Connection

Important information for Fallon Health physicians and providers

April 2020

What's new

MHQP Patient Experience Awards

Massachusetts Health Quality Partners, (MHQP) has announced the winners of the 2019 MHQP Patient Experience Awards, recognizing the primary care practices that perform highest on their annual Patient Experience Survey, the only statewide survey of patient experience in primary care in Massachusetts.

Awards have been given to the adult and pediatric practices that performed highest in each of nine performance categories, as well as an overall performance category determined by the practices with the best-in-class results across multiple categories.

Congratulations to all the providers and especially these top overall performers:

Baystate Medical Practices Northern Edge Adult and Pediatric Medicine

Belmont Cambridge Health Care, PC

Community Pediatrics of Milford

Drs. Benjamin, Spingarn, Rottenberg, LLC

Grove Medical Associates, PC

Internists Associated

Newton Wellesley Physicians, Primary Care – Weston

Newton Wellesley Primary Care, PC

Personal Physicians Health Care, PC

Reading Pediatric Associates PC

Wareham Pediatrics n

fallonhealth

Prior Authorization requirement change for certain behavioral health outpatient services

Effective April 1, 2020, prior authorization has been removed for outpatient psychiatric diagnostic evaluation and individual/couple/family therapy.

This change applies to our Commercial and Medicaid (MassHealth Accountable Care Organization) membership.

Codes that *no longer need prior authorization:*

Code	Description
90791	Psychiatric Diagnostic Evaluation
90792	Psychiatric Diagnostic Evaluation with Medical Services
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes, when performed with an evaluation and management service
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes, when performed with an evaluation and management service
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes, when performed with an evaluation and management service
90846	Family Psychotherapy without the patient present
90847	Family/Couple Therapy

Please note that even though prior authorization is no longer required, clinical documentation may be requested periodically to ensure treatment is medically necessary.

Should you have any questions about this change, please call Beacon Health Options at 1-800-397-1630. ■

Free colorectal cancer screening program

Fallon offers a free and voluntary colorectal cancer screening program for our Fallon Medicare Plus, Fallon Medicare Plus Central and NaviCare members. Colorectal cancer screening is an important Quality measure. Members who do not have evidence of colorectal cancer screening are identified from a claims file using current HEDIS technical specifications. Members can meet colorectal cancer screening requirements by having one of the following:

- a colonoscopy every ten years,
- a flexible sigmoidoscopy or CT colonography (virtual colonoscopy) every five years,
- a stool DNA test every three years (e.g., Cologuard®),
- or a fecal occult blood test yearly.

Our program uses a fecal occult blood test, the InSure® ONE™ kit, provided by Quest Diagnostics™. This kit is designed to be simpler and more user-friendly than other screenings specific for human hemoglobin; it requires only one stool sample and does not require fecal handling, or dietary or medication restrictions.

Your patients can receive an InSure ONE kit from Fallon via mail with a provider order. Fallon will be reaching out to eligible members' PCPs via fax to request a provider order for the InSure ONE kit. The kits are resulted by Quest Diagnostics and a copy of the results is faxed to the member's PCP. ■

Product spotlight

NaviCare® – Model of Care training

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

Every member has a customized member centric plan of care developed by their Care Team. The care plan contains details about the member's goals and the benefits that are part of their care plan. Benefits may include, but are not limited to, in-home supportive services such as homemakers, the Personal Care Attendant (PCA) Program, Adult Day Health Care, Group Adult and Adult Foster Care. Each member's care plan is unique to meet their needs.

Additional NaviCare benefits that all members receive include:

- Unlimited transportation to medical appointments
- 140 one-way trips per calendar year to places like the grocery story, gym, church and more within a 30-mile radius of the member's home Up to $400 per year in fitness reimbursements to a qualified fitness facility
- A free SilverSneakers™ gym membership $500 per year on the Save Now card, to purchase certain health-related items like fish oil, contact lens solution, cold/allergy medications, probiotics, incontinence products and more.
- The ability to earn $100 annually on the Healthy Food Card for completing healthy activities such as:
    - Welcome to Medicare/Annual physical or qualified wellness visits
    - Preventive vaccines such as Annual flu vaccine, Tdap, Pneumococcal vaccine, and the Shingles vaccine

NaviCare members also get an entire Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as a coordinated care plan to reference and other Care Team members to communicate with to have the best information possible for each NaviCare patient.

