ElderCare provides support for caregivers

We know how challenging it is to be a caregiver. That's why, at Summit ElderCare, we work hard to support our members' caregivers.

We have 24-hour telephone access for emergencies and unexpected situations.

We host monthly support groups for caregivers at each Summit location. These meetings are free and open to the public. They feature monthly topics and speakers. Some recent topics have been dealing with grief, ways to prevent wandering, an overview of dementia: types, stages and tips to help along the way, and caregiver resources online.

Check out our [Caregiver Connection blog](#) that provides information and support. ■

## Doing business with us

### Online form to sign up for Provider Tools

Effective June 19, 2017, we moved to an online form to sign up for provider tools. The form is available [here](#).

The online application mimics the content of the PDF that was used previously. This process is quicker and more efficient, and improves the quality and legibility of the forms.

We will continue to keep a PDF on file should you require one. If you have any questions or concerns, please contact your Provider Relations Representative. ■

### New Opioid Strategy

Effective February 1, 2018, Fallon Health will implement a new opioid strategy for Commercial, Medicaid and Exchange lines of business. Please note: this does not include members who are enrolled in a Medicare plan. The new strategy will require prior authorization on:

- Opioids that exceed 90 morphine milligram equivalents (MME) per day with a limit of 200 MME/day
- Extended-release opioids where there is no previous claim for an immediate-release opioid
- Immediate-release opioids exceeding seven days

Opioids that are less than these limits will process without prior authorization. This strategy does not include drugs for opioid abuse treatment, such as Suboxone®. Our previous opioid criteria will be retired January 31, 2018. Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

### **Nexium® 24 HR OTC covered under prescription benefit**

Effective January 1, 2018, Nexium® 24 HR OTC will be a preferred proton-pump inhibitor (PPI) on all Fallon Health's Commercial plans. Please note: this does not include members who are enrolled in a Medicare or Medicaid plan. As a result, current authorizations for prescription Nexium® or esomeprazole will be terminated as of December 31, 2017. Impacted members will be notified via mail of this change. In order to continue to receive prescription Nexium (esomeprazole), members must have tried and failed Nexium® 24 HR OTC. Trial of Nexium® 24 HR OTC has been added to the prescription Nexium criteria. Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

### **All non-LifeScan test strips to require prior authorization**

Effective January 1, 2018, glucose test strips, other than LifeScan strips, will require prior authorization for all Commercial plans. Please note: this does not include members who are enrolled in a Medicare or Medicaid plan. The current step requirement will be removed. Claims that have processed under the step requirement will reject for prior authorization. These members will be notified via mail of this change. LifeScan test strip products will process if under five strips per day. LifeScan test strip products over five strips per day will continue to require prior authorization. All non-LifeScan test strips will require prior authorization regardless of quantity. Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

### **Avonex® to require prior authorization**

Effective January 1, 2018, Avonex® will require prior authorization for all of our Commercial, Exchange and Medicaid members. Please note: this does not include members who are enrolled in a Medicare plan. Patients currently taking these medications will be able to continue to do so, provided continuation of therapy criteria is met based on prescriber-submitted documentation. Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

### **Alinia® – Quantity limit added**

Effective January 1, 2018, Alinia®, an antiprotozoal indicated for the treatment of diarrhea caused by *Giardia lamblia* or *Cryptosporidium parvum*, will be limited to a three-day supply for Commercial, Exchange, and Medicaid plans. Please note: this does not include members who are enrolled in a Medicare plan. The quantity limit will be six tablets or 150 ml. A prior authorization will be required for durations longer than three days. Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

## New-to-market medications added to formulary

The following medications *will be added* to the Commercial, Exchange, and Medicaid formularies **effective November 1, 2017**:

