January 2025

Connection

Important information for Fallon Health physicians and providers

In the January issue:

Important updates

Fallon Health MassHealth ACO plan pharmacy coverage changes for 2025 – anti-obesity drugs

These changes apply to our MassHealth ACO plans—Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative:

- Zepbound will be the only covered anti-obesity GLP-1*.
- Wegovy and Saxenda will only be available for members aged 12-17 for anti-obesity.
- Wegovy will also be covered for prevention of cardiovascular events in members who meet those criteria*.
- Oral phentermine trial will be required for new starts (no GLP-1 therapy in previous 90 days) on GLP-1 for obesity (inadequate response, adverse reaction, or contraindication)*.
- Generic phentermine will no longer require prior authorization for members 12 years of age or older*.
- Lomaira will not have PA between the ages of 12 and 17 years old.

**Also applies to NaviCare plans that follow the MassHealth policy for anti-obesity agents.*

fallonhealth

What's new

Community Care service area expansion

Community Care—Fallon Health's affordable health plan for individuals and families through the Massachusetts Health Connector—is expanding its service area again!

Effective January 1, 2025, the Community Care service area will include all of Berkshire, Bristol, Hampden, Middlesex, Plymouth, and Worcester counties, and parts of Norfolk County. Visit our *website* for more information.

Changes to prior authorization requirements

As previously communicated in July and October, effective January 1, 2025—to align with industry practice—Fallon Health and our vendor partners will be eliminating retrospective authorization requests. We will no longer allow authorization requests after the service is rendered for all Fallon Health products, except Summit ElderCare®.

What you need to know:

- Providers must submit authorization requests in advance to ensure an authorization decision is received prior to the service date.
- If a prior authorization is not obtained in advance of the service, the claim will be denied.
- A provider appeal will only be granted for extenuating circumstances, such as an enrollment/eligibility mismatch or technology malfunction.
- In the rare instance that a prior authorized surgical code needs to be changed or amended after the surgery, the provider appeal process should be utilized.
- For a continuation of services such as durable medical equipment (DME) or infusion, providers should submit additional clinical information prior to future service dates for authorization of continued services.
- Home care, oxygen services, hospice, and non-emergency transportation are currently excluded from this change to the prior authorization requirements. Please continue to follow the current process.
- Urgent and emergent inpatient admissions are excluded from this change to the prior authorization requirements. Please continue to follow the current process.
- Our vendor partners are also making this change.
- Providers requesting authorization retrospectively will receive a denial notice stating the request was made after the service was delivered.

Please visit our website as a resource for which codes require *prior authorization*. If you have questions about this change, please contact your Provider Relations representative.

New Medicare Prescription Payment Plan—starting in 2025!

The Medicare Prescription Payment Plan is a new payment option available for those with Medicare Part D. Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with Part D drug coverage can use this payment option. All plans offer this payment option, and participation is voluntary.

If members choose this option, each month they'll receive an invoice from their health plan to pay for their prescription drugs, instead of paying at the pharmacy. It allows members to spread out the cost of their prescriptions over the rest of the year.

This applies to Fallon Health members in:

- Fallon Medicare Plus™ Orange HMO
- Fallon Medicare Plus™ Premier HMO
- Fallon Medicare Plus™ Green HMO
- Fallon Medicare Plus™ Central Premier HMO
- Fallon Medicare Plus™ Blue HMO

If a patient is interested in this program, please have them reach out to Fallon Health at the number on the back of their member ID card.

Product spotlight

Health Related Social Needs Services program

Beginning January 1, 2025, MassHealth members enrolled in Accountable Care Organizations (ACOs) may be able to get help with food and housing needs through the MassHealth Health Related Social Needs (HRSN) Services program. MassHealth has developed a standard set of criteria that members need to meet to receive these services.

The following HRSN providers will be partnering with Fallon Health and our ACOs to provide these supports to members:

Berkshire Fallon Health Collaborative

- Upside 413/Berkshire County Regional Housing Authority
- Just Roots

Fallon Health-Atrius Health Care Collaborative

- Just Roots
- Community Servings
- Project Bread
- Massachusetts Coalition for the Homeless

Fallon 365 Care

- Just Roots
- Project Bread
- Elder Services of Worcester Area
- Massachusetts Coalition for the Homeless

Providers interested in learning more about HRSN services or referring a patient can speak directly with Fallon Health Care Management staff working in your practices. Providers are also welcome to reach out to the Fallon Health Community Services team by sending a secure email to *CP.referrals@fallonhealth.org* with any questions about eligibility for the program or how to refer patients.

NaviCare – Model of Care training

NaviCare utilizes both Medicare and Medicaid covered benefits and services to help our members function at the safest level in the most appropriate setting. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. NaviCare is available in every county in Massachusetts, except for Nantucket and Dukes, and there are no costs to the member for covered benefits.

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 care, and adult foster care. Each member's care plan is unique to meet their needs.

Benefits that all NaviCare members receive include:

- 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 coordinated care plans to reference and other Care Team members to communicate with to have the best information possible for each NaviCare member. Care Team members visit and assess members in their homes with the member's consent, and work closely with community providers and resources providing value to both our members and providers.
- Unlimited transportation to medical appointments. 130 one-way trips per calendar year to additional places including grocery stores, gyms, and churches, within a 30-mile radius of the member's home. Transportation must be arranged 2 business days in advance by calling our transportation vendor, Coordinated Transportation Solutions (CTS), at 1-833-824-9440. The member or caregiver can arrange transportation. Fallon Health Navigators are also available to assist. Members' friends and family can receive reimbursement for mileage of pre-approved rides.
- Up to $400 per year in fitness reimbursements for new fitness trackers, like a Fitbit or Apple Watch, new cardiovascular home fitness equipment, and/or a membership in a qualified health club or fitness facility.

- Up to $1,100 per year on the Save Now card ($275 every quarter), to purchase items—like cold/allergy medicine, pain relievers, probiotics, and more—to keep our members healthy. Purchases can be made over the phone, at stores like CVS Pharmacy, Dollar General, and Walmart, or online with free home delivery.
- Outpatient behavioral health services (Covered through our contracted providers. No authorization required.)
- Covered prescription drugs and certain approved over-the counter (OTC) drugs and items. Members may receive a 100-day supply of some medications via mail order.
- Vision care and eyeglasses ($403 annual eyewear allowance, up to 2 pairs of glasses per year)
- Hearing aids (and batteries)
- Dental care, including dentures. For comprehensive dental, including endodontics, extractions, oral surgery services in a provider's office (except for the removal or exposure of impacted teeth), periodontics, prosthodontics, restorative services, and other oral/maxillofacial surgery services to be covered, the dental provider must get prior authorization from DentaQuest. Members have access to the DentaQuest network of dental providers.
- Durable medical equipment (DME) such as wheelchairs, crutches, walkers, and related supplies. Members are allowed one Seat Lift chair per lifetime after prior authorization, up to $900.
- Diabetic services and supplies. In addition to Freestyle Libre monitors, additional glucometers may be covered. (Previously, only Freestyle Libre monitors were covered). Also, Medtronic non-therapeutic or adjunctive continuous glucose monitors may be obtained at network DME providers.

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 Services 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 disorder 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 who 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 1-877-700-6996.

To refer a patient to NaviCare or learn more about eligibility criteria, call 1-877-255-7108.

NaviCare – Model of Care success

Focus on preventive health screenings

One of the purposes of NaviCare's Model of Care, and one of the actions performed by NaviCare Clinical Team staff members, is to educate patients and their caregivers about the importance of health care screenings (tests/exams) according to the Massachusetts Health Quality Partners Adult Preventative Care Guidelines.

Clinical reminders are used to enhance preventive health screenings for our NaviCare patients. These reminders are also part of Healthcare Effectiveness and Data Information Set (HEDIS) measures and included as part of the 5-Star Rating for Medicare.

The health care screenings included are:

- Colorectal cancer screenings
- Comprehensive diabetes care
  - Hemoglobin A1c (HbA1c)
  - Retinal eye exam
- Kidney function
- Breast cancer screening

The NaviCare program can identify patients who have had the screenings, and those who need such screening(s) due by the end of the calendar year.

When patients have been identified as needing a screening test(s), the Navigator and/or Nurse Case Manager educates them about the need and facilitates access to the screenings in partnership and agreement with the patient and their PCP with the goal of closing gaps in care and coordinating screenings and services.

Important reminders

Home health care prior authorization reminders

- Skilled nursing services prior authorization requests may be submitted for up to 30 days per episode with supporting documentation.
- Skilled occupational therapy, physical therapy, and speech therapy prior authorization requests may be submitted for up to 30 days per episode with supporting documentation.
- Medication assistance visits require prior authorization (covered benefit for MassHealth ACO and NaviCare).

Please note:

- Speech therapy and medical social worker services do not stand alone, and a member must be receiving skilled nursing or physical therapy services for these requests to be submitted with supporting documentation.
- Homemaker services are not a covered skilled service.

Enhancements are being considered for the Prior Authorization process; updates will be communicated as they become available.

Please see the Home Health Care Payment Policy and Home Health Care Services Medical Policy located *here*.

Helping your patients get the care they need

Fallon Health understands how challenging it can be for providers to ensure their patients are getting the care they need.

Real and perceived challenges accessing care are strongly related to negative health outcomes. Providers can help mitigate that risk by utilizing some of the tools below:

- Highlighting the multiple avenues for accessing care: telehealth/phone, patient portals, urgent care clinics, 24/7 RN, etc.
- Providing education to members to help them understand what alternatives exist to in-person care, and how to access them.
    - Outreach to patients with perceived access or care coordination challenges.
        - Patients with high clinical needs may need to be prioritized to avoid future hospitalizations and rehospitalizations.
        - Patients may not be as knowledgeable and able to gain access to, understand, and use the resources available to them, despite what might already be available to members at the clinic, their provider's office, or from their health plan.
    - NaviCare members can utilize Fallon Health's Navigators as a resource.

Fallon Health recommends conducting outreach to engage your patients, and offering the following types of assistance:

- **Access to care**
    - Contact patients proactively to help schedule appointments and routinely follow up after the appointments to see how the patients are doing.
    - Offer appointments with a nurse or the next available doctor for urgent needs.
    - Offer same-day appointments for patients who need to be seen quickly.
    - Encourage patients to self-serve and view test results on your patient portal where applicable (and note that some patients may need additional help setting up an account and accessing the portal).
- **Care coordination**
    - Host morning care team huddles to review patients' reason for visit, medical history, recent specialist visits, outstanding referrals, and new prescriptions your patients might be taking.
    - Follow up with patients over the phone after they visit a specialist, undergo a procedure, or try a new medication.
    - Assess patients for Health Related Social Needs (HRSN) to identify potential barriers to care or community resources.

- **Unmet social needs of your patients may be underlying barriers to engagement in care.**
  - Include information that can be used to guide further assessment of the patient's current circumstances. Ask questions like:
    - 'Do you have reliable transportation to get to your appointments/get your prescription filled?'
    - 'How often do you get out of the house to socialize?'
    - 'What do you like to do?'
  - Have contact information for government assistance and local community resources handy to offer to patients with an expressed need.
  - Find federal and state resources at *211.org*.

Members of Fallon Health's NaviCare plan can also get assistance from a Navigator. The Navigator is the main contact between the member and their Care Team. The Navigator also:

- 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 the Care Team when patient has a care transition

To refer a patient to NaviCare or to learn more about eligibility criteria, call 1-877-255-7108.

Important CAHPS reminder

CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys will be mailed to patients between March and May. The survey asks patients about aspects of quality, such as provider communication skills and ease of health care services. It's overseen by the Agency for Healthcare Research and Quality.

Medicare opioid edits and programs for 2025

There are several opioid safety edits and programs for the 2025 Medicare Part D plan year. This impacts all Medicare beneficiaries: Fallon Medicare Plus, NaviCare, and Summit ElderCare®.

The criteria used to identify members potentially at risk or for the point-of-sale pharmacy edits are not intended as prescribing limits. They are used to identify members that may be at risk for opioid overuse. The edits are not a substitute for your professional judgment and do not mean that you cannot prescribe over these limits.

Decisions by clinicians to taper opioid dosages should be carefully considered and individualized, if appropriate. Opioids should not be tapered rapidly or discontinued suddenly due to the significant risks of opioid withdrawal, unless there is a life-threatening issue confronting the individual patient. Tapering is most likely to be effective when there is patient buy-in and collaboration, tapering is gradual, and clinicians provide support.

You need to attest that the identified medications and doses are intended and medically necessary for the member. Please be aware that network pharmacies, the Fallon Health Pharmacy Department, our MTM vendor (Clarest Health), and/or our opioid drug management vendor and PBM (Optum Rx) may outreach to you for your assistance in resolving these safety edits and opioid management cases.

Please assist us in meeting the expectation that prescribers respond to pharmacy outreach related to opioid safety alerts in a timely manner, including educating their on-call staff. Some of these issues can be completed directly with the retail pharmacy by attesting that the medications and doses are intended and medically necessary for the member. If you need to submit a coverage determination or an exception request, please call 1-844-657-0494 or fax 1-844-403-1028.

A summary of the programs follows:

Point of Sale (POS) opioid safety edits

CMS requires certain prospective safety edits. These edits will occur when the member is filling the prescription at the pharmacy. These edits require resolution. The pharmacist at the pharmacy may override some of the edits with appropriate codes, may need to consult with the provider, and may need to inform the provider that a prior authorization is required. Since these are safety edits, they will still apply during a member's transition period, meaning the claims will still reject with the edits and require resolution. Buprenorphine for medication-assisted treatment (MAT) is not included in the safety edits.

Members who are in hospice/palliative care, long-term care, or who have cancer-related pain, or sickle cell disease, are excluded from the safety edits. Members have coverage determination and appeal rights under this program. The edits include:

- Soft edit for concurrent opioid and benzodiazepine use – pharmacy can override
- Soft edit for duplicative long-acting (LA) opioid therapy – pharmacy can override
- Soft edit for concurrent opioid and prenatal vitamins use – pharmacy can override
- Soft edit for concurrent opioid and Medication Assisted Therapy (MAT) use – pharmacy can override
- Care coordination edit at 90 morphine milligram equivalents (MME) and 2 prescribers – pharmacy can override only after consultation with the prescriber, documentation of the discussion, and if the prescriber confirms intent (the opioids and/or day supply is intended and medically necessary for the member), using an override code that indicates the prescriber has been consulted.
- Hard edit for a 7-day supply limit for initial opioid fills (opioid naïve) with a 120-day look- back. If the pharmacy cannot resolve at point of sale (POS), this will require a prior authorization to be submitted. Provider needs to attest that the opioids and/or day supply is intended and medically necessary for the member. Member is considered opioid naïve if there are no opioid claims in the past 120 days.

Medication Therapy Management (not applicable to Programs of All-Inclusive Care for the Elderly

We are also including special eligibility criteria in our Medication Therapy Management Program (MTMP). In addition to traditional MTMP eligibility, members are eligible for MTMP if they have been identified as an At-Risk Beneficiary (ARB) under a Drug Management Program (DMP).

Comprehensive Addiction and Recovery Act of 2016 (CARA) – Drug Management Program (DMP)

This is a comprehensive opioid management program required under CARA. This is a retrospective drug utilization review (DUR) program to identify members at risk for frequently abused drugs and conduct case management. Frequently abused drugs are defined by CMS as opioids and benzodiazepines. Buprenorphine for Medication-Assisted Treatment (MAT) is not included in the 90 MME accumulations. The program excludes members with cancer pain, palliative/hospice care, sickle cell disease, and in LTC. Dual/Low Income Subsidy (LIS) members are limited in their ability to change plans to avoid intervention once identified as at-risk.

Criteria for identification into the program include any of the below:

- Members with opioid pharmacy claims equal to or greater than 90 MME and 3+ opioid prescribers and 3+ opioid dispensing pharmacies
- Members with opioid pharmacy claims equal to or greater than 90 MME and 5+ opioid prescribers
- Members with any MME level and 7+ opioid prescribers or 7+ opioid dispensing pharmacies
- Members identified as having a history of opioid-related overdose are also included in the DMP.
- Program includes case management and clinical outreach to providers to determine if the member is at risk for opioid overutilization, notifications to the member, potential lock-in restrictions to specific provider(s), pharmacy(ies), and/or at the drug level. Members have appeal rights under this program.

Opioid safety alert	Prescriber tips
7-day supply limit for opioid naïve patients This hard edit alert triggers when a member who has not filled an opioid prescription recently (such as within the past 60 days) attempts to fill an opioid prescription for more than a 7-day supply. This edit should not impact members who already take opioids but may occur for members who enroll in a new plan that does not know their current prescription information.	• Member may receive up to a 7-day supply without taking any action. • Member or prescriber can request a coverage determination for full days' supply as written. Prescriber only needs to attest that the days' supply is the intended and medically necessary amount. • Subsequent prescriptions filled within the plan's look-back window are not subject to the 7-day supply limit, as the member will no longer be considered opioid naïve.
Optional Safety Alert at 200 morphine milligram equivalent (MME) or more Some plans may implement a hard edit safety alert when an member's cumulative opioid daily dosage reaches 200 MME or more. Some plans have this alert only when the member uses multiple opioid prescribers and/or opioid dispensing pharmacies. This alert stops the pharmacy from processing the prescription until an override is entered or authorized by the plan.	• Resolving this alert generally requires the plan to process a coverage determination which may be requested by the enrollee or prescriber. In the absence of other approved utilization management requirements, once the prescriber attests that the identified cumulative MME level is the intended and medically necessary amount, the plan should approve the higher MME, allowing the claim to adjudicate.

Opioid safety alert	Prescriber tips
Opioid care coordination alert at 90 MME This alert triggers when a member's cumulative MME per day across all their opioid prescription(s) reaches or exceeds 90 MME. Some plans use this alert only when the member uses multiple opioid prescribers and/or opioid dispensing pharmacies. This consultation usually occurs once per plan year.	• The pharmacist may call to confirm the dose and medical need for the opioid prescription that prompts the alert, even if it's below 90 MME. • The prescriber may be informed of other opioid prescribers or increasing level (MME) of opioids. • Prescriber only needs to attest that the identified cumulative MME level days' supply is the intended and medically necessary amount.
Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy These soft edit alerts trigger when opioids and benzodiazepines or multiple long-acting opioids are taken concurrently.	• The pharmacist will conduct additional safety reviews to determine if the member's medication use is safe and clinically appropriate. The pharmacist may contact the prescriber to confirm medical necessity.

Opioid safety alerts

Opioid safety alerts are not prescribing limits. Part D plans are expected to implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. CMS encourages prescribers to respond to plan and pharmacist outreach in a timely manner and to give appropriate information to on-call prescribers as needed to resolve opioid safety edits and avoid disruption of therapy.

CMS expects all Part D plan sponsors to have a mechanism in place which allows all opioid safety alerts, including hard edits, to be overridden at point of sale at the pharmacy based on information from the prescriber or otherwise known to the pharmacy that an enrollee is exempt.

Prescribers have the right to request a coverage determination for a drug(s) on behalf of an enrollee, including the right to request an expedited or standard coverage determination in advance of prescribing.

Drug Management Programs (DMPs)

All Part D plans must have a DMP that limits access to opioids and/or benzodiazepines for members who are considered by the plan to be at risk for prescription drug abuse or misuse. The goal of a DMP is better care coordination for safer use. Members are identified by opioid use involving multiple doctors and pharmacies or a recent history of opioid-related overdoses and undergo case management conducted by the plan and involving their prescribers.

DMP limitations can include requiring the member to obtain these medications from a specified prescriber and/or pharmacy, or implementing an individualized point of sale edit that limits the amount that will be covered.

After case management, and at least 30 days before implementing a coverage limitation, the plan will notify the member in writing. Plans are required to make reasonable efforts to notify prescribers. After 30 days, the plan must send the member a second written notice confirming the details of the limitation. This notice also explains that the member, their representative, or their prescriber have the right to appeal.

To learn more, visit *cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.*

Medication prior authorization requests

It's important to send medication prior authorizations to the correct unit to prevent delays in review and member care. PAs for medications are sent to either Prime Therapeutics Management (Prime) or OptumRx. **Medication requests should NOT be sent to the Fallon Health Clinical UM department.**

Patient-administered drugs (pharmacy benefit) – all plans

Prior authorizations (PA) for these medications must be sent to OptumRx for review. Please see the chart on our *website* for contact information.

Please refer to our online *formularies* to determine which patient-administered drugs require a PA.

Physician-administered drugs (medical benefit) – all plans

PAs for these medications must be sent to Prime for review. Please see the contact information on our *website*.

Please refer to the Procedure Code Lookup *tool* to determine which physician-administered drugs require a PA. You may also refer to our online medical benefit *formulary*.

2025 update

Medicare glucose monitors and related testing supplies (including test strips and CGMs) for Medicare, NaviCare, and PACE plans are now reviewed by our partner, OptumRx. Please use the contact information below to submit these PA requests.

Reference chart:

Type	Vendor/Unit	Phone	Fax
Medical Benefit PA Drug	Prime	1-800-424-1740	1-888-656-6671
Pharmacy Benefit PA Drug – Fallon Medicare Plus NaviCare Summit ElderCare	OptumRx	1-844-657-0494	1-844-403-1028

Pharmacy Benefit PA Drug – Fallon 365 Care Berkshire Fallon Health Collaborative Fallon Health-Atrius Health Care Collaborative	OptumRx	1-844-720-0033	1-844-403-1029
Pharmacy Benefit PA Drug – Community Care	OptumRx	1-844-720-0035	1-844-403-1029

Doing business with us

CAQH provider data process reminder

As you know, several Massachusetts health plans utilize CAQH to collect provider directory information. This streamlined process simplifies provider data entry and ensures that consumers have accurate information to contact you when they need care.

Federal requirements and state regulations emphasize provider directory information and the accuracy of your information. Health plans must collect your information at least every 90 days. Your data submission and attestation in the CAQH Provider Data Portal satisfies these requirements.

To avoid reminder emails and phone calls about validating your information, you must validate and update your information every 90 days. If details about your practice have not changed, you still must verify and attest to your data regularly.

Log into the CAQH Provider Data *Portal* to review your information now.

If you are not the person who completes this process, please share this information with the person who does.

Coding Corner

Neuro psychological testing prior authorization update

Effective January 1, 2025, prior authorization (approval in advance) is *not required* for neuro psychological testing. This applies to all Fallon Health lines of business, *except* Summit ElderCare (PACE):

- Fallon Medicare Plus
- NaviCare
- Community Care
- Berkshire Fallon Health Collaborative
- Fallon 365 Care
- Fallon Health-Atrius Health Care Collaborative

New 2025 CPT/HCPCS codes

All new codes will require prior authorization until a final review is performed by Fallon Health. Fallon Health will review and assign the appropriate coverage and determine prior authorization requirements for all new codes by January 1. We will notify all contracted providers of this determination in the April issue of the Connection newsletter.

ICD code update

Obesity poses serious health risks contributing to reduced quality of life and increased medical costs. ICD-10 obesity codes have expanded to provide greater specificity to better capture patient complexity.

There are 3 new BMI-based categories for obesity with serious comorbid conditions including, but not limited to: coronary heart disease; DM; sleep apnea; atherosclerotic disease; hypertension; and hyperlipidemia.

- **E66.811:** Class 1 - BMI 30.0 to 34.9
- **E66.812:** Class 2 - BMI 35.0-39.9
- **E66.813:** Class 3 - BMI 40.0 and above

As always, supporting documentation of comorbidities is required, along with BMI status code (I.E. Z68.41).

CMS NCCI edits

After March 1, 2024, Fallon Health began implementing the CMS National Correct Coding Initiative (NCCI) edits for Fallon Medicare Plus, NaviCare, Summit ElderCare, and Community Care claims.

CMS develops its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Laboratory services: Medical necessity and National Coverage Determinations (NCDs)

The Centers for Medicare & Medicaid Services (CMS) created National Coverage Determinations (NCDs) for specific clinical laboratory tests of which Fallon Health implemented. Whereas most NCDs describe covered indications and limitations in narrative form, laboratory NCDs list specific ICD-10 codes that fall into 3 categories:

- Covered ICD-10 codes
- Non-covered ICD-10 codes
- Codes that do not support medical necessity

New HCPCs, CPT and dental codes effective January 1, 2025

Effective January 1, 2025, the following codes will be configured as *covered with prior authorization* for all lines of business, except for MassHealth ACO plans, which will be *deny vendor liable:*

Code	Description
0901T	Placement of bone marrow sampling port, including imaging guidance when performed
0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device
0903T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report
0904T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only
0905T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only
0906T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm
0907T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm (List separately in addition to code for primary procedure)
0908T	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed
0909T	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed
0910T	Removal of integrated neurostimulation system, vagus nerve
0911T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by physician or other qualified health care professional
0912T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by physician or other qualified health care professional
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g., drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch
0914T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g., drug-coated, drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch (List separately in addition to code for percutaneous coronary stent or atherectomy intervention)
0915T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator and dual transvenous electrodes/leads (pacing and defibrillation)
0916T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator only

Code	Description
0917T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; single transvenous lead (pacing or defibrillation) only
0918T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; dual transvenous leads (pacing and defibrillation) only
0919T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); pulse generator only
0920T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous pacing lead only
0921T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead only
0922T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only
0923T	Removal and replacement of permanent cardiac contractility modulation-defibrillation pulse generator only
0924T	Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters
0925T	Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator
0926T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation-defibrillation system
0927T	Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system
0928T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system with interim analysis and report(s) by a physician or other qualified health care professional
0929T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results
0930T	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator
0931T	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), separate from initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator
0932T	Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional

Code	Description
0933T	Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring, including sensor calibration and deployment, right heart catheterization, transseptal puncture, imaging guidance, and radiological supervision and interpretation
0934T	Remote monitoring of a wireless left atrial pressure sensor for up to 30 days, including data from daily uploads of left atrial pressure recordings, interpretation(s) and trend analysis, with adjustments to the diuretics plan, treatment paradigm thresholds, medications or lifestyle modifications, when performed, and report(s) by a physician or other qualified health care professional
0935T	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral
0936T	Photobiomodulation therapy of retina, single session
0937T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional
0938T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)
0939T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report
0940T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional
0941T	Cystourethroscopy, flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization
0942T	Cystourethroscopy, flexible; with removal and replacement of prostatic urethral scaffold
0943T	Cystourethroscopy, flexible; with removal of prostatic urethral scaffold
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation
0945T	Intraoperative assessment for abnormal (tumor) tissue, in-vivo, following partial mastectomy (e.g., lumpectomy) using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)
0946T	Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure, including data acquisition, data preparation and transmission, interpretation and report (including CT scan of the joint or extremity performed with paired views)
0947T	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed
15011	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less

Code	Description
15012	Harvest of skin for skin cell suspension autograft; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)
15013	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin
15014	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure)
15015	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less
15016	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)
15017	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less
15018	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)
49186	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less
49187	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm
49188	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 10.1 to 20 cm
49189	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm
49190	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm
51721	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed
53865	Cystourethroscopy with insertion of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate
53866	Catheterization with removal of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation

Code	Description
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed
60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency
60661	Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed
64466	Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed
64467	Thoracic fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed
64468	Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed
64469	Thoracic fascial plane block, bilateral; by continuous infusion(s), including imaging guidance, when performed
64473	Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed
64474	Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed
66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed
81195	Cytogenomic (genome-wide) analysis, hematologic malignancy, structural variants and copy number variants, optical genome mapping (OGM)
81515	Infectious disease, bacterial vaginosis and vaginitis, real-time PCR amplification of DNA markers for Atopobium vaginae, Atopobium species, Megasphaera type 1, and Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), utilizing vaginal-fluid specimens, algorithm reported as positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata/Candida krusei, when reported
81558	Transplantation medicine (allograft rejection, kidney), mRNA, gene expression profiling by quantitative polymerase chain reaction (qPCR) of 139 genes, utilizing whole blood, algorithm reported as a binary categorization as transplant excellence, which indicates immune quiescence, or not transplant excellence, indicating subclinical rejection
82233	Beta-amyloid; 1-40 (Abeta 40)
82234	Beta-amyloid; 1-42 (Abeta 42)
83884	Neurofilament light chain (NfL)
84393	Tau, phosphorylated (e.g., pTau 181, pTau 217), each

Code	Description
84394	Tau, total (tTau)
86581	Streptococcus pneumoniae antibody (IgG), serotypes, multiplex immunoassay, quantitative
87513	Infectious agent detection by nucleic acid (DNA or RNA); Helicobacter pylori (H. pylori), clarithromycin resistance, amplified probe technique
87564	Infectious agent detection by nucleic acid (DNA or RNA); Mycobacterium tuberculosis, rifampin resistance, amplified probe technique
87594	Infectious agent detection by nucleic acid (DNA or RNA); Pneumocystis jirovecii, amplified probe technique
87626	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), separately reported high-risk types (e.g., 16, 18, 31, 45, 51, 52) and high-risk pooled result(s)
93896	Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)
93897	Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)
93898	Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)
A9615	Injection, pegulicianine, 1 mg
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)
C1738	Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device
C1739	Tissue marker, imaging and non-imaging device (implantable)
C7562	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7563	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, initial artery and all additional arteries
C7564	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance with intravascular ultrasound (noncoronary vessel(s)) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation

Code	Description
C7565	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s) less than 3 cm, reducible with removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair
C8001	3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)
C8003	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (e.g., fluoroscopy)
C9610	Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)
C9804	Elastomeric infusion pump (e.g., on-q* pump with bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9806	Rotary peristaltic infusion pump (e.g., ambit pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
E1803	Dynamic adjustable elbow extension only device, includes soft interface material
E1804	Dynamic adjustable elbow flexion only device, includes soft interface material
E1807	Dynamic adjustable wrist extension only device, includes soft interface material
E1808	Dynamic adjustable wrist flexion only device, includes soft interface material
E1813	Dynamic adjustable knee extension only device, includes soft interface material
E1814	Dynamic adjustable knee flexion only device, includes soft interface material
E1822	Dynamic adjustable ankle extension only device, includes soft interface material
E1823	Dynamic adjustable ankle flexion only device, includes soft interface material

Code	Description
E1826	Dynamic adjustable finger extension only device, includes soft interface material
E1827	Dynamic adjustable finger flexion only device, includes soft interface material
E1828	Dynamic adjustable toe extension only device, includes soft interface material
E1829	Dynamic adjustable toe flexion only device, includes soft interface material
G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583t)
G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
G0564	Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training
G0565	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation
G0555	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring
Q4346	Shelter dm matrix, per square centimeter
Q4347	Rampart dl matrix, per square centimeter
Q4348	Sentry sl matrix, per square centimeter
Q4349	Mantle dl matrix, per square centimeter
Q4350	Palisade dm matrix, per square centimeter
Q4351	Enclose tl matrix, per square centimeter
Q4352	Overlay sl matrix, per square centimeter
Q4353	Xceed tl matrix, per square centimeter

Effective January 1, 2025, the following codes will be configured as *covered without prior authorization* for all lines of business, except for MassHealth ACO plans, which will be *deny vendor liable*:

Code	Description
25448	Arthroplasty, intercarpal or carpometacarpal joints; suspension, including transfer or transplant of tendon, with interposition, when performed
76014	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes
76015	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)
76016	MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR examination, analysis of risk vs clinical benefit of performing MR examination, and determination of MR equipment, accessory equipment, and expertise required to perform examination, with written report
76017	MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or other qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies, with written report
76018	MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/ or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room, with written report
76019	MR safety implant positioning and/or immobilization under supervision of physician or other qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room, with written report
90593	Chikungunya virus vaccine, recombinant, for intramuscular use
92137	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography

Code	Description
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
G0532	Take-home supply of nasal nalmefene hydrochloride; one carton of two, 2.7 mg per 0.1 ml nasal sprays (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0533	Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
G0534	Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0535	Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0536	Peer recovery support services, provided directly or by referral; including leveraging knowledge of the condition or lived experience to provide support, mentorship, or inspiration to meet oud treatment and recovery goals; conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes; developing and proposing strategies to help meet person-centered treatment goals; assisting the patient in locating or navigating recovery support services; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0537	Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ascvd) risk assessment, 5-15 minutes, not more often than every 12 months
G0538	Atherosclerotic cardiovascular disease (ascvd) risk management services; clinical staff time; per calendar month
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes

Code	Description
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use g0542 in conjunction with g0541)
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
G0545	Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, subsequent or discharge)
G0546	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review
G0547	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review
G0548	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review

Code	Description
G0549	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review
G0550	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time
G0551	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan
G0553	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month
G0554	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month

Code	Description
G0556	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/ caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; deliver care in alternative ways to traditional office visits to best meet the patient›s needs, such as home visits and/ or expanded hours; overall comprehensive care management; ++ systematic needs assessment (medical and psychosocial). ++ system-based approaches to ensure receipt of preventive services. ++ medication reconciliation, management and oversight of self-management. development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant; ++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/ caregiver; coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ongoing communication and coordinating receipt of needed services from practitioners, home-and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/ internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

Code	Description
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; overall comprehensive care management; ++ systematic needs assessment (medical and psychosocial). ++ system-based approaches to ensure receipt of preventive services. ++ medication reconciliation, management and oversight of self-management. development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

Code	Description
G0558	Advanced primary care management services for a patient that is a qualified Medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: consent; ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ document in patient's medical record that consent was obtained. initiation during a qualifying visit for new patients or patients not seen within 3 years; provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; deliver care in alternative ways to traditional office visits to best meet the patient›s needs, such as home visits and/or expanded hours; overall comprehensive care management; ++ systematic needs assessment (medical and psychosocial). ++ system-based approaches to ensure receipt of preventive services. ++ medication reconciliation, management and oversight of self-management. development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/ caregiver;coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/ internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

Code	Description
G0559	Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation. research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. communicate with the practitioner who performed the procedure if any questions or concerns arise. (list separately in addition to office/outpatient evaluation and management visit, new or established)
G0560	Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe
Q0521	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription

Effective January 1, 2025, the following codes will be configured as *covered with prior authorization* for all lines of business, except for MassHealth ACO and Community Care plans, which will be *deny vendor liable:*

Code	Description
0521U	Rheumatoid factor IgA and IgM, cyclic citrullinated peptide (CCP) antibodies, and scavenger receptor A (SR-A) by immunoassay, blood
0522U	Carbonic anhydrase VI, parotid specific/secretory protein and salivary protein 1 (SP1), IgG, IgM, and IgA antibodies, chemiluminescence, semiqualitative, blood
0523U	Oncology (solid tumor), DNA, qualitative, next-generation sequencing (NGS) of single-nucleotide variants (SNV) and insertion/deletions in 22 genes utilizing formalin-fixed paraffin-embedded tissue, reported as presence or absence of mutation(s), location of mutation(s), nucleotide change, and amino acid change
0524U	Obstetrics (preeclampsia), sFlt-1/PlGF ratio, immunoassay, utilizing serum or plasma, reported as a value
0525U	Oncology, spheroid cell culture, 11-drug panel (carboplatin, docetaxel, doxorubicin, etoposide, gemcitabine, niraparib, olaparib, paclitaxel, rucaparib, topotecan, veliparib) ovarian, fallopian, or peritoneal response prediction for each drug
0526U	Nephrology (renal transplant), quantification of CXCL10 chemokines, flow cytometry, urine, reported as pg/mL creatinine baseline and monitoring over time
0527U	Herpes simplex virus (HSV) types 1 and 2 and Varicella zoster virus (VZV), amplified probe technique, each pathogen reported as detected or not detected

Code	Description
0528U	Lower respiratory tract infectious agent detection, 18 bacteria, 8 viruses, and 7 antimicrobial-resistance genes, amplified probe technique, including reverse transcription for RNA targets, each analyte reported as detected or not detected with semiquantitative results for 15 bacteria
0529U	Hematology (venous thromboembolism [VTE]), genome-wide single-nucleotide polymorphism variants, including F2 and F5 gene analysis, and Leiden variant, by microarray analysis, saliva, report as risk score for VTE
0530U	Oncology (pan-solid tumor), ctDNA, utilizing plasma, next-generation sequencing (NGS) of 77 genes, 8 fusions, microsatellite instability, and tumor mutation burden, interpretative report for single-nucleotide variants, copy-number alterations, with therapy association

Effective January 1, 2025, the following codes will be configured as *not separately reimbursable without prior authorization* for all lines of business, except for MassHealth ACO plans, which will be *deny vendor liable:*

Code	Description
38225	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day
38226	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)
38227	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
38228	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous
96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter

Effective January 1, 2025, the following codes will be configured as *deny vendor liable* for all lines of business:

Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Code	Description
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

Code	Description
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
H0052	Missing and murdered indigenous persons (mmip) mental health and clinical care
H0053	Historical trauma (ht) mental health and clinical care for indigenous persons
M1371	Most recent glycemic status assessment (hba1c or gmi) level < 7.0%
M1372	Most recent glycemic status assessment (hba1c or gmi) level >= 7.0% and < 8.0%
M1373	Most recent glycemic status assessment (hba1c or gmi) level >= 8.0% and <= 9.0%
M1374	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1375	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1376	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1377	Recommended follow-up interval for repeat colonoscopy of 10 years documented in colonoscopy report and communicated with patient
M1378	Documentation of medical reason(s) for not recommending 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, other medical reasons)
M1379	A 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified
M1380	Filled at least two prescriptions during the performance period for any combination of the qualifying oral antipsychotic medications listed under “denominator note” or the long-acting injectable antipsychotic medications listed under “denominator note”
M1381	Patients with secondary stroke (e.g., a subsequent stroke that may occur with vasospasm in the setting of subarachnoid hemorrhage) within 5 days of the initial procedure
M1382	Patient encounter during the performance period with place of service code 11
M1383	Acute pvd
M1384	Patients who died during the performance period
M1385	Documentation of patient reasons for patients who were not seen for the second pam survey (e.g., less than four months between baseline pam assessment and follow-up
M1386	Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial ajcc staging of 0, i, or ii at the start of the performance period
M1387	Patients who died during the performance period
M1388	Patients with documentation of an exam performed for recurrence of melanoma

Code	Description
M1390	Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period
M1391	All patients who were diagnosed with recurrent melanoma during the current performance period
M1392	Documentation of patient reasons for no examination, i.e., refusal of examination or lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail - at least one method must be documented)
M1393	Patients who were not diagnosed with recurrent melanoma during the current performance period
M1394	Stages i-iii breast cancer
M1395	Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
M1396	Patients on a therapeutic clinical trial
M1397	Patients with recurrence/disease progression
M1398	Patients with baseline and follow-up promis surveys documented in the medical record
M1399	Patients who leave the practice during the follow-up period
M1400	Patients who died during the follow-up period
M1401	Stages i-iii breast cancer
M1402	Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
M1403	Patients with baseline and follow-up promis surveys documented in the medical record
M1404	Patients on a therapeutic clinical trial
M1405	Patients with recurrence/disease progression
M1406	Patients who leave the practice during the follow-up period
M1407	Patients who died during the follow-up period
M1408	Patients who have germline brca testing completed before diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer
M1409	Patients who received germline testing for brca1 and brca2 or genetic counseling completed within 6 months of diagnosis
M1410	Patients who did not have germline testing for brca1 and brca2 or genetic counseling completed within 6 months of diagnosis
M1411	Currently on first-line immune checkpoint inhibitors without chemotherapy
M1412	Patients with metastatic nsclc with epidermal growth factor receptor (egfr) mutations, alk genomic tumor aberrations, or other targetable genomic abnormalities with approved first-line targeted therapy, such as nsclc with ros1 rearrangement, braf v600e mutation, ntrk 1/2/3 gene fusion, met ex14 skipping mutation, and ret rearrangement

Code	Description
M1413	Patients who had a positive pd-l1 biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
M1414	Documentation of medical reason(s) for not performing the pd-l1 biomarker expression test prior to initiation of first-line immune checkpoint inhibitor therapy (e.g., patient is in an urgent or emergent situation where delay of treatment would jeopardize the patient's health status; other medical reasons/contraindication)
M1415	Patients who did not have a positive pd-l1 biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
M1416	Patient received hospice services any time during the performance period
M1417	Patients who are up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
M1418	Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination because of a medical contraindication documented by clinician
M1419	Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
M1420	Complete ophthalmologic care mips value pathway
M1421	Dermatological care mips value pathway
M1422	Gastroenterology care mips value pathway
M1423	Optimal care for patients with urologic conditions mips value pathway
M1424	Pulmonology care mips value pathway
M1425	Surgical care mips value pathway

Effective January 1, 2025, the following codes will be configured as *covered without prior authorization* for all lines of business, but will need to be submitted to MassHealth:

Code	Description
D9913	Administration of neuromodulators
D9914	Administration of dermal fillers
D6180	Implant maintenance procedures when a full-arch fixed hybrid prosthesis is not removed
D6193	Replacement of implant screw
D7252	Partial extraction for immediate implant placement
D7259	Nerve dissection
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery

Effective March 1, 2025, the following code will be *not covered* for Community Care:

Code	Description
H0044	SUPPORTED HOUSING, PER MONTH

Effective March 1, 2025, the following code will *require plan prior authorization* for MassHealth ACO (Berkshire Fallon Health Collaborative (BFHC), Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative (FACC)):

Code	Description
82166	Anti-mullerian hormone (AMH)

Effective March 1, 2025, the following code will be *not covered* for Fallon Medicare Plus, Community Care, NaviCare and Summit ElderCare, and deny vendor liable for MassHealth ACO (BFHC, Fallon 365 Care, FACC):

Code	Description
P2031	Hair analysis (excluding arsenic)

Effective March 1, 2025, the following codes will be *not covered* for Fallon Medicare Plus and Community Care:

Code	Description
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal

Effective March 1, 2025, the following code will be *not covered* for Community Care:

Code	Description
74263	CT COLONOGRAPHY SCREENING IMAGE POSTPROCESSING

Effective March 1, 2025, the following codes will be *not covered* for Fallon Medicare Plus:

Code	Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

Effective March 1, 2025, the following codes will be *not covered* for Community Care:

Code	Description
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection

Effective March 1, 2025, the following codes will be *not covered* for Fallon Medicare Plus, Community Care, NaviCare and Summit ElderCare:

Code	Description
61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel
61641	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular territory family (List separately in addition to code for primary procedure)
61642	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory family (List separately in addition to code for primary procedure)
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
G0122	Colorectal cancer screening; barium enema
G0252	PET IMAGING INITIAL DX

Effective March 1, 2025, the following codes will be *not covered* for Fallon Medicare Plus and Community Care:

Code	Description
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
92370	Repair and refitting spectacles; except for aphakia
99174	Instrument-based ocular screening (e.g., photo screening, automated-refraction), bilateral; with remote analysis and report

Effective December 1, 2024, the following codes will be *not covered* for Community Care:

Code	Description
S9977	Meals, per diem, not otherwise specified
T2050	Financial management, self-directed, waiver; per diem

Effective December 1, 2024, the following code is *deny vendor liable* with CMS message "I" for Medicare Advantage (PSP and HMO):

Code	Description
T2028	SPECIAL SUPPLY, NOS WAIVER ▮

Payment policies

Clarification to Aging Services Access Points (ASAPs) payment policy

To ensure consistent understanding of the responsibilities specific to the oversight, regulatory guidelines, and standards of care for members receiving services from our contracted ASAPs, Fallon Health has refined our ASAP payment policy. Please refer to the *payment policy section* for the current policy version. ▮

Revised policies – Effective March 1, 2025

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

- **Non-Covered Services –** Updated code report (generated 01/02/2025).
- **Remote Patient Monitoring, formerly COVID-19 Remote Patient Monitoring –** Updated to include Remote Patient Monitoring (CPT codes 99091, 99453, 99454, 99457, and 99458), title changed from COVID-19 Remote Patient Monitoring to Remote Patient Monitoring.
- **Retroactive Prior Authorization –** Updated to include notification of elimination of retroactive authorization request effective January 1, 2025.
- **Aging Service Access Points (ASAP) –** Updated Definitions, updated Reimbursement section; updated Billing/coding guidelines.
- **Drugs and Biologicals –** Updated to reflect Magellan Rx rebrand to Prime Therapeutics Management effective October 1, 2024; added new paragraph for Medical Drug Wastage Program under Billing/coding guidelines; under Billing/coding guidelines updated to indicate that effective January 1, 2025 Medicare is requiring that all 340B drugs are submitted with modifier JB. Modifier JG is being discontinued effective 12/31/2024.

- **Laboratory and Pathology –** Under Reimbursement, Laboratory Services the Plan Does Not Reimburse, added lab tests ordered by a plan member through a website or online platform; updated COVID-19 Diagnostic Testing to reflect current coverage and reimbursement; removed outdated information about Signatera by Natera, Inc. under Advanced Diagnostic Laboratory Tests (ADLTs); added new section under Reimbursement for Laboratory NCDs.
- **Renal Dialysis Services (Including Hemodialysis) –** Updated to indicate that prior authorization is not required for CPT 90999.

New policy – Effective January 1, 2025

- **Health-Related Social Needs (HRSN) Supplemental Services –** MassHealth ACO

New policy – Effective March 1, 2025

- **Dental Services –** MassHealth ACO

Medical policies

Revised policies – Effective December 1, 2024 (annual review)

- **Varicose Veins of the Lower Extremities**
- **Spine Surgery**
- **Prostatic Urethral Lift** (UroLift™ System)
- **Capsule Endoscopy** (formerly Wireless Capsule Endoscopy)

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

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