Care Team members and their roles include:

Navigator

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

Nurse Case Manager or Advanced Practitioner

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

Primary Care Provider (PCP)

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

Geriatric Support Service Coordinator employed by local Aging Service Access Points (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 MassHealth paperwork
- Connects patients with helpful resources

Behavioral Health Case Manager *(as needed)*

- Identifies and coordinates services to support patients' emotional health and well-being
- Supports patients through transition to older adulthood
- Helps connect patients with their Care Team and patients' mental health providers and substance-use counselors, if present

Clinical pharmacist *(as needed)*

- Visits patients after care transition to perform a medication reconciliation and teaches them proper medication use

PCPs are welcome to provide input to their patient's care plan at any time by contacting the NaviCare Enrollee Service Line at 1-877-700-6996 or by speaking directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you are interested in having a Navigator and/or Nurse Case Manager embedded in your practice, please contact us at the above phone number.

To refer a patient to NaviCare or learn more about eligibility criteria, contact a Representative at the NaviCare Marketing Line 1-877-255-7108. ■

NaviCare Model of Care Successes

The NaviCare Model of Care has been designed to support members during times of care transition. A recent Model of Care Success is the design and implementation of our Embedded Navigator Program. With this program, Navigators are working with high-volume hospital facilities in Central Massachusetts to ensure collaborative communication between the facilities and the NaviCare Care Teams. Their goal is to provide enhanced support to members as they return back to the community. Care Teams are focused on supporting members to ensure they follow up with their providers as recommended in the discharge plan.

Additionally, the NaviCare Embedded Navigators are making appointments with members for in-home visits by a Fallon Health Safe Transition Pharmacist at time of discharge. These pharmacists complete medication reconciliations and provide follow-up feedback to the PCP. The Safe Transitions Program has proven to be successful in reducing the number of members readmitted to the hospital within 30 days of discharge.

Another Model of Care Success that we are very proud of is the work the Care Teams do to close HEDIS gaps in care. Efforts during 2018 and reported in 2019 saw all HEDIS measures for the NaviCare population scoring at a 4 or 5-star rating from CMS. We thank our providers for partnering closely with us to resolve gaps in care and ensure that our members receive high-quality, evidenced based care. We'll be measuring our 2019 efforts this spring and plan to begin our 2020 efforts on this project in 2nd quarter 2020. We thank you in advance for your partnership. ■

Important reminders

Cultural Competency training

Medicaid Managed Care plans are required to indicate in their provider directories whether each provider has completed cultural competency training. Fallon strongly encourages you to complete this training, update your *practice information* and fill out the section called "Update Information Form". Here you will be asked if you have completed cultural competency training. When you have finished, please hit the submit button at the bottom of the screen. Visit our *Cultural competency page* for suggested courses and resources. ■

Provider enrollments and Medicare certification

Providers who treat Fallon Health Medicare members must be Medicare certified. As part of the provider enrollment process, it is important to validate the Medicare certification as part of the enrollment paperwork. On all HCAS forms, providers should indicate if they are certified by either a Yes or No, and submit the Medicare number that is provided by Medicare. ■

1/1/20 PCP referral change for Medicare beneficiaries (Please note: This change will resume once the Federal State of Emergency has been cancelled.)

For Medicare and NaviCare members only, PCP referrals must be submitted to Fallon Health for referrals made outside of the PCP's provider group, also referred to as a health care option (HCO)*. PCP referrals should be submitted via our tool, ProAuth. ProAuth can also be used to submit prior authorization requests to the plan. If you do not currently have access to ProAuth, please complete the ProAuth enrollment form and send it to askfchp@fallonhealth.org. Training is available upon request. If you are unable to get access to ProAuth, referrals can be submitted on the standardized PA form and faxed in. Please note on the top of the form, "PCP Referral." Our intent is to transition to ProAuth. Should you fax in a PCP referral, we will reach out to you to discuss your access to ProAuth. If you have any questions about this change, please contact your Provider Relations representative at 1-866-275-3247, prompt 4.