| Medication  | Pharmacy or medical benefit | Formulary restrictions |
|---|-----------------------------|------------------------|
| Bavencio® (avelumab)                                    | Medical                     | PA required            |
| Imfinzi™ (durvalumab)                                   | Medical                     | PA required            |
| Alunbrig™ (brigatinib)                                  | Pharmacy                    | PA required            |
| Zejula™ (niraparib)                                     | Pharmacy                    | PA required            |
| Rydapt® (midostaurin)                                   | Pharmacy                    | PA required            |
| Ocrevus™ (Ocrelizumab)                                  | Medical                     | PA required            |
| Kevzara® (sarilumab)                                    | Pharmacy                    | PA required            |
| Dupixent® (dupilumab)                                   | Pharmacy                    | PA required            |
| Ingrezza™ (valbenazine)                                 | Pharmacy                    | PA required            |
| Austedo™ (deutetrabenazine)                             | Pharmacy                    | PA required            |
| Xadago® (safinamide)                                    | Pharmacy                    | PA required            |
| Radicava™ (edaravone)                                   | Medical                     | PA required            |
| Tymlos™ (teriparatide)                                  | Pharmacy                    | PA required            |
| Intrarosa™ (prasterone)                                 | Pharmacy                    | Step Therapy           |
| Synjardy XR® (empagliflozin/metformin extended release) | Pharmacy                    | PA required            |

Please visit our Provider [website](#) for the latest criteria and prior authorization forms. ■

## Statins for prevention of cardiovascular disease-ACA update

The Affordable Care Act (ACA) requires health plan coverage of certain preventive services and medications with no copayment to participants or beneficiaries. The list of preventive medications to be provided without copayment was recently updated based on recommendations from the United States Preventative Services Task Force (USPSTF). The ACA has required the addition of low-to-moderate dose statins used for the primary prevention of cardiovascular disease to the list of medications available at \$0 copayment for members meeting the following criteria:

- Age 40-75
- Have one or more cardiovascular risk factors such as high cholesterol, hypertension, diabetes or smoking
- Have a ten percent or greater calculated ten-year risk of a cardiovascular event

In accordance with the ACA requirements and USPSTF recommendations, beginning November 1, 2017, the following **generic** medications and doses will be available at no cost to Fallon Health Commercial members between the ages of 40 and 75 when used for primary prevention of cardiovascular disease (This does not apply to Medicare or Medicaid members or to Commercial members under age 40 or over age 75):

- Atorvastatin 10 and 20 mg tablets\*
- Fluvastatin 20 and 40 mg tablets
- Lovastatin 10, 20 and 40 mg tablets
- Pravastatin 10, 20, 40 and 80 mg tablets\*
- Simvastatin 5, 10, 20 and 40 mg tablets

*\*Available at \$0 cost share based on previous pharmacy claims for medications used to treat hypertension and diabetes which are considered cardiovascular risk factors; otherwise, covered at customary copayment for member's plan. Providers may also submit documentation that the statin is being prescribed for primary prevention when the member meets the criteria noted above. If these criteria are met, Fallon Health may cover the medication at \$0 copayment. ■*

## Reminders when ordering laboratory services:

### 1. Verify contracted laboratories

Fallon will only reimburse medically necessary laboratory and pathology services provided at contracted facilities. The use of non-contracted labs may have the unintended consequence of subjecting our members to unreasonable financial exposure or unnecessary services that you did not order. Fallon may hold you responsible for services referred to and provided by non-contracted labs.

Please confirm that a laboratory is contracted with Fallon prior to making a referral. A list of contracted labs can be found [here](#). Follow the steps below:

- Select "I'm a Fallon Health contracted provider."
- Select "Ancillary provider."
- Select the service type.

### 2. Functional health/Alternative medicine

Laboratory services related to or associated with alternative, holistic, naturopathic or functional health medicine are not covered benefits and will be denied.

For more information on the above topics, see the [Laboratory and Pathology Payment Policy](#). ■

## Change in NaviCare grace period for those who lose MassHealth Standard eligibility

Effective January 1, 2018, NaviCare members/enrollees who lose their MassHealth Standard eligibility will continue to be eligible and enrolled in the NaviCare plan for up to two months after the loss of MassHealth Standard. All NaviCare covered services will continue to be available to these enrollees during this time period. If the member/enrollee is unable to regain their MassHealth eligibility within the two-month timeframe, they will be involuntarily disenrolled from the plan following the Centers for Medicare & Medicaid Services (CMS) and the Executive Office of Health and Human Services (EOHHS) disenrollment regulations.

This new regulation is a change from the three-month grace period (remainder of current month plus 60 calendar days) to a two-month grace period (remainder of current month plus 30 calendar days) in 2018.

If you have any questions, please contact one of the Fallon Health Government Programs Eligibility Specialists or Senior Care Enrollee Services at 1-877-700-6996. ■

## Summit ElderCare prior authorization update

Effective February 1, 2017, Summit ElderCare no longer requires authorization for services that would not require authorization with contracted providers. Authorizations are still required for all services that would require authorization with contracted providers.

Click [here](#) to check the authorization requirement of a specific CPT code. ■

## Prior authorization for observation stays at acute hospitals

As of January 1, 2018, Fallon Health will no longer require authorizations for observation stays at acute hospitals. The claims can be submitted without authorizations for all lines of business. This change will not apply to out-of-network hospitals, as the rule for authorizations for all services from out-of-network providers or facilities will still apply. ■

## Provider website updates

We made it easier to get to the tools you use most on [fallonhealth.org/providers](http://fallonhealth.org/providers). You may have noticed some additional sidebars and links on the home page. We'll be working on further streamlining and improving content in the coming months. ■

## Fallon to apply Zelis™ Healthcare claims editing software in 2018

Fallon Health currently uses claims editing software for automated claims coding verification and to ensure that Fallon is processing claims in compliance with general industry standards. In the first quarter of 2018, Fallon will begin using an integrated claims editing tool offered by Zelis™ to further evaluate claims for adherence to industry-recognized edits and guidelines and to ensure compliance with payment policies and standard coding practices. ■

## Quality focus

### Osteoporosis management in older women—Fallon Health screenings

Our Health Promotions Department is doing bone mineral density (BMD) screenings for a selection of our female Fallon Senior Plan™ members and NaviCare enrollees who are age 67-85 and who have had a bone fracture within the past 180 days.

This is a free and voluntary program offered by Fallon Health. The population we are screening is selected from a monthly claims file created by our quality data analyst. 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)\*.

Our BMD machine is a Sahara® Clinical Bone Sonometer Unit by Hologic, which uses ultrasound technology (not an X-ray). This is a screening tool only—it's not meant to diagnose osteoporosis. Low bone-density results will suggest greater risk of fracture, and all enrollees will be advised to follow up with their PCP. Our BMD screening is a quick procedure which uses the heel of the foot. The enrollee gets immediate results, along with education on osteoporosis and its risk factors.

Participants are encouraged to review a copy of the results with their PCP, who can then determine if any further testing is needed or what treatment options may prevent future fractures. If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4, or Tyler Smith in Health Promotions at 1-508-368-9719.

*\*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. ■*

### Comprehensive Diabetes Care (CDC): Retinal Eye Test

Our Health Promotions Department, along with our Quality Department, will be launching a free and voluntary retinal eye test program for our diabetic NaviCare enrollees. The population we screen is selected from a claims file created by our Quality Data Analyst.

Similar to our Osteoporosis Management in Women program, retinal eye testing for enrollees with diabetes is a component of the Comprehensive Diabetes Care HEDIS measure per the NCQA. Older individuals with diabetes are at risk for developing diabetic retinopathy, which can cause serious damage if left untreated. An annual diabetic retinal eye test is crucial to detect the disease and stop further damage.

This program offers an in-home retinal eye test using the RetinaVue™ 100 Imager by Welch Allyn. This test is a quick and painless procedure, the results of which can be used to diagnose diabetic retinopathy. The camera captures an image of the retina, which is sent to a board-certified ophthalmologist for interpretation. The diagnostic report is then sent to the enrollee's PCP. Participants are encouraged to meet with their PCP to discuss the results and treatment.



This screening is not meant to be a substitution for an in-person thorough evaluation. We continue to encourage enrollees who have this screening to schedule visits with an eye professional for comprehensive eye care. Fallon provides coverage for the screening as well as other types of eye exams, based on benefit plan design. If you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4, or Tyler Smith in Health Promotions at 1-508-368-9719. ■

### Colorectal Cancer Screening

NaviCare will be launching a free and voluntary colorectal cancer screening program for enrollees. The population we screen is selected from a claims file created by our Quality Data Analyst. We also welcome your referrals.

Similar to our Osteoporosis Management in Women and Retinal Eye Test programs, colorectal cancer screening is a HEDIS measure under the NCQA. Health experts recommend colon cancer tests for healthy people between the ages of 50 and 75. Enrollees can meet HEDIS requirements by having either a colonoscopy every ten years, a flexible sigmoidoscopy every five years or a fecal occult blood test yearly.

