

# CONNECTION

Important information for Fallon Health Weinberg physicians and providers

March 2017

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## Quality focus

### Fallon Health Weinberg-HMO SNP Clinical Practice Initiatives

You now have the convenience of viewing the updated Clinical Practice Initiatives for 2017 from the provider section of our website, and can easily print PDF versions of each topic. You'll find the most current version of the following initiatives [here](#):

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



While on our site, please take a few minutes to browse our various tools and resources that can help you stay informed and interact with us more smoothly. If you have any questions, please contact your Provider Relations Representative for assistance at 1-855-827-2003 (TTY 711), option 4. ■

### **Clinical Practice Guidelines update**

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

#### [American Diabetes Association Standards of Medical Care in Diabetes–2017](#)

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

## Doing business with us

### **Please keep your practice information current**

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

Please use the tool on our website to update your practice information. It's quick and easy. Just go to the "[Update your practice information](#)" page. Please be sure to hit the submit button at the bottom. Updates will be made within 30 days if there are no questions in the information you have provided.

- Your ability to accept new patients
- Street address
- Phone number
- Specialty
- Hospital affiliations
- Languages spoken by you or your staff
- Any other change that impacts your availability to patients ■

## Reminder: Claims submissions address

Fallon Health Weinberg has a Post Office Box for all paper claim submissions, adjustments and appeals.

The P.O. Box is:

Fallon Health Weinberg

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 Weinberg Claims

Smart Data Solutions\*

2401 Pilot Knob Road, Suite 140

Mendota Heights, MN 55120

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

## Product spotlight

### Fallon Health Weinberg-HMO SNP Model of Care

When someone enrolls in Fallon Health Weinberg-HMO SNP, he or she is matched with a team of experts, called a Care Team. The Care Team is dedicated to helping members meet their health goals, and the team works together to create a care plan based on the needs and health records of each member. Members of the team review this plan together regularly, to make any adjustments based on how the member is responding to the treatment and services.

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

Here is what the Care Team looks like:

#### Navigator

- Organizes benefits and services
- Advocates for members so they receive the care they need
- Helps members schedule medical appointments and arranges transportation, as needed

### **Care Manager**

- Assesses clinical needs
- Educates members about conditions and medications
- Helps members get the care they need, where and when they need it

### **Social Worker**

- Evaluates services and resources for member's health needs, including behavioral health
- Counsels about benefits and resources available in the community
- Assists members in maintaining Medicare and Medicaid benefits

### **Primary Care Provider**

- Directs member's care and provides routine services
- Refers members to specialists
- Orders prescriptions and supplies

### **Behavioral Health Clinician (as needed)**

- Assesses member's emotional and psychological needs
- Facilitates short-term counseling
- Works with behavioral health provider to coordinate services
- Understands behavioral health medications

### **Clinical Pharmacist**

- Provides drug information and consults with other Care Team members
- Educates about drugs and usage
- Identifies and communicates potential adverse reactions and gaps in medication therapy ■

## **Medication Therapy Management program**

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

- Enrolled in a Medicare Part D plan
- Taking at least eight prescriptions
- Have three or more chronic conditions (Qualifying chronic conditions include: high blood pressure, high cholesterol, diabetes, COPD and depression)
- The amount his or her health plan spends on drugs is more than \$3,919 annually

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

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

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

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

## Coding corner

### Coding updates

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

Code	Description
<b>C1842</b>	Retinal prosthesis, includes all internal and external components

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

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

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

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

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

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

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

Code	Description
<b>22867</b>	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
<b>22868</b>	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure.)
<b>22869</b>	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
<b>22870</b>	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure.)
<b>33340</b>	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation
<b>36473</b>	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated

Code	Description
<b>36474</b>	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure.)
<b>43284</b>	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed
<b>43285</b>	Removal of esophageal sphincter augmentation device
<b>58674</b>	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency
<b>62380</b>	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
<b>0466T</b>	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure.)
<b>0467T</b>	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator
<b>0468T</b>	Removal of chest wall respiratory sensor electrode or electrode array
<b>81327</b>	SEPT9 (Septin9) (e.g., colorectal cancer) methylation analysis
<b>81413</b>	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
<b>81414</b>	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
<b>81422</b>	Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
<b>81439</b>	Inherited cardiomyopathy (e.g., hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN
<b>87483</b>	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (e.g., neisseria meningitidis, streptococcus pneumoniae, listeria, haemophilus influenzae, E. coli, streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpes virus 6, cytomegalovirus, varicella zoster virus, cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