Please note: If a specialist claim is received from outside of the member's PCP provider group for a date of service post January 1, 2020, and a PCP referral was not submitted, **the claim will deny**. You have up to 90 days past the date of service of the specialist visit to enter the PCP referral.

** Some specialties are exempt from this requirement. These include obstetrics and gynecology, routine eye exams, and behavioral health. Exempt specialties also include emergency and urgent care services. Physical, occupational and speech therapy (when not provided as part of home health services), as well as chiropractic services, are also exempt, however a prescription is necessary for these services. For Medicare members, kidney dialysis services outside of the area on a temporary basis, routine dental services, flu shots and pneumonia vaccinations, one supplemental routine eye exam and Medicare covered preventive services are exempt. For members in NaviCare SCO, routine women's health services, flu shots and pneumonia vaccinations are exempt.* ■

Doing business with us

Voluntary Site of Service beginning April 1, 2020

Fallon Health is offering health plan members new options for infusion therapy. The Site of Service Program, administered by Magellan Rx Management, identifies lower-cost, clinically appropriate and convenient options for members needing infusions.

How does the Site of Service Program work?

Magellan Rx identifies members receiving hospital-based infusion therapies from a set list of drugs that are considered to be safe to administer at an alternate site, including the member's home. Magellan Rx works with providers and patients to coordinate infusions at these convenient, high-quality, alternate treatment sites. In-home infusions eliminate both the time needed to travel to an infusion site and the time a member has to take off from work to receive these infusions.

Please consider partnering with the Site of Service team to transition your patients to an alternative infusion site. The Site of Service team can provide real-time answers about benefits while helping members maximize plan benefits and/or minimize out-of-pocket expenses. Fallon Health and Magellan Rx aim to provide the best possible care at the most affordable price.

How do I learn more?

A Magellan Rx registered nurse will contact you and your patient needing infusion therapy to discuss the Site of Service Program. Call Magellan Rx at 1-800-424-1762 if you have questions about this program. ■

Electronic Prior Authorization (ePA)

We wish to remind providers to use the ePA options for both pharmacy benefit and medical benefit drugs when submitting PA requests. This will save providers time and assist with better PA turnaround times. The instructions below are located on our pharmacy web page at: *http://www.fchp.org/en/providers/pharmacy/pharmacy-prior-authorization.aspx* ■

Zelis™

Fallon Health uses 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. Providers will find a message on the Remittance Advice Summary (RAS) and the Electronic Remittance Advice (835 file) indicating an edit was applied by Zelis.

Questions related to an edit should be directed to Zelis at 1-866-489-9444.

Zelis corrected claims and/or appeals should be sent to Zelis at the following address:

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

Zelis appeals require:

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

Zelis corrected claims require:

- A completed Request for Claim Review Form
- A new claim
- Must be sent within 120 days of the original RAS
- Cannot be sent electronically ■

Clinical practice guidelines update

Our Clinical Practice Guidelines are available at *http://www.fchp.org/providers/medical-management/health-care-guidelines.aspx.*

For a paper copy, please contact Robin Byrne at 1-508-368-9103.

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

- Massachusetts Health Quality Partners 2020 Pediatric and Adult Preventive Care Guidelines
- Massachusetts Health Quality Partners 2020 Perinatal Care Guidelines
- Centers for Disease Control and Prevention Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger
- Centers for Disease Control and Prevention Recommended Adult Immunization Schedule
- Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain-United States, 2016
- 2020 Standards of Medical Care in Diabetes ■

Updates to clinical criteria for Elective Procedures and SNF

Effective June 1, 2020, Fallon Health will be referencing updated clinical criteria for the following guidelines:

- Subacute/Skilled Nursing level of care and the following elective procedures:
  - Cervical Artificial Disc Replacement
  - Cochlear Implantation
  - Interspinous Process Decompression
  - Lumbar Artificial Disc Replacement
  - Neurosurgical Procedures of the Spine
  - Orthognathic Surgery
  - Percutaneous Vertebroplasty and Kyphoplasty
  - Spinal Cord Stimulation
  - Transplantation
  - Vagus Nerve Stimulation
  - Varicose Vein Treatments
  - Weight Loss Surgery

Please review and begin referencing these updated medical policies, which use updated criteria. While these specific policies will be externally vetted and aligned with industry standards, they will no longer be referencing Interqual. Please continue to refer to Fallon Health policies for appropriate clinical criteria. ■

Quality focus

HOS-M

The (Health Outcomes Survey) HOS-M is a cross-sectional modified version of the Medicare HOS that contains 19 questions measuring the physical and mental health functioning of beneficiaries at a single point in time. The core components of the survey include The Veterans RAND 12-Item Health Survey (VR-12) and Activity of Daily Living (ADL) items.

Survey Administration and Eligibility

The HOS-M is distributed annually between April and June to participants and enrollees in both Fallon Health NaviCare HMO SNP and Summit ElderCare subject to the limitations below:

- NaviCare HMO SNP
  - 1200 randomly selected enrollees enrolled at the time of the survey
  - Excludes enrollees who reside in nursing homes
  - Excludes enrollees with end stage renal disease
  - Excludes enrollees who only have Medicaid
- Summit ElderCare
  - All participants enrolled at the time of the survey
  - Excludes participants who reside in nursing homes
  - Excludes participants with end stage renal disease
  - Exclude participants who only have Medicaid

Why is HOS-M important for your patients?

One of the main goals of the HOS-M is to assess annually the frailty of the population enrolled in both Medicare Advantage D-SNP plans and PACE organizations nationally. In keeping with CMS's goal to gather clinically meaningful data, the results of the survey are used to monitor participating health plan performance as well as to assist these plans and CMS in improving quality of care.

Please consider supporting your patients to provide honest and candid responses and encouraging them to reach out to family, caregivers or members of their Fallon Health or Summit ElderCare care teams for assistance in completing the survey.

For more information regarding the HOS-M or the administration of the survey to members and participants, please visit the official Health Outcome Survey website at www.HOSOnline.org/en/hos-modified-overview/.

Coding corner

Fallon is updating its definition of Sepsis for validation of hospital claims

Sepsis 2 was defined in 2001, but the current definition of Sepsis was published in February 2016 from an international group working with the newest evidence. For the purpose of clinical validation of hospital claims, as of June 1, 2020, Fallon Health will use the Sepsis 3 definition in order to correctly pay claims. ■

Coding updates

Effective January 1, 2020, the following codes will be *deny vendor liable*. For Medicaid and Fallon Health Weinberg these codes are *not a covered benefit:*

Code	Description
G1000	Clinical decision support mechanism applied pathways, as defined by the Medicare appropriate use criteria program
G1002	Clinical decision support mechanism medcurrent, as defined by the Medicare appropriate use criteria program
G1003	Clinical decision support mechanism medicalis, as defined by the Medicare appropriate use criteria program
G1004	Clinical decision support mechanism national decision support company, as defined by the Medicare appropriate use criteria program
G1005	Clinical decision support mechanism national imaging associates, as defined by the Medicare appropriate use criteria program
G1006	Clinical decision support mechanism test appropriate, as defined by the Medicare appropriate use criteria program
G1007	Clinical decision support mechanism aim specialty health, as defined by the Medicare appropriate use criteria program
G1008	Clinical decision support mechanism cranberry peak, as defined by the Medicare appropriate use criteria program
G1009	Clinical decision support mechanism sage health management solutions, as defined by the Medicare appropriate use criteria program
G1010	Clinical decision support mechanism stanson, as defined by the Medicare appropriate use criteria program
G1011	Clinical decision support mechanism, qualified tool not otherwise specified, as defined by the Medicare appropriate use criteria program

Effective January 1, 2020, the following dental codes are *not a covered benefit* for any line of business:

Code	Description
D0419	Assessment of salivary flow by measurement
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant
D8696	Repair of orthodontic appliance – maxillary
D8697	Repair of orthodontic appliance – mandibular
D8698	Re-cement or re-bond fixed retainer – maxillary
D8699	Re-cement or re-bond fixed retainer – mandibular
D8701	Repair of fixed retainer, includes reattachment – maxillary
D8702	Repair of fixed retainer, includes reattachment – mandibular
D8703	Replacement of lost or broken retainer – maxillary
D8704	Replacement of lost or broken retainer – mandibular
D9997	Dental case management – patients with special health care needs

Effective January 1, 2020, the following codes *will require plan prior authorization:*

Code	Description
L2006	Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated

Effective February 1, 2020, the following codes *will not be a covered benefit:*

Code	Description
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscle(s)
90694	Influenza virus vaccine, quadrivalent (allV4), inactivated, adjuvanted, preservative free, 0.5mL dosage, for intramuscular use
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171	Health behavior intervention, family (without the patient present), face-to-face; each addition-al 15 minutes (List separately in addition to code for primary service)
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Effective February 2, 2020, the following code *will be a covered benefit* and *will require plan prior authorization:*

Code	Description
U0001	Real Time Reverse transcription polymerase chain reaction (RT_PCR) diagnostic

This code will be available in the Medicare billing system 4/1/2020, but will be retroactive back to 2/3/2020.

Effective April 1, 2020, the following codes *will be set up as deny vendor liable* for all lines of business:

Code	Description
G1012	Clinical decision support mechanism agilemd, as defined by the medicare appropriate use criteria program
G1013	Clinical decision support mechanism evidencecare imaging advisor, as defined by the medicare appropriate use criteria program
G1014	Clinical decision support mechanism inveniqa semantic answers in medicine, as defined by the medicare appropriate use criteria program
G1015	Clinical decision support mechanism reliant medical group, as defined by the medicare appropriate use criteria program
G1016	Clinical decision support mechanism speed of care, as defined by the medicare appropriate use criteria program
G1017	Clinical decision support mechanism healthhelp, as defined by the medicare appropriate use criteria program
G1018	Clinical decision support mechanism infinx, as defined by the medicare appropriate use criteria program
G1019	Clinical decision support mechanism logicnets, as defined by the medicare appropriate use criteria program

Effective July 1, 2020, the following codes *will be added to the Fallon Health Auxiliary and Fallon Health Weinberg Auxiliary fee schedules:*

Code	Description	Rate
58300	Insertion of intrauterine device (IUD)	$56.15
99173	Screening test of visual acuity, quantitative, bilateral	$3.08
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	$123.84
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = I day supply	$79.42

Effective July 1, 2020, the following code *will be removed from the Fallon Health Auxiliary and Fallon Health Weinberg Auxiliary fee schedules as it is considered not separately reimbursed:*

Code	Description
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick) ■

Payment policies

Revised policies – effective June 1, 2020:

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

- ***Claims Editing Software –*** Policy name changes from Claims Auditing Software to Claims Editing Software.
- ***Code Review –*** Clarified policy section
- ***Early Intervention –*** Updated billing/coding section.
- ***Modifiers –*** Updated modifier tables.
- ***Transportation Services*** - Clarified billing of multiple patients transported.
- ***Vaccines –*** Updated coding.
- ***Podiatry***
- ***Drugs and Biologicals*** ■

Annual Review

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

- ***Adult Day Health (NaviCare)***
- ***Anesthesia***
- ***Cardiology Services***
- ***Coding Analysis***
- ***Group Adult Foster Care***
- ***MassHealth Preventable Conditions***
- ***Neonatal Intensive Care Services***
- ***Personal Care Attendant (NaviCare)***
- ***Serious Reportable Events*** ■

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

Send information to:

Provider Relations
Fallon Health
10 Chestnut St.
Worcester, MA 01608

or

Email your Provider Relations representative

Richard Burke
President and CEO

Dr. Carolyn Langer
Senior Vice President and Chief Medical Officer

Susan Keser
Vice President, Network Development and Management

Kathy Bien
Director, Provider Relations

fallonhealth.org/providers

Questions?

1-866-275-3247

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