Our program uses the InSure® FIT™ test, which is a fecal immunochemical test provided by Quest Diagnostics™. Enrollees are offered the opportunity to receive this kit in the mail to screen for colorectal cancer and other sources of lower gastrointestinal bleeding. The InSure FIT is designed to be simpler and more user-friendly than other screenings specific for human hemoglobin. More importantly, the InSure FIT does not require fecal handling, or dietary or medication restrictions. The results will be interpreted by Quest Diagnostics™, and Fallon Health will send the results to the member's PCP. Providers are asked to acknowledge receipt of the enrollees' results and 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. ■

### Disease Management Program empowers your patients

The Fallon Health Disease Management Program is a proactive, patient-centered program for individuals diagnosed with chronic diseases—including asthma, diabetes, chronic obstructive pulmonary disease (COPD), cardiac disease or heart failure. It reinforces standards of care by providing health education, health coaching and self-management skills. We work toward empowering your patients to take a more active role in improving and maintaining their health.

We welcome referrals for your patients, our Fallon members, to our Disease Management Program and look forward to working with you. For more information or to make a referral, please call our team at 1-800-333-2535, ext. 69898, Monday through Friday from 8:30 a.m. to 5:00 p.m. You also may use our online [Disease Management/Health Promotions Referral Form](#) ■

## Antipsychotics and diabetes

Individuals with severe mental illness may be at risk for complications due to medications. Those living with schizophrenia or bipolar disorder are at high risk of developing diabetes, among other serious illnesses. The risk of developing diabetes is further increased if they are prescribed an antipsychotic.

Antipsychotics can cause significant weight gain and changes in a person's metabolism. According to the HEDIS® measure, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, people 18-64 years of age with schizophrenia or bipolar disorder should have a diabetes screening each year. Screening may lead to earlier identification and treatment in patients taking these types of medications. ■

## Access to Complex Case Management

For your patients who need a lot of care and resources, we offer the Complex Case Management Program. You may refer a patient to this program if he or she has a "critical event or diagnosis"—for example, a car accident, a fall that results in serious injury, cancer or serious health decline. We'll do a brief assessment to confirm eligibility.

Our Nurse Case Managers and Social Workers coordinate their care in collaboration with caregivers and you. We want to help ensure that your patients receive all the appropriate services and have access to all the resources needed to resolve their health issues in the best way possible.

For more information, or to ask about enrolling in the program, you may call us at 1-800-333-2535, ext. 78002 (TRS 711), Monday-Friday, 8:30 a.m.-5:00 p.m. Or you may use our online [Case Management Referral Form](#) ■

## Important links to information about care

We hope you'll take this time to explore [fallonhealth.org](http://fallonhealth.org) to learn how we work with you and your patients to ensure the quality and safety of clinical care. If you'd like to receive a copy of this information, please call Provider Relations at 1-866-275-3247, option 4.

- **Clinical criteria for utilization care services:** Fallon uses national, evidence-based criteria reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care. Criteria are available [here](#) or as a paper copy upon request.
- **Learn more about our quality programs:** Fallon is proud of its long history of quality accomplishments, including our accreditation from the National Committee for Quality Assurance. A detailed description of our quality programs, goals and outcomes is available [here](#). We also welcome suggestions from our physicians about specific goals or projects that may further improve the quality of our care and services.

- **Know our members' rights:** Fallon members have the right to receive information about an illness, the course of treatment and prospects for recovery in terms that they can understand. They have the right to actively participate in decisions regarding their own health and treatment options, including the right to refuse treatment. View a complete list of Fallon members' rights and responsibilities [here](#). ■

### Utilization Management incentives

Fallon Health affirms the following:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage.
- Fallon Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization. ■

### Clinical Practice Guideline update

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

#### Recent updates:

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

- National Heart, Lung, and Blood Institute (NHLBI)
- National Asthma Education and Prevention Program Expert Panel Report (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Summary Report ©2007 and Asthma Care Quick Reference ©2011 ■

### The HEDIS® 2018 season is approaching fast.

For a comprehensive list of HEDIS measures, including a description of what is measured and the care, treatment or test that is required for compliance, please visit us [here](#).

The HEDIS 2018 season begins in December of 2017 and continues through May 2018.

If you receive a medical record request pertaining to services provided for HEDIS measures, please keep in mind that:

- Medical chart requests may be for a regular patient of yours or someone who was only seen once in your office.
- Medical records must have the patient's name and date of birth, the date of service, the provider's signature and credentials, and date of the provider's signature.

- Please provide medical records within 14 days of the request.
- Member authorizations are not required.
- Medical record request materials will include contact information for assistance you or your staff may need.

If you have questions regarding a HEDIS medical record request, please contact Robin Byrne, Senior Manager, Accreditation at 1-508-368-9103. She is available Monday through Friday from 8:30 a.m. to 4:30 p.m. ■

## Fraud, waste and abuse

### Faxed prescription requests

You may have received faxes from out-of-state pharmacies requesting that you sign off on prescriptions for compounded products or diabetic supplies for your patients. The faxes usually have numerous different prescription orders that can be checked off. There may even be a statement on the form that authorizes the pharmacy to change the order based on the patient's insurance status.

While some of these pharmacies may be acting in the best interest of the patient, others may not.

Often, multiple medications, which are only approved as oral therapies, are being compounded into a single topical product. These compound products may have no guidance to support their use and may have questionable efficacy and safety.

A common request is for large quantities of lidocaine ointment or other topical products. Typical quantities are ten 30-gram tubes per month, which costs about \$1,700.

We wanted to alert you to this practice. We ask that you confer with your patient before signing such forms. Please determine whether the patient truly requires the medication and consider using the patient's local pharmacy whenever possible. ■

## Compliance

### Provider Enrollment Requirement

On November 15, 2016, the Centers for Medicare and Medicaid Services finalized the *2017 Physician Final Rule*. The regulation outlined a new provision requiring all providers or suppliers contracted with Medicare Advantage (MA), Medicare Advantage and Prescription Drug, (MAPD), Program of All-inclusive Care for the Elderly (PACE), and demonstration plans to be enrolled in original Medicare in an approved status for an effective date of January 1, 2019.

The rule applies to the following providers or suppliers:

- MA network providers and suppliers
- First tier, downstream, and related entities (FDR)
- Health care providers and suppliers in PACE plans
- Suppliers in Cost Health Maintenance Organizations (Cost HMOs) or competitive medical plans (CMPs)
- Health care providers and suppliers participating in demonstration and pilot programs
- Vendors who provide physician staffing services for hospitals, outpatient medical centers, government and military facilities, group practices, community health centers and correctional facilities
- Incident to suppliers that furnish integral, but incidental, professional services in the course of diagnosis or treatment of an injury or illness.

The provider or suppliers must be enrolled in Medicare in an approved status. This means that they must meet all of the requirements for enrollment into the Medicare program. There are no exceptions. Starting on January 1, 2019, MA, MAPD, PACE and demonstration plans will be prohibited from paying providers or suppliers who are not enrolled in an approved status with the Medicare program. The payment prohibition will continue its effect on providers that are excluded, revoked or opted out of Medicare.

This new mandate expands the requirement to enroll in Medicare from Part D prescribers to all providers or suppliers contracted with MA, MAPD, PACE and demonstration plans. The Part D Prescriber enrollment requirement, which was issued on May 23, 2014 in the *2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* (Final Rule), and amended on May 6, 2015 in interim final rule with comment (IFC) *Changes to the Requirements for Part D Prescribers*, applies to all prescribing providers including physicians, dentists, nurse practitioners, behavioral health providers and other professionals who are permitted to write Part D prescriptions by applicable state law.

CMS is expected to release additional guidance regarding the Medicare enrollment requirement in the future. The guidance will include information on how plans may check a provider or supplier's Medicare status against the data in the Provider Enrollment, Chain and Ownership System (PECOS). Providers or suppliers should check their statuses regularly to ensure their enrollment is active and up to date.

We will continue to share updates as we receive them from CMS. Providers or suppliers may also monitor the [Medicare Provider-Supplier Enrollment](#) webpage maintained by CMS. The site can be accessed by logging onto [cms.gov](https://www.cms.gov) and searching for "Medicare Provider-Supplier Enrollment." ■

## *Jimmo v. Sebelius* and the rejection of the “Improvement Standard”

In an August 7, 2017 HPMS memo, CMS reminded the Medicare community of the *Jimmo v. Sebelius* Settlement Agreement (January 2014). This settlement clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare’s skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in **order to maintain function or to prevent or slow decline or deterioration** (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement Agreement required manual revisions to restate a “maintenance coverage standard” for both skilled nursing and therapy services under these benefits:

- Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The *Jimmo* Settlement Agreement may reflect a change in practice for those providers, adjudicators and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve—the so-called “Improvement Standard.” The settlement is consistent with the Medicare program’s regulations governing:

- maintenance nursing and therapy in skilled nursing facilities
- home health services
- outpatient therapy (physical, occupational, and speech)
- nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide

For more information, please see the *Jimmo* Settlement Agreement [webpage](#) developed by CMS. ■

## Coding corner

### **New 2018 CPT/HCPCS codes**

All new codes will require prior authorization until a final review is performed by Fallon Health. Fallon will review and assign the appropriate coverage and determine prior authorization requirements for all new codes by January 1. Fallon will notify all contracted providers of this determination via *Connection* in the first few months of 2018 and on the Fallon Health website in the *Provider Manual*. ■

### **Annual system maintenance of CPT codes**

Fallon Health is performing annual system maintenance of CPT codes to improve alignment with current Medicare payment types and rates. These updates will be effective January 1, 2018 and could result in payment changes for some service codes billed by physician offices. For example, these changes may affect the SDP (Drug) codes, clinical lab codes and DME codes. For all questions, prior to or following the January 1, 2018 changes, please contact your Provider Relations representative. ■

### **ICD-10-CM and ICD-10-PCS annual code update**

The annual update of the ICD-10-CM diagnosis and ICD-10-PCS procedure codes is effective October 1, 2017. An ICD-10-CM diagnosis code is required on all paper and electronic claims billed to Fallon Health. ■

### **MCO non-covered services – a reminder**

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. ■

## Transportation services, non-emergent

| Code                | Description  |
|---------------------|--|
| A0100               | Non-emergency transportation, taxi                   |
| A0110               | Non-emergency transportation, bus                    |
| A0120               | Non-emergency transportation, mini-bus               |
| A0130               | Non-emergency transportation, wheel chair van        |
| A0140               | Non-emergency transportation and air travel          |
| A0425               | Ground mileage                                       |
| A0426               | Ambulance service, ALS, Non-emergency                |
| A0428               | Ambulance service, BLS, Non-emergency                |
| A0434               | Specialty care transport                             |
| S0215               | Non-emergency transportation, wheelchair van mileage |
| T2001               | Non-emergency transportation, wheelchair van, escort |
| T2002               | Non-emergency transportation, per diem               |
| T2003               | transportation (also under day habilitation)         |
| T2004               | Non-emergency transport, commercial carrier, multi   |
| T2005               | N-ET; stretcher van                                  |
| rev code<br>540-549 | Ambulance services ■                                 |



## Coding updates

Effective August 1, 2017, the following codes are covered and *will require plan authorization* for all lines of business:

| Code  | Description   |
|-------|---|
| 0006U | Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service |
| 0007U | Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service  |
| 0008U | Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin            |
| 0009U | Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non amplified  |
| 0010U | Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate  |
| 0011U | Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites  |
| 0012U | Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)   |
| 0013U | Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)   |
| 0014U | Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)   |
| 0015U | Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support  |
| 0016U | Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation   |
| 0017U | Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected   |

**Effective January 1, 2018**, the following code will be moving from *deny vendor liable* for all lines of business to *not a covered benefit*. Per CMS, this code has a status indicator of "N" which is non-covered services.

| Code  | Description   |
|-------|---|
| 0469T | Retinal polarization scan, ocular screening with on-site automated results, bilateral |

**Effective July 1, 2017**, the following codes will be set up as *deny vendor liable* for all lines of business:

| Code  | Description   |
|-------|---|
| 0469T | Retinal polarization scan, ocular screening with on-site automated results, bilateral   |
| 0470T | Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion   |
| 0471T | Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation and report; each additional lesion (List separately in addition to code for primary procedure.)   |
| 0472T | Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional |
| 0473T | Device evaluation and interrogation of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional  |
| 0474T | Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space   |
| 0475T | Recording of fetal magnetic cardiac signal using at least three channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional   |
| 0476T | Recording of fetal magnetic cardiac signal using at least three channels; patient recording, data scanning, with raw electronic signal transfer of data and storage   |
| 0477T | Recording of fetal magnetic cardiac signal using at least three channels; signal extraction, technical analysis and result  |
| 0478T | Recording of fetal magnetic cardiac signal using at least three channels; review, interpretation, report by physician or other qualified health care professional   |

Effective July 1, 2017, the following codes will be covered and *will require plan prior authorization*:

| Code  | Description   |
|-------|---|
| C9745 | Nasal endoscopy, surgical; balloon dilation of eustachian tube  |
| C9746 | Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed |
| C9747 | Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance   |
| K0553 | Elevating footrests, articulating (telescoping), each   |
| K0554 | Oral cushion for combination oral/nasal mask, replacement only, each  |

Effective July 1, 2017, the following codes will be covered and *will require plan prior authorization*:

| Code  | Description   |
|-------|---|
| C9489 | injection, nusinersen, 0.1mg  |
| C9490 | injection, bezlotoxumab, 10mg   |
| Q9984 | levonorgestrel-releasing intrauterine contraceptive system (kyleena) 19.5mg |
| Q9985 | injection, hydroxyprogesterone caproate, nos                                |
| Q9986 | injection, hydroxyprogesterone caproate (makena), 10mg                      |
| Q9989 | ustekinumab, for intravenous injection, 1mg                                 |

Effective January 1, 2018, the following CPT codes *will require prior authorization*:

| Code  | Description  |
|-------|--|
| 52441 | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant   |
| 52442 | Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure.) |

Effective January 1, 2018, the below code *will require prior authorization*:

| Code  | Description  |
|-------|--|
| 43210 | Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed |

Effective January 1, 2018, the following code *will require plan authorization*:

| Code  | Description  |
|-------|--|
| 81500 | Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score |

Effective November 1, 2017, we are *removing the prior authorization* from **J0641** - Injection, levoleucovorin calcium, 0.5 mg.

Effective October 1, 2017, the following codes will be covered and *will require plan prior authorization*:

| Code  | Description   |
|-------|---|
| 0018U | Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy  |
| 0019U | Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents                                       |
| 0020U | Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, with specimen verification including DNA authentication in comparison to buccal DNA, per date of service                          |
| 0021U | Oncology (prostate), detection of 8 autoantibodies (ARF 6, NKX3-1, 5'-UTR-BMI1, CEP 164, 3'-UTR-Ropporin, Desmocollin, AURKAIP-1, CSNK2A2), multiplexed immunoassay and flow cytometry serum, algorithm reported as risk score                    |
| 0022U | Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider |
| 0023U | Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin ■    |

## Payment policy updates

**New policies – effective January 1, 2018:**

- **Home Delivered Meals** ■

## Revised policies – effective January 1, 2018:

**Ambulatory Surgery – Facility** – Added implantable definition.

**Clinical Trials** – Clarified MassHealth follows CMS criteria.

**Durable Medical Equipment (DME) and Medical Supplies** – Updated the reimbursement section.

**Evaluation and Management** – Updated the billing/coding guidelines section.

**Group Adult Foster Care** – Added leave of absence coverage language.

**Hearing Aid and Hearing Aid Exam** – Added NaviCare specific language.

**Laboratory and Pathology** – Updated to state that functional medicine services are not a covered benefit.

**Non-Covered Services** – Updated codes.

**Obstetrics/Gynecology** – Updated the reimbursement section.

**Outpatient Payment Policy** – Updated MassHealth coding section.

**Personal Care Attendant** – Updated initial timely filing from 120 to 360 days.

**Sleep Management Services** – Clarified language regarding authorization and reimbursement for sleep supplies.

**Transportation Services** – Clarified payment of MassHealth non-emergency transport, NaviCare Social Transportation Limits increased/criteria added.

**Vaccine** – Clarified part B vs part D billing guidelines for Hepatitis B Vaccine. ■

## Annual Review

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

- **Observation Status**
- **Nurse Practitioner/Advanced Practice Registered Nurse**
- **Palliative Care Consultation**
- **Physician Assistant** ■

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

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