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

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



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

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

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

Code	Description
<b>G9731</b>	Patient unable to complete the foto foot or ankle intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
<b>G9732</b>	Patient refused to participate
<b>G9733</b>	Patient unable to complete the foto lumbar intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
<b>G9734</b>	Patient refused to participate
<b>G9735</b>	Patient unable to complete the foto shoulder intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
<b>G9736</b>	Patient refused to participate
<b>G9737</b>	Patient unable to complete the foto elbow, wrist or hand intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
<b>G9738</b>	Patient refused to participate
<b>G9739</b>	Patient unable to complete the foto general orthopedic intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
<b>G9740</b>	Hospice services given to patient any time during the measurement period
<b>G9741</b>	Patients who use hospice services any time during the measurement period
<b>G9742</b>	Psychiatric symptoms assessed
<b>G9743</b>	Psychiatric symptoms not assessed, reason not otherwise specified
<b>G9744</b>	Patient not eligible due to active diagnosis of hypertension.
<b>G9745</b>	Documented reason for not screening or recommending a follow-up for high blood pressure
<b>G9746</b>	Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery).
<b>G9747</b>	Patient is undergoing palliative dialysis with a catheter.
<b>G9748</b>	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant.
<b>G9749</b>	Patient is undergoing palliative dialysis with a catheter.
<b>G9750</b>	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant.
<b>G9751</b>	Patient died at any time during the 24-month measurement period.
<b>G9752</b>	Emergency surgery

Code	Description
<b>G9753</b>	Documentation of medical reason for not conducting a search for dicom format images for prior patient CT imaging studies completed at non-affiliated external healthcare facilities, or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., trauma, acute myocardial infarction, stroke, aortic aneurysm where time is of the essence)
<b>G9754</b>	A finding of an incidental pulmonary nodule
<b>G9755</b>	Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has a known malignancy that can metastasize, other medical reason(s))
<b>G9756</b>	Surgical procedures that included the use of silicone oil
<b>G9757</b>	Surgical procedures that included the use of silicone oil
<b>G9758</b>	Patient in hospice and in terminal phase
<b>G9759</b>	History of preoperative posterior capsule rupture
<b>G9760</b>	Patients who use hospice services any time during the measurement period
<b>G9761</b>	Patients who use hospice services any time during the measurement period
<b>G9762</b>	Patient had at least three HPV vaccines on or between the patient's 9 <sup>th</sup> and 13 <sup>th</sup> birthdays
<b>G9763</b>	Patient did not have at least three HPV vaccines on or between the patient's 9 <sup>th</sup> and 13 <sup>th</sup> birthdays
<b>G9764</b>	Patient has been treated with an oral systemic or biologic medication for psoriasis.
<b>G9765</b>	Documentation that the patient declined therapy change, has documented contraindications, or has not been treated with an oral systemic or biologic for at least six consecutive months (e.g., experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by PGA, BSA, PASI, DLQI
<b>G9766</b>	Patients who are transferred from one institution to another with a known diagnosis of CVA for endovascular stroke treatment
<b>G9767</b>	Hospitalized patients with newly diagnosed CVA considered for endovascular stroke treatment
<b>G9768</b>	Patients who utilize hospice services any time during the measurement period
<b>G9769</b>	Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months.
<b>G9770</b>	Peripheral nerve block (PNB)
<b>G9771</b>	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Code	Description
<b>G9772</b>	Documentation of one of the following medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., emergency cases, intentional hypothermia, etc.)
<b>G9773</b>	At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
<b>G9774</b>	Patients who have had a hysterectomy
<b>G9775</b>	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively
<b>G9776</b>	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)
<b>G9778</b>	Patients who have a diagnosis of pregnancy
<b>G9779</b>	Patients who are breastfeeding
<b>G9780</b>	Patients who have a diagnosis of rhabdomyolysis
<b>G9781</b>	Documentation of medical reason(s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who are receiving palliative care, patients with active liver disease or hepatic disease or insufficiency, and patients with end stage renal disease)
<b>G9782</b>	History of or active diagnosis of familial or pure hypercholesterolemia
<b>G9783</b>	Documentation of patients with diabetes who have a most recent fasting or direct LDL-C laboratory test result < 70 mg/dl and are not taking statin therapy
<b>G9784</b>	Pathologists/dermatopathologists providing a second opinion on a biopsy
<b>G9785</b>	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) sent from the pathologist/dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist
<b>G9786</b>	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) was not sent from the pathologist/dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist
<b>G9787</b>	Patient alive as of the last day of the measurement year
<b>G9788</b>	Most recent blood pressure is less than or equal to 140/90 mm Hg
<b>G9789</b>	Blood pressure recorded during inpatient stays, emergency room visits, urgent care visits, and patient self-reported blood pressure (home and health fair results)

Code	Description
<b>G9790</b>	Most recent blood pressure is greater than 140/90 mm hg, or blood pressure not documented
<b>G9791</b>	Most recent tobacco status is tobacco free
<b>G9792</b>	Most recent tobacco status is not tobacco free
<b>G9793</b>	Patient is currently on a daily aspirin or other antiplatelet
<b>G9794</b>	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed or intra-cranial bleed or documentation of active anticoagulant use during the measurement period
<b>G9795</b>	Patient is not currently on a daily aspirin or other antiplatelet
<b>G9796</b>	Patient is currently on a statin therapy
<b>G9797</b>	Patient is not on a statin therapy
<b>G9798</b>	Discharge(s) for AMI between July 1 of the year prior measurement year to June 30 of the measurement period
<b>G9799</b>	Patients with a medication dispensing event indicator of a history of asthma any time during the patient's history through the end of the measure period
<b>G9800</b>	Patients who are identified as having an intolerance or allergy to beta-blocker therapy
<b>G9801</b>	Hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis
<b>G9802</b>	Patients who use hospice services any time during the measurement period
<b>G9803</b>	Patient prescribed a 180-day course of treatment with beta-blockers post discharge for AMI.
<b>G9804</b>	Patient was not prescribed a 180-day course of treatment with beta-blockers post discharge for AMI.
<b>G9805</b>	Patients who use hospice services any time during the measurement period
<b>G9806</b>	Patients who received cervical cytology or an HPV test
<b>G9807</b>	Patients who did not receive cervical cytology or an HPV test
<b>G9808</b>	Any patients who had no asthma controller medications dispensed during the measurement year
<b>G9809</b>	Patients who use hospice services any time during the measurement period
<b>G9810</b>	Patient achieved a PDC of at least 75% for their asthma controller medication
<b>G9811</b>	Patient did not achieve a PDC of at least 75% for their asthma controller medication
<b>G9812</b>	Patient died, including all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure
<b>G9813</b>	Patient did not die within 30 days of the procedure or during the index hospitalization

Code	Description
G9814	Death occurring during hospitalization
G9815	Death did not occur during hospitalization
G9816	Death occurring 30 days post procedure
G9817	Death did not occur 30 days post procedure
G9818	Documentation of sexual activity
G9819	Patients who use hospice services any time during the measurement period
G9820	Documentation of a chlamydia screening test with proper follow-up
G9821	No documentation of a chlamydia screening test with proper follow-up
G9822	Women who had an endometrial ablation procedure during the year prior to the index date (exclusive of the index date)
G9823	Endometrial sampling or hysteroscopy with biopsy and results documented
G9824	Endometrial sampling or hysteroscopy with biopsy and results not documented
G9825	HER-2/neu negative or undocumented/unknown
G9826	Patient transferred to practice after initiation of chemotherapy
G9827	Her2-targeted therapies not administered during the initial course of treatment
G9828	Her2-targeted therapies administered during the initial course of treatment
G9829	Breast adjuvant chemotherapy administered
G9830	Her-2/neu positive
G9831	AJCC stage at breast cancer diagnosis = ii or iii
G9832	AJCC stage at breast cancer diagnosis = i (Ia or Ib) and t-stage at breast cancer diagnosis does not equal = t1, t1a, t1b
G9833	Patient transfer to practice after initiation of chemotherapy
G9834	Patient has metastatic disease at diagnosis
G9835	Trastuzumab administered within 12 months of diagnosis
G9836	Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation not complete)
G9837	Trastuzumab not administered within 12 months of diagnosis
G9838	Patient has metastatic disease at diagnosis
G9839	Anti-EGFR monoclonal antibody therapy
G9840	Kras gene mutation testing performed before initiation of anti-EGFR moab
G9841	Kras gene mutation testing not performed before initiation of anti-EGFR moab
G9842	Patient has metastatic disease at diagnosis

Code	Description
G9843	Kras gene mutation
G9844	Patient did not receive anti-EGFR monoclonal antibody therapy
G9845	Patient received anti-EGFR monoclonal antibody therapy
G9846	Patients who died from cancer
G9847	Patient received chemotherapy in the last 14 days of life
G9848	Patient did not receive chemotherapy in the last 14 days of life
G9849	Patients who died from cancer
G9850	Patient had more than one emergency department visit in the last 30 days of life
G9851	Patient had one or less emergency department visits in the last 30 days of life
G9852	Patients who died from cancer
G9853	Patient admitted to the ICU in the last 30 days of life
G9854	Patient was not admitted to the ICU in the last 30 days of life
G9855	Patients who died from cancer
G9856	Patient was not admitted to hospice
G9857	Patient admitted to hospice
G9858	Patient enrolled in hospice
G9859	Patients who died from cancer
G9860	Patient spent less than three days in hospice care
G9861	Patient spent greater than or equal to three days in hospice care
G9862	Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is = 66 years old, or life expectancy < 10 years old, other medical reasons)
G9700	Patients who use hospice services any time during the measurement period
G9724	Patients who had documentation of use of anticoagulant medications overlapping the measurement year
G9722	Documented history of renal failure or baseline serum creatinine = 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation the cr has been or is 4.0 or higher
G9777	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively



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

Code	Description
A9285	Inversion/eversion correction device

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

Code	Description
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure.)
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode

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

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

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

Code	Description
<b>99155</b>	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
<b>99156</b>	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
<b>99157</b>	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service.)

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

Code	Description
<b>A4553</b>	Non-disposable underpads, all sizes
<b>A9515</b>	Choline c-11, diagnostic, per study dose up to 20 millicuries
<b>A9587</b>	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie
<b>A9588</b>	Fluciclovine f-18, diagnostic, 1 millicurie
<b>A9597</b>	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
<b>A9598</b>	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified
<b>C1889</b>	Implantable/insertable device for device intensive procedure, not otherwise classified
<b>G0502</b>	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Code	Description
<b>G0503</b>	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms or other treatment goals and are prepared for discharge from active treatment
<b>G0504</b>	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure); (use G0504 in conjunction with G0502, G0503)
<b>G0505</b>	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home
<b>G0507</b>	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team
<b>J2182</b>	Injection, mepolizumab, 1 mg
<b>J2786</b>	Injection, reslizumab, 1 mg
<b>J2840</b>	Injection, sebelipase alfa, 1 mg
<b>J7320</b>	Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg
<b>J7322</b>	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg
<b>J8670</b>	Rolapitant, oral, 1 mg
<b>J9034</b>	Injection, bendamustine HCL (bendeka), 1 mg
<b>J9145</b>	Injection, daratumumab, 10 mg
<b>J9176</b>	Injection, elotuzumab, 1 mg
<b>J9295</b>	Injection, necitumumab, 1 mg

Code	Description
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
J9352	Injection, trabectedin, 0.1 mg
Q4166	Cytal, per square centimeter
Q4167	Truskin, per square centimeter
Q4168	Amnioband, 1 mg
Q4169	Artacent wound, per square centimeter
Q4170	Cygnus, per square centimeter
Q4171	Interfyl, 1 mg
Q4172	Puraply or puraply AM, per square centimeter
Q4173	Palingen or palingen xplus, per square centimeter
Q4175	Miroderm, per square centimeter
T1040	Medicaid certified community behavioral health clinic services, per diem
T1041	Medicaid certified community behavioral health clinic services, per month
Q4174	Palingen or promatrix, 0.36 mg per 0.25 cc

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

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

# Payment Policy Updates

## New policy – effective May 1, 2017:

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

## Revised policies – effective May 1, 2017:

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

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

## Annual review

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

- ***Ambulatory Surgery*** – Facility
- ***Ambulatory Surgery*** – Professional
- ***Aging Service Access Points (ASAP)***
- ***Assistant Surgeon***
- ***Code Review*** ■

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