January 2026

# Connection

Important information for Fallon Health physicians and providers

## In the January issue:



# What's new

## InterQual smart sheets embedded in ProAuth

Starting in the first quarter of 2026, InterQual Medical Review Tip Sheets (smart sheets) will be available in ProAuth when submitting certain authorizations.

This electronic questionnaire will help guide you on what information is needed to complete an authorization request. Filling out the questionnaire is not mandatory, but an optional process that may speed up the determination process. ■

## Fallon Health MassHealth ACO Humira® and Stelara® biosimilar policy update summary

**Humira biosimilar policy update**

- **Effective January 5, 2026,** Fallon Health MassHealth ACOs will prefer Hadlima® (adalimumab-bwwd) and adalimumab-adaz, in addition to covering Humira (adalimumab).
- **Effective April 1, 2026,** Humira (adalimumab) will no longer be a preferred drug and will require a trial of all preferred biosimilars.

**Expectation for prior authorization processing**

- Prior to the transition to the new preferred biosimilars, all active Humira prior authorizations will be end dated to March 31, 2026.
- New prior authorizations for the preferred Humira biosimilars will be created with the same expiration date as the existing Humira prior authorization to support member transitions.

**Communications**

- Member and provider letters will be sent out at least 30 days prior to April 1, 2026.
- Fallon Health will work with ACO groups to provide impacted member reports.
- MassHealth will be drafting a Prescriber E-Letter and Pharmacy Facts to be distributed.

| Reference product | Covered biosimilars |
|---|---|
| Humira (adalimumab) (CF) 10 mg/0.1 mL | adalimumab-adaz (CF) 10 mg/0.1 mL |
| Humira (adalimumab) (CF) 20 mg/0.2 mL | adalimumab-adaz (CF) 20 mg/0.2 mL |
| Humira (adalimumab) (CF) 40 mg/0.4 mL | adalimumab-adaz (CF) 40 mg/0.4 mL<br>Hadlima (adalimumab-bwwd) (CF) 40 mg/0.4 mL |
| Humira (adalimumab) 40 mg/0.8 mL | Hadlima (adalimumab-bwwd) 40 mg/0.8 mL |
| Humira (adalimumab) (CF) 80 mg/0.8 mL | adalimumab-adaz (CF) 80 mg/0.8 mL |

**Stelara biosimilar policy update**

- Effective **January 5, 2026,** Fallon Health MassHealth ACOs will prefer Imuldosa® (Ustekinumab-srlf) – available as 45 mg/mL and 90 mg/mL syringes, and 130mg/26mL vials – and Pyzchiva® (Ustekinumab-ttwe) available as 45 mg/0.5 mL and 90 mg/mL syringes, and 45 mg/0.5 mL and 130 mg/26 mL vials – in addition to continuing to cover Stelara (ustekinumab).
- Steqeyma® (ustekinumab-stba) will be accessible at parity with other preferred ustekinumab biosimilars. Available as 45 mg/0.5 mL and 90 mg/mL syringes, and 130 mg/26 mL vials.
- Effective **April 1, 2026**, Stelara (ustekinumab) will no longer be a preferred drug and will require a trial for all preferred biosimilars.

**Expectation for prior authorization processing**

- Prior to the transition to the new preferred biosimilars, all active Stelara prior authorizations will be end dated to March 31, 2026.
- New prior authorizations for the preferred Stelara biosimilars will be created with the same expiration date as the existing Stelara prior authorization to support member transitions.

**Communications**

- Member and provider letters will be sent out at least 30 days prior to April 1, 2026.
- Fallon Health will work with ACO groups to provide impacted member reports.
- MassHealth will be drafting a Prescriber E-Letter and Pharmacy Facts to be distributed.

| Reference product | Covered biosimilars |
|---|---|
| Stelara® (ustekinumab) 45 mg/0.5 mL syringe | Imuldosa (ustekinumab-srlf) 45 mg/0.5 mL syringe<br>Pyzchiva (ustekinumab-ttwe) 45 mg/0.5 mL syringe<br>Steqeyma (ustekinumab-stba) 45 mg/0.5 mL syringe |
| Stelara® (ustekinumab) 90 mg/1 mL syringe | Imuldosa (ustekinumab-srlf) 90 mg/1 mL syringe<br>Pyzchiva (ustekinumab-ttwe) 90 mg/1 mL syringe<br>Steqeyma (ustekinumab-stba) 90 mg/1 mL syringe |
| Stelara® (ustekinumab) 45 mg/0.5 mL vial | Pyzchiva® (ustekinumab-ttwe) 45 mg/0.5 mL vial |
| Stelara® (ustekinumab) 130 mg/26 mL vial | Imuldosa (ustekinumab-srlf) 130 mg/26 mL vial<br>Pyzchiva (ustekinumab-ttwe) 130 mg/26 mL vial<br>Steqeyma (ustekinumab-stba) 130 mg/26 mL vial |
| Stelara® (ustekinumab) 45 mg/0.5 mL syringe | Imuldosa (ustekinumab-srlf) 45 mg/0.5 mL syringe<br>Pyzchiva (ustekinumab-ttwe) 45 mg/0.5 mL syringe<br>Steqeyma (ustekinumab-stba) 45 mg/0.5 mL syringe ■ |

## Prior authorization requirement for ASAP services, effective January 1, 2026

As shared in the October *Connection* newsletter, beginning **January 1, 2026**, Aging Services Access Points (ASAPs) will be required to obtain prior authorization (PA) for service codes listed in the updated ASAP Payment Policy.

**How to submit requests**

The primary method for submission will be through the ASAP Service Request Assessment tool within the TruCare system. Please note:

- There is no requirement to submit a fax or other formal PA request for these services.
- All NaviCare members have an assigned GSSC as part of their care team.
- The requirement is bi-annual GSSC assessments.
- The service evaluation submission will automatically trigger the PA request for review.

**What services are impacted?**

This requirement applies to ASAP services included in the attached ASAP Payment Policy. Additionally, Fallon Health NaviCare now has approved Clinical Coverage Criteria for:

- Community-based LTSS services
- Personal Care Attendant
- Group Adult Foster Care

- Adult Foster Care
- Adult Day Health
- Day Habilitation

Please visit fallonhealth.org/providers and go to the *Criteria, policies and guidelines* section for full details. If you have any questions, please contact your Provider Relations Representative, or reach out to Regina Greene, Manager of LTC and LTSS Services, at regina.greene@fallonhealth.org. ■

## NaviCare Long-Term Care authorization changes and new custodial payment policy

Effective January 1, 2026, Fallon Health will implement a new Short-Term Custodial and Long-Term Care Payment Policy. All Massachusetts-based, contracted skilled nursing and long-term care facilities will be required to actively submit prior authorization for NaviCare members residing in an institutional rating category.

Prior authorization requests will be completed using Fallon Health's Standardized Prior Authorization Request form, and the following guidelines apply:

**For members already residing in the facility (as of January 1, 2026):**

- Submit **prior authorization via fax** once the first **MDS 3.0 virtual gateway submission** is completed in the new year.
- Attach the following documents with your request:
    - Updated **MDS 3.0** with date of completion
    - Updated **HIPPS code**

**For new Long-Term Care members:**

- Once the initial **MDS** is submitted within the first **14 days of admission**, Fallon Health will create an initial authorization to start the prior authorization process.
- With the first request, please attach:
    - Initial **MDS 3.0** with HIPPS code
    - **SC-1 form**
    - **PASSR screening tool**

**Fax prior authorization requests to:** 1-774-317-6801.

**Please note:**

- The process for obtaining short-term custodial or skilled level of care authorization is not changing at this time. Continue using current processes for these levels of care.
- The updated Custodial Payment Policy is attached for your reference.

For questions, please contact your Provider Relations Representative. ■

### Prior authorization required for Adult Foster Care (AFC) assessments, effective January 1, 2026

Fallon Health is implementing a new requirement for Adult Foster Care (AFC) services beginning January 1, 2026. To ensure proper coordination and compliance, **prior authorization will be required for the one-time initial AFC Assessment code (T1028).**

**What you need to know**

- Authorization must be requested and approved by Fallon Health before completing the initial AFC assessment.
- This change applies to all providers delivering AFC services.
- Best Practice: Contact the NaviCare team in advance to confirm the member's eligibility for the AFC program before submitting your authorization request.

**Why this matters**

This update helps streamline care coordination and ensures members receive services aligned with program requirements.

For questions or assistance with prior authorization requests, please reach out to the NaviCare team. ■

# Important updates

### IHCS update

From August 1, 2025, through December 31, 2025, Fallon Health and IHCS have allowed hospital discharges requiring the following services that meet applicable medical guidelines to be exempt from prior authorizations.

**This exemption will extend through March 31, 2026.** In order to streamline the process, IHCS is working with third party vendors (CarePort, Availity, and Parachute) to enable hospitals to leverage existing infrastructure when sending a prior authorization. These enhancements are in development and will be rolled out in Q1 2026. Additional notification will be sent in advance communicating the "Go-live" dates of these additional avenues for submitting a prior authorization to IHCS. Furthermore, advanced notice will be sent if there are any further changes to the exemptions list or the time frame noted above.

**Exemption list**

*Home Health Services:*

- Initial RN evaluation and up to three additional RN visits – G0299-550, G0299-551, T1030 and T1001
- Initial PT evaluations and up to three PT visits - G0151-424, G0151-421
- Initial OT evaluation and up to three OT visits. G0152-0434, G0152-0431

*DME equipment:*

- Cane – E0100, E0105
- Walker – E0135, E0143

- Shower chair – E0240
- Standard wheelchair rental (up to 1 month) – K0001
- Standard hospital bed rental (up to 1 month) – E0260

Although these services are exempt from prior authorizations, orders and referrals must continue to be submitted to IHCS. If a member requires ongoing services, please contact IHCS for prior authorization. ■

## Annual update: Fallon Health Provider Manual now available

Fallon Health is committed to supporting our provider network with clear, consistent, and up-to-date guidance. We're pleased to announce the release of the 2026 provider manual, now available online.

The Fallon Health Provider Manual is a comprehensive resource that outlines the policies, procedures, and operational guidelines for healthcare providers participating in our network. It serves as a vital reference tool to ensure consistency, compliance, and clarity in provider interactions with Fallon Health. The manual supports quality care delivery and efficient business practices by detailing clinical, administrative, and operational standards.

As part of our commitment to transparency and continuous improvement, the manual is reviewed and updated annually in collaboration with subject matter experts across Fallon Health. Updates reflect changes in policy, regulatory requirements, and best practices to help providers stay informed and aligned with our expectations.

You can access the provider manual here.

We encourage all providers and office staff to review the updated manual and to reach out to your Provider Relations representative with any questions. ■

## Understanding EVV compliance: What Massachusetts providers need to know

The 21st Century Cures Act requires Electronic Visit Verification (EVV) for all personal care services, ensuring 6 key data elements are captured for every visit:

- Type of service
- Individual receiving the service
- Date of service
- Location of service
- Individual providing the service
- Start and end times

Massachusetts operates under an open EVV model, allowing providers to choose between the state's Sandata system or a third-party solution. Regardless of the system, all visit data must flow into the Sandata Aggregator, which serves as the central repository for compliance reporting to the state and CMS.

**Why EVV compliance matters**
EVV compliance is calculated using the percentage of visits that are auto-verified—meaning all required elements were captured electronically without manual edits. Providers should aim for high compliance rates to avoid billing delays and ensure accurate claims processing.

**Common exceptions**
Visits may fail compliance due to issues like missing service details, unknown client or employee, or incomplete call data. Resolving these exceptions promptly is critical, as only verified visits can match to claims.

**Best practices for providers**

- Register for a Sandata account, even if using a third-party EVV system.
- Train staff on proper clock-in/clock-out procedures.
- Regularly review visit data and resolve exceptions.

Monitor compliance reports at least two weeks after the service period for accuracy. ■

## Fallon Health launches new provider portal

We're excited to announce that Fallon Health is **now live with our new provider portal**, designed to deliver a more streamlined, efficient, and user-friendly experience for our contracted providers. **Full retirement of existing tools happened on December 15.**

**What's new?**
The new portal offers a suite of features to simplify day-to-day operations, including:

- Eligibility and benefit verification
- Claim status checks
- Claims submission for 1,500 claim forms
- Authorization and referral status tracking
- And much more!

These enhancements are aimed at reducing administrative burden and improving access to critical information—helping providers focus more on patient care.

**Introducing the super user role**
A key component of the new portal is the super user (practice administrator) role.
Each provider group, defined by Tax Identification Number (TIN), must designate a super user to manage portal access for their organization.

**Super users will:**

- Serve as the primary contact for portal access
- Set up and maintain user accounts within their group
- Assign roles for claims, eligibility, benefits, and authorizations
- Approve third-party biller registrations

**Important: Individual registrations will not be accepted and will be denied.** All users must be added by their group's designated super user.

**Appeals functionality**
As part of the new portal, providers can submit **member appeals** on behalf of NaviCare members when a **Personal Representative Authority (PRA)** form is on file. Member appeals include:

- Medical necessity denials
- Claims that deny member responsibility

**Provider appeals** (post-service appeals that generate a provider-liable denial) **cannot** be submitted through the portal. These must be submitted via the **Request for Claims Review form** with all appropriate supporting documentation for review. These provider appeals should be sent in via mail or fax as described in the Fallon Health provider manual.
Any provider appeal submitted through the portal will **not** be processed.

Fallon Health is committed to supporting our provider partners through this transition and beyond. **Thank you for your continued partnership!** ■

# Product spotlight

## 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 aged 65 or older, enrolled in MassHealth Standard (Medicaid) and enrolled in Medicare Part A and Part B. Prior to January 1, 2026, members could qualify for NaviCare with only MassHealth Standard (Medicaid). As of January 1, 2026, members must be enrolled in MassHealth Standard (Medicaid) as well as Medicare Part A and Part B.

NaviCare is available in every county in Massachusetts, except for Nantucket and Dukes, and there are $0 copays 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 members' 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 individualized 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 rides to and from medical appointments and places where members receive health care
- 48 one-way rides to the pharmacy
- Mileage reimbursement for friends and family who give rides when pre-approved

- 100 one-way rides to run errands, visit friends, attend religious services, and more, for members who have a qualifying chronic condition*
- **$400/year** to pay for fitness classes, a new fitness tracker, new cardiovascular fitness equipment, or a fitness/gym membership.
- Each calendar quarter, **Fallon Health will load $375** onto a member's Save Now card so that they can buy over the counter (OTC) health and personal care items. They'll get up to $1,500 during the year to use at select retail stores or for phone and online orders through Fallon Health's mail order partner, Medline.
- If members have a qualifying chronic condition: Each calendar quarter, a portion of their over the counter (OTC) benefit* is set aside for them to buy healthy food. To learn more, contact Fallon Health.

**The $200 (per calendar quarter) food benefit and 100 annual one-way rides to run errands, visit friends, attend religious services, and more, are part of a special supplemental program for the chronically ill. To qualify, enrollees must have chronic-condition diagnoses documented with Fallon Health, such as cardiovascular disorders, chronic and disabling behavioral health conditions, chronic lung disorders, diabetes, and neurologic disorders. This is not a complete list of eligible chronic conditions. Not all members with an eligible condition will qualify. Other eligibility and coverage criteria also apply.*

****** *To qualify for the Special Supplemental Benefits for the Chronically Ill (SSBCI) grocery benefit, members must be enrolled in NaviCare and have a documented qualifying chronic condition. To determine if members have a qualifying chronic condition, a member of the Care Team may send a Provider Attestation form to the Primary Care Provider or specialist overseeing the member's care for completion and return to the plan.*

- Telehealth visits for virtual primary care providers, specialists, or other health care providers
    - 24/7 access to doctors by phone, internet, or mobile device—with Teladoc®
    - 24/7 access to nurses, by phone, who can recommend where members should receive care or connect them to their doctor—with Care Connect
- 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 medications via mail order.
- Vision care and eyeglasses ($403 annual eyewear allowance to buy up to 2 pairs of prescription eyeglasses, contacts, lenses, frames, or upgrade to anti-scratch lenses)
- Hearing aids and batteries
- Comprehensive dental services designed to maintain and improve member's oral health, including but not limited to:
    - Preventive services: routine oral examinations, cleanings, and X-rays
    - Basic services: fillings, extractions, and periodontal treatments
    - Major services: crowns, bridges, and dentures
    - Pre-authorization requirements: certain dental procedures require pre-authorization to ensure they are medically necessary and appropriate. For services to be covered, the dental provider must get prior authorization (approval in advance) 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

**Care Team members and their roles include:**

**Navigator**

- Provides information to your patient about benefits and services.
- Assists with care plan development, reviews and obtains consent for care plans.
- Assists patients with provider access and service coordination.
- Provides care coordination around patient care transitions.

**Nurse Case Manager or Advanced Practitioner**

- Assesses clinical and daily functional needs.
- Supports patient in accessing the care they need when transitioning between or out of facility settings.
- Provides education about chronic disease and medication management.

**Primary Care Provider**

- Provides overall clinical direction.
- Provides primary medical services including acute and preventive care.
- Orders prescriptions, supplies, equipment, and home-based services and supports.
- Documents and complies with advance directives in alignment with the patient's wishes for future treatment and health care decisions.
- Provides input into patient's care plan and receives periodic care plans for review and involvement.

**Geriatric Support Services Coordinator** *(as needed)*
*(Employed by local ASAPs for community-based patients)*

- Evaluates need for services to help patient remain at home and coordinates those services.
- Helps patient with completion and submission of MassHealth, Medicare, or other financial documents.
- Connects patient with community resources.

**Behavioral Health Case Manager** *(as needed)*

- Identifies and coordinates services to support patient's emotional health and well-being.
- Supports patient through transition phases of older adulthood.
- Helps connect patient with their Care Team, mental-health providers, and substance-use counselors, if needed.
- Supports patient through life transitions such as offering resources related to grief and loss, Alzheimer's/dementia resources, and family caregiver support.

**Clinical Pharmacist** *(as needed)*

- Visits patients after care transitions to perform a medication reconciliation and teach them proper medication use.
- Participates in case conferences for patients with complex medication profiles.
- Supports patients after care transitions; may complete medication reconciliations via telehealth, provides additional education and resources around medication management.

- Collaborates with providers to ensure a safe, effective medication regimen is in place. The goal is to prevent medication errors, complications, or adverse outcomes when possible.

PCPs are welcome to provide input to their patient's care plan at any time by contacting NaviCare Enrollee Service at 1-877-700-6996 (TRS 711). They're available 8 a.m. – 8 p.m., Monday – Friday (7 days a week, Oct. 1 – March 31). You may also speak directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you're 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 to learn more about eligibility criteria, call 1-877-255-7108. ■

## NaviCare – Model of Care success

**Safe and supported at home**

When a NaviCare member's dementia progressed, she faced challenges managing daily tasks like cooking, medication management, and home upkeep. She and her family wanted her to remain at home with her beloved pets, but her family could not provide the necessary support themselves.

Our Nurse Case Manager (NCM) stepped in to coordinate and implement a comprehensive care plan that centered around the member's goals. Within a week, the member was enrolled in a **Group Adult Foster Care (GAFC)** program, ensuring in-home assistance with tasks like shopping, laundry and light housekeeping. Additional services included:

- **Medication delivery and management** with a secure lockbox and VNA services
- **Meal support** through Heart to Home meal deliveries
- **Home-based geriatric primary care** via Reliant Medical Group, bringing a primary care provider directly to her home

Through education and collaboration, the member overcame initial resistance to nursing visits and now receives consistent oversight for her complex medical needs.

**The result?** The member remains safely at home, her family feels reassured, and she enjoys life with her pets. Both the member and her family expressed deep gratitude for the support provided. ■

# Important reminders

## Telehealth services coverage

Fallon Medicare Plus™ and NaviCare HMO SNP plans include coverage for certain telehealth services when provided by network providers, including primary care, specialist care, outpatient mental health services, opioid treatment and outpatient substance use disorder services, and a telehealth vendor under supplemental Medicare benefits coverage. Covered telehealth services are limited to those that involve both an audio and video component and must be done in real time over a secure communication method administered by a network provider.

**The expiration of the extension from the Federal government for original Medicare coverage of telehealth services does not apply to Fallon Health's coverage for Fallon Medicare Plus and NaviCare members.** Please refer to the Procedure Code Look-Up tool to verify allowable CPT codes for telehealth services. ■

## 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 access to registered nurses, 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.
    - Share lab and test results with your patients as soon as they are available. It's important your patients understand what the results mean and how they impact their particular situation.
- **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:

- Provides information to your patient about benefits and services.
- Assists with care plan development, reviews and obtains consent for care plans.
- Assists patient with provider access and service coordination.
- Provides care coordination around patient care transitions.

To refer a patient to NaviCare or to learn more about eligibility criteria, call 1-877-255-7108, 8 a.m. – 8 p.m., Monday – Friday (7 days a week, Oct. 1 – March 31).

**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. Additional things you can do to help your patients get the care they need include:

- **Close the loop on referrals**
    - Ensure specialists receive relevant records before visits.
    - Follow up after specialist visits to integrate findings into the care plan.

- **Medication management**
    - Review medications at every visit and reconcile changes from other providers.
- **Information sharing**
    - Use patient portals and secure messaging to keep patients informed, and to remind patients this is how you may communicate.
    - Encourage patients to bring discharge summaries or test results from other facilities.
- **Team-based approach**
    - Engage nurses, care managers, and pharmacists in coordination efforts.
- **Set expectations**

Explain timelines for test results, referrals, and follow-up. PCPs are welcome to provide input to their patient's care plan at any time by contacting NaviCare Enrollee Service at 1-877-700-6996 (TRS 711). They're available 8 a.m. – 8 p.m., Monday – Friday (7 days a week, Oct. 1 – March 31). You may also speak directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you're 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 to learn more about eligibility criteria, call 1-877-255-7108. ■

## Upcoming claims editing enhancements – effective April 2026

To continue improving accuracy and compliance in claims processing, several new edits will be implemented in April. These updates are designed to align with CMS guidelines and industry best practices. Below is an overview of the new rules:

**1. Ineligible co-surgeon|**
This edit identifies claim lines billed with the co-surgery modifier (62) that do not meet CMS criteria for co-surgery payment. Claims failing these requirements will be flagged for review.

**2. Therapy services professional**
Audits therapy claims to ensure:

- Correct therapy modifiers are applied
- Untimed therapy procedures are reported appropriately for the date of service. This rule includes three distinct paths for each therapy discipline:
    - Speech-Language Pathology
    - Occupational Therapy
    - Physical Therapy

**3. Modifier 78 without global procedure**
Recommends denial of claims billed with modifier 78 when no related procedure code is present within the applicable global period:

- Same day for 0-day global codes
- Previous 10 days for 10-day global codes
- Previous 90 days for 90-day global codes (This applies to services billed by the same provider group.)

**4. Add-on code without base code**
Flags claim lines containing CPT add-on codes submitted without the required primary/base procedure. This rule also addresses vaccine and immunoglobulin administration requirements.

**5. Pay percent professional therapy**
Ensures CMS-compliant reimbursement for therapy services in office or non-institutional settings:

- First therapy procedure reimbursed at 100%.
- Subsequent procedures adjusted to 50% of the non-facility Practice Expense RVU. Modifier adjustments apply when CO or CQ is appended.

**6. Missing professional component modifier**
Recommends denial of claims missing modifier 26 (professional component) when billed in a facility setting.

**Why this matters**
These edits help maintain compliance, reduce improper payments, and support accurate reimbursement for providers. Please review these changes and ensure your teams are prepared for implementation in April. ■

## The importance of complying with medical records requests from health plans

Legal and regulatory compliance of health plans—especially those under Medicare and Medicaid—are governed by strict documentation requirements. A request for medical records is often made to verify correct coding practices to ensure reimbursement is accurate. Failure to comply can result in recovery audits and/or investigations by CMS.

The medical record is the only accepted proof of a diagnosis. If a condition isn't documented clearly, it cannot be coded or reimbursed. Proper documentation protects against denials, take-backs, and audit failures. ■

## Diversity, equity, inclusion, and belonging (DEIB)

At Fallon Health, diversity, equity, inclusion, and belonging guide the decisions we make and the work we do as an employer, as a health plan, as a provider of care, and as an organization with responsibilities to the communities we serve.

Fallon Health celebrates diversity and inclusion and is committed to providing inclusive services for all. We recognize and support individuals' abilities and rights to fully participate in society and believe that our communities are better served when we commit to providing equitable services.

**Help us share this important information with our members by:**

1. Indicating the languages spoken by providers in your practice/office. Simply fill out the appropriate field on the HCAS Provider Enrollment form.

2. Completing the cultural competency training. Update your practice information to let us know you have completed the cultural competency training.

**Translation services available for Fallon Health members**
Fallon Health offers free audio translation services for our members in over 350 languages. If a member needs translation assistance, they can contact Fallon Health's Customer Service Department at 1-800-868-5200, Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m., and Wednesday from 9 a.m. to 6 p.m. ■

## Why complete and timely pharmacy prior authorization submissions matter

In today's healthcare environment, timely access to medications is critical to patient outcomes. One of the most impactful ways providers can support this goal is by submitting **complete and clinically thorough prior authorization (PA) requests** and responding promptly to any requests for additional information.

**Regulatory requirements drive timely reviews**
Regulatory bodies such as **CMS, NCQA**, and various **state agencies** mandate strict turnaround times for pharmacy PA reviews, many of which are within 24 or 72 hours. These timeframes are designed to ensure patients receive timely decisions regarding their medication access. When we request additional information, it is with these regulatory deadlines in mind. If the necessary information is not received within the required timeframe, we are obligated to **deny the request** due to insufficient documentation.

**The top pharmacy benefit drugs denied for lack of response to our request for additional information include:**

- Incretin mimetics (Mounjaro®, Ozempic®, Trulicity, Wegovy®, Zepbound®)
- Atypical antipsychotics (Aripiprazole, Caplyta, Invega Sustenna®, Lurasidone Hydrochloride, Lybalvi®, Quetiapine Fumarate, Rexulti®, Risperidone, Vraylar)
- Diabetic testing supplies/devices (Dexcom and Freestyle Libre)

**The top medical benefit drugs denied for lack of response to our request for additional information include:**

- Prolia®
- Zilretta®
- Inflectra®
- Aloxi®
- Vabysmo®

**Avoiding delays through complete initial submissions**
A common pattern we observe is that denied initial PA requests are quickly followed by appeals. While appeals are a valid part of the process, they often have **longer turnaround times** than initial reviews. This delay can result in **interrupted or postponed access to medications** for members.

Submitting a **complete and clinically supported PA request from the start** is the best way to avoid unnecessary delays and denials. This includes:

- Answering all questions thoroughly
- Providing clinical rationale when answering questions or listing alternative therapies
- Including relevant documentation such as chart notes, lab results, and treatment history

**Clinical oversight is key**
We've also noted that some PA requests or responses to additional information are completed by **non-clinical staff**, which can lead to **incomplete or inaccurate submissions**. This often results in denials that could have been avoided with proper clinical input.

**Best practice:** Ensure that staff handling PA submissions have **clinical knowledge** or that requests are **escalated to clinical team members** when appropriate.

**Tips for successful PA submissions**

- **Be proactive:** Submit all relevant clinical documentation with the initial request.
- **Be responsive:** Reply to requests for additional information as quickly and thoroughly as possible, keeping in mind the short turnaround times for initial PA reviews.
- **Be specific:** When listing alternative therapies or explaining why a drug cannot be used, include a clear clinical rationale.
- **Be collaborative:** Ensure coordination between administrative and clinical staff to avoid gaps in information.

**The bottom line**
Complete and timely PA submissions not only help meet regulatory requirements, they also **reduce delays, minimize denials**, and most importantly, **support better patient care**. We appreciate your partnership in ensuring that members receive the medications they need without unnecessary barriers.

For more information on our Pharmacy PA process visit our website:
https://fallonhealth.org/en/providers/pharmacy/pharmacy-prior-authorization

Our formulary and clinical criteria may also be accessed from our website:
https://fallonhealth.org/en/providers/pharmacy/online-drug-formulary ■

## Medical benefit – step therapy updates for 2026

| Requested drug | Previous step therapy requirement | New step therapy requirement | Line of business | Date effective |
|---|---|---|---|---|
| **Eylea HD Vabysmo** | Step through Bevacizumab ophthalmic | Step through Bevacizumab ophthalmic and aflibercepts | Medicare (new starts only)<br>Exchange (new starts only) | Medicare 1/1/2026<br><br>Exchange 2/1/2026 |
| **Bendamustines** | Step through Belrapzo/Treanda | Step through Treanda | Medicare (new starts only) | 1/1/2026 |
| **Acthar Gel** | Step through corticotropin gel | Step therapy removed | Medicare<br>Exchange<br>Medicaid | All lines of business (LOB) 1/1/2026 |
| **Rituximabs, including Rituxan Hycela** | Step through Truxima / Ruxience | Step through Riabni/ Truxima | Medicare (new starts only)<br>Exchange<br>Medicaid | Medicare 1/1/2026<br><br>Exchange/ Medicaid 2/1/2026 |
| **Trastuzumabs Including Herceptin Hylecta** | Step through Kanjinti / Trazimera | Step through Ontruzant/ Hercessi | Medicare (new starts only)<br>Exchange<br>Medicaid | Medicare 1/1/2026<br><br>Exchange/ Medicaid 2/1/2026 |
| **Denosumabs** | Step through zoledronic acid | Step through zoledronic acid and Jubbonti/ Bildyos, Wyost/ Bilprevda | Medicare (new starts only)<br>Exchange<br>Medicaid | Medicare 1/1/2026<br><br>Exchange/ Medicaid 2/1/2026 |
| **Ustekinumabs** | None | Medicare: Step through Wezlana/Steqemya<br><br>Exchange: Step through Stelara/Wezlana | Medicare (new starts only)<br>Exchange | Medicare 1/1/2026<br><br>Exchange 2/1/2026 |

| Requested drug | Previous step therapy requirement | New step therapy requirement | Line of business | Date effective |
|---|---|---|---|---|
| **Eculizumabs** | **PNH/aHUS** – Ultomiris<br>**NMOSD** – Uplinza or Ruxience or Truxima<br>**AChR+ gMG –** Vyvgart/Vyvgart Hytrulo, Rystiggo, AND Ultomiris | **Medicare:**<br>**PNH/aHUS** – Ultomiris and Epysqli<br>**NMOSD** – Uplinza or Truxima or Riabni AND Ultomiris **AChR+ gMG –** Vyvgart/Vyvgart Hytrulo, Rystiggo, AND Ultomiris | **Exchange:**<br>**PNH/aHUS** – Ultomiris and Epysqli<br>**NMOSD** – Uplinza or Truxima or Riabni AND Ultomiris **AND** Epysqli<br>**AChR+ gMG –** Vyvgart/Vyvgart Hytrulo, Rystiggo, AND Ultomiris AND Epysqli | Medicare (new starts only)<br>Exchange ■ |

## Medicare opioid edits and programs for 2026

There are several opioid safety edits and programs for the 2026 Medicare Part D plan year. This impacts all Fallon Health Medicare members: Fallon Medicare Plus, NaviCare, Summit ElderCare® PACE, and Fallon Health Weinberg PACE.

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, Fallon Health's 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. Below is a summary of the programs.

**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.

Hospice/palliative care, cancer-related pain, sickle cell disease, and LTC members 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.
- Hard edit for concurrent use of opioid and benzodiazepines (COB) in members who are 18 years of age or older, with concurrent use of opioid and benzodiazepine for greater than fourteen (14) days. If the pharmacy cannot resolve at point of sale (POS), this will require a prior authorization to be submitted.

**Medication Therapy Management (not applicable to PACE)**
We are also including special eligibility criteria into 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 the Comprehensive Addiction and Recovery Act of 2016 (CARA). This is a retrospective 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 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.

**Medicare Part D opioid policies: Information for prescribers**

Medicare Part D **opioid policies** include **safety alerts** when opioid prescriptions are dispensed at the pharmacy and **drug management programs** for Part D enrollees at risk for misuse or abuse of opioids or other frequently abused drugs.

Residents of long-term care facilities, and those receiving hospice, palliative or end-of-life care, being treated for active cancer-related pain, or who have sickle cell disease are exempt from these interventions. Enrollee access to medication-assisted treatment (MAT), such as buprenorphine, should not be impacted.

| Opioid safety alert | Prescriber tips |
|---|---|
| **Seven-day supply limit for opioid naïve patients**<br>This hard edit alert triggers when an enrollee 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.<br><br>This edit should not impact enrollees who already take opioids but may occur for enrollees who enroll in a new plan that does not know their current prescription information. | Enrollee may receive up to a 7-day supply without taking any action.<br><br>Enrollee 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.<br><br>Subsequent prescriptions filled within the plan's look back window are not subject to the 7-day supply limit, as the enrollee will no longer be considered opioid naïve. |

| | |
|---|---|
| **Optional Safety Alert at 200 morphine milligram equivalent (MME) or more**<br>Some plans may implement a hard edit safety alert when an enrollee's cumulative opioid daily dosage reaches 200 MME or more.<br><br>Some plans have this alert only when the enrollee uses multiple opioid prescribers and/or opioid dispensing pharmacies.<br><br>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 care coordination alert at 90 MME**<br>This alert triggers when an enrollee's cumulative MME per day across all their opioid prescription(s) reaches or exceeds 90 MME.<br><br>Some plans use this alert only when the enrollee uses multiple opioid prescribers and/or opioid dispensing pharmacies.<br>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.<br><br>The prescriber may be informed of other opioid prescribers or increasing level (MME) of opioids.<br><br>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**<br>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 enrollee'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 the medication.

**Drug Management Programs (DMPs)**
All Part D plans must have a DMP that limits access to opioids and/or benzodiazepines for enrollees 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. Enrollees are identified by opioid use involving multiple doctors and pharmacies or a recent history of opioid-related overdose, and undergoing case management conducted by the plan that involves their prescribers.

DMP limitations can include requiring the enrollee 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 enrollee in writing. Plans are required to make reasonable efforts to notify prescribers. After 30 days, the plan must send the enrollee a second written notice confirming the details of the limitation. This notice also explains that the enrollee, their representative, or their prescriber has the right to appeal.

Learn more at:
www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization ■

## Important MassHealth requirements for hospice providers when members transition to Fee-For-Service (FFS) hospice

MassHealth Hospice Election Form Requirements for Fee-For-Service Transitions:

- Providers must obtain the member's signature on the MassHealth Hospice Election Form, which includes MassHealth-specific information.
- The effective date of the MassHealth hospice election cannot be earlier than the date of the member's signature.
- Per 130 CMR 437.412, hospice providers must notify MassHealth of the hospice election through the LTSS Provider Portal within 14 days after the effective date of election.

For detailed guidance on completing the MassHealth Hospice Election Form, please review Hospice Bulletin 24. ■

# Doing business with us

## CMS-0057-F prior authorization interoperability: What providers need to know

**What is CMS-0057-F?**

CMS-0057-F refers to the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule. This is a federal regulation aimed at reducing administrative burden and accelerating care delivery by improving the efficiency, transparency, and interoperability of the prior authorization process.

**What are the key requirements of CMS-0057-F?**

- **Electronic APIs:** Real-time service coverage criteria screenings and authorization submissions to payers across Massachusetts
- **Provider access:** Real-time access to patient claims and authorization status
- **Faster decisions:** 72 hours for urgent requests and 7 days for standard requests
- **Payer-to-payer data sharing:** Ensure continuity of care when patients change health plans
- **Public reporting:** Annual publication of prior authorization metrics

**How does this benefit providers?**

- Reduced paperwork and manual efforts
- Faster, more predictable authorization decisions
- Improved member experience and satisfaction
- Greater transparency and data access
- Seamless integration into your electronic health record and practice management systems

**How is Fallon Health supporting implementation?**

We're making a variety of upgrades to the ProAuth system, including API integration, business rule optimization, and electronic health record integration capabilities to support improved provider experience and better care outcomes. Fallon Health also offers training and onboarding to providers utilizing—or interested in utilizing—the ProAuth system.

**What's next?**

Watch for outreach from Fallon Health regarding ProAuth onboarding and training, or contact your Fallon Health Provider Relations Representative for support with ProAuth access.

Review upcoming Fallon Health communications for more details on new workflows and system enhancements. ■

# Coding Corner

## Coding updates

**Effective October 1, 2025,** the following codes are *deny vendor liable* for Medicare PSP and HMO:

| Code | Description |
|---|---|
| **T1041** | COMM BH CLINIC SVC PER MONTH |
| **T1505** | ELEC MED COMP DEV, NOC (for NY only one time) |
| **T2012** | HABILITATION ED WAIVER; DIEM |
| **T2013** | HABILITATION ED WAIVER; HOUR |
| **T2014** | HABILITATN PREVOCATIONL WAIVR;DIEM |
| **T2015** | HABILITATION PREVOCATIONAL WAIVR;HR |
| **T2016** | HABILITATION RES WAIVER; PER DIEM |
| **T2017** | HABILITATION RES WAIVER; PER 15 MIN |
| **T2018** | HABILITATN SUPP EMPLMNT WAIVR;DIEM |
| **T2019** | HABILTATN SUPP EMPLMNT WAIVR;15 MIN |
| **T2020** | DAY HABILITATION WAIVER; PER DIEM |
| **T2021** | DAY HABILITATION WAIVER; PER 15 MIN |
| **T2022** | CASE MANAGEMENT; PER MONTH |
| **T2024** | SRVC ASSESS/PLAN CARE DVLP WAIVER |
| **T2025** | WAIVER SERVICES; NOS |
| **T2038** | CMTY TRANSITION WAIVER; PER SERVICE |
| **T2039** | VEHICLE MOD WAIVER; PER SERVICE |
| **T2042** | HOSPICE ROUTINE HOME CARE PER DIEM |
| **T2043** | HOSPICE CONTINUOUS HOME CARE PER HR |
| **T2044** | HOSPICE INPAT RESPITE CARE PER DIEM |
| **T2045** | HOSPICE GENERAL INPAT CARE PER DIEM |
| **T2046** | HOSPICE LT CARE RM AND BD PER DIEM |
| **T2049** | NON-EMERG TRNSPRT; VAN MILEAGE;MILE |
| **T5999** | SUPPLY NOT OTHERWISE SPECIFIED |

**Effective January 1, 2026,** the following codes will be *covered with prior authorization* for all lines of business, except MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative), which is *deny vendor liable*:

| Code | Description |
|---|---|
| **27458** | Osteotomy(ies), femur, unilateral, with insertion of an externally controlled intramedullary lengthening device, including iliotibial band release when performed, imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device |
| **27713** | Osteotomy(ies), tibia, including fibula when performed, unilateral, with insertion of an externally controlled intramedullary lengthening device, including imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device |

| Code | Description |
|---|---|
| **52597** | Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed |
| **62330** | Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; one interspace, lumbar |
| **62331** | Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure) |
| **63032** | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone-anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure) |
| **70471** | Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing |
| **70472** | Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure) |
| **70473** | Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy |
| **75577** | Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional |
| **81524** | Oncology (central nervous system tumor), DNA methylation analysis of at least 10,000 methylation sites, utilizing DNA extracted from formalin-fixed tumor tissue, algorithm(s) reported as probability of matching a reference tumor family and class, and MGMT (O-6-methylguanine-DNA methyltransferase) promoter methylation status, if performed |
| **87627** | Infectious agent detection by nucleic acid (DNA or RNA); joint space pathogens and drug resistance genes, multiplex amplified probe technique, 26 or more targets |
| **92945** | Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches |

| Code | Description |
|---|---|
| 98986 | Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period |
| C1607 | Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system |
| C1608 | Prosthesis, total, dual mobility, first carpometacarpal joint (implantable) |
| C9810 | Water circulating motorized cold therapy device (e.g., iceman) including all system components (e.g. pads, console, disposable parts), 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) |
| C9811 | Electronic ambulatory infusion pump (e.g. sapphire pump), including all pump components, including disposable 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) |
| C9812 | Echogenic nerve block needles (e.g. sonoplex, sonoblock, sonotap), 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) |
| C9813 | Perforated continuous infusion catheter set (e.g. infiltralong), including all 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) |
| C9814 | Continuous anesthesia echogenic conduction catheter set (e.g. sonolong), 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) |
| C9815 | Linear peristaltic pain management infusion pump (e.g. cadd-solis ambulatory infusion pump), 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) |
| **Code** | **Description** |
| C9816 | Rotary peristaltic infusion pump (e.g., reusable ambit pump) including all disposable system components, reusable 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) |
| C9817 | Electronic cryo-pneumatic compression, pain management system (e.g. game ready grpro 2.1 system), including control unit, anatomically correct wrap(s), and other system component(s), 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) |
| Q4398 | Summit ac, per square centimeter (add-on, list separately in addition to primary procedure) |
| Q4399 | Summit fx, per square centimeter (add-on, list separately in addition to primary procedure) |

| Code | Description |
|---|---|
| **Q4400** | Polygon3 membrane, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4401** | Absolv3 membrane, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4402** | Xwrap 2.0, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4403** | Xwrap dual plus, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4404** | Xwrap hydro plus, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4405** | Xwrap fenestra plus, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4406** | Xwrap fenestra, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4407** | Xwrap tribus, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4408** | Xwrap hydro, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4409** | Amniomatrixf3x, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4410** | Amchomatrixdl, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4411** | Amniomatrixf4x, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4412** | Choriofix, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4413** | Cygnus solo, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4414** | Simplichor, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4415** | Alexiguard sl-t, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4416** | Alexiguard tl-t, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4417** | Alexiguard dl-t, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4420** | Nuform, per square centimeter (add-on, list separately in addition to primary procedure) |
| **Q4431** | Pma skin substitute product, not otherwise specified (list in addition to primary procedure) |
| **Q4432** | 510(k) skin substitute product, not otherwise specified (list in addition to primary procedure) |
| **Q4433** | 361 hct/p skin substitute product, not otherwise specified (list in addition to primary procedure) |

**Effective January 1, 2026,** the following codes will be *covered without prior authorization* for all lines of business, except MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative), which will be *deny vendor liable*:

| Code | Description |
|---|---|
| **33882** | Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stent graft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation |
| **35602** | Bypass graft, with other than vein; carotid-contralateral carotid |
| **37254** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel |
| **37255** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37256** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel |
| **37257** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **37258** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37259** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37260** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| **37261** | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37263** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel |

| Code | Description |
|---|---|
| **37264** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37265** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel |
| **37266** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37267** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37268** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **37269** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| **37270** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37271** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37272** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37273** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |

| Code | Description |
|---|---|
| **37274** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37275** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37276** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37277** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| **37278** | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **37280** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel |
| **37281** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37282** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel |
| **37283** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37284** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37285** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **37286** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| **37287** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37288** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| **37289** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **37290** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| **37291** | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| 37292 | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel |
| 37293 | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |
| 37294 | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel |
| 37295 | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| 37296 | Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel |
| 37297 | Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **37298** | Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel |
| **37299** | Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) |
| **55707** | Biopsy, prostate, transrectal, ultrasound-guided (i.e., sextant, ultrasound-localized discrete lesion[s]) |
| **55708** | Biopsy, prostate, transrectal, ultrasound-guided (i.e., sextant) with MRI-fusion-guidance, first targeted lesion |
| **55709** | Biopsy, prostate, transperineal, ultrasound-guided (i.e., sextant, ultrasound-localized discrete lesion[s]) |
| **55710** | Biopsy, