CONNECTION

Important information for Fallon Health Weinberg physicians and providers

June 2016

In this issue

What's new

CDC releases guideline for prescribing opioids for chronic pain

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

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

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

fallonhealth weinberg

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

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

For more information:

2016 CDC Guideline for prescribing opioids for chronic pain

2016 CDC Checklist for prescribing opioids for chronic pain

New York list of SAMHSA providers (prescribers of Suboxone)

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

Let's connect

New address for claims submissions

Effective January 1, 2016, Fallon Health Weinberg has a new P.O. Box for all paper claim submissions, Claims Adjustment forms, adjustments, and appeals.

Member ID cards will be updated with the new claims address as members' policies renew. The only change for providers is the new P.O. Box. The fax numbers are the same.

The new P.O. Box is:
Fallon Health 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.* ■

Are you making changes?

Are you moving? Changing your name, billing company or email address? Closing or opening your panel?

Please help us to best communicate with you, our providers, and make sure that patients have the most up-to-date information about your practice by completing the *Standardized Provider Information Change form* when making changes to your practice information.

Please note: This form is not to be used for credentialing or contractual changes and, in certain limited circumstances, we may need to follow up with providers for additional information. ■

Product spotlight

Providing the care our HMO SNP members need

At Fallon Health Weinberg we know that caring for our members takes a team. With our HMO SNP plan, members are paired with a Care Team of medical professionals who are dedicated to providing the care and services they deserve.

The Care Team works together to create a care plan based on the needs and health records of each member. The team reviews this plan regularly and makes 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.

On the next page, we have provided details about who is on the Care Team and what services they provide. ■

How we care for our HMO SNP members

The Fallon Health Weinberg-HMO SNP Care Team includes:

Navigator

- Organizes members' benefits and services
- Advocates for members to receive the care they need
- Helps members make medical appointments and arranges rides
- May visit members at home
- Places referrals and follows up to ensure services are in place

Care Manager

- Educates members about conditions and medications
- Ensures members get the care they need while in a hospital or facility and at home
- Actively involved with member care during planned and unplanned admissions
- Helps develop members' personal care plans
- Assesses members' clinical needs

Primary Care Provider

- Directs member care and provides routine services
- Works with the Care Team to decide the best treatment for members
- Refers members to specialists
- Orders prescriptions and supplies

Social Worker

- Evaluates services and resources for members' health needs
- Counsels members and caregivers about benefits and resources available in the community
- Assists members with maintaining their Medicare and Medicaid coverage

Clinical Pharmacist

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

Behavioral Health Clinical

(as needed)

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

Quality focus

Measuring blood pressure

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

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

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

Clinical Practice Guideline update

Our *Clinical Practice Guidelines* are available online. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

Recent updates:

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

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

Coding corner

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

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

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

Amended medical records fall into three primary categories:

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

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

For paper medical records:

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

For electronic records:

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

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

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

Official "Do Not Use" List[1]		
Do Not Use	**Potential Problem**	**Use Instead**
U, u (unit)	**Mistaken for** • "0" (zero), • the number "4" (four) • or "cc"	Write ***"unit"***
IU (International Unit)	**Mistaken for** • IV (intravenous) or • the number 10 (ten)	Write ***"International Unit"***
Q.D., QD, q.d., qd (daily) **Q.O.D., QOD, q.o.d, qod** (every other day)	**Mistaken for** • each other • Period after Q mistaken for "I" • the "O" mistaken for "I"	Write ***"daily"*** Write ***"every other day"***
Trailing zero (X.0 mg)* **Lack of leading zero** (.X mg)	**Decimal point is missed**	Write ***X mg*** Write ***0.X mg***
MS	**Can mean** morphine sulfate or magnesium sulfate	Write ***"morphine sulfate"***
MSO_4 and **$MgSO_4$**	**Confused for one another**	Write ***"magnesium sulfate"***

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

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

jointcommission.org/standardsinformation/npsgs.aspx ■

Commonly under-coded medical conditions

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

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

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

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

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

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

Coding updates

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

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

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

Code	Description	Reason
99050	Services requested after posted office hours in addition to basic service	**Not separately reimbursed** *(effective 5/1/16)*
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	
99053	Services requested between 10 p.m. and 8 a.m. at 24-hour facility, in addition to basic service	
99056	Services provided at request of patient in a location other than physician's office which are normally provided in the office	
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	Code has a Medicare rate.
99377	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	**Not separately reimbursed** *(effective 5/1/16)*

Code	Description	Reason
99379	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	**Not separately reimbursed** *(effective 5/1/16)*
99380	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	**Termed code**
D9220	General anesthesia - first 30 minutes	
D9221	General anesthesia - each additional 15 minutes	
D9241	IV sedation - first 30 minutes	
D9242	IV sedation - each additional 15 minutes	
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Code has a Medicare rate.

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

Code	Description
92251	Screening test, pure tone, air only

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

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

Payment policy updates

New policies– effective July 1, 2016

- ***Ventricular Assist Devices***
- ***Speech Therapy*** ■

Revised policies– effective July 1, 2016

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

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

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

Obstetrics/Gynecology– Updated to address IUD reimbursement.

Preventive Services– Added codes 99497 and 99498.

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

Annual review

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

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

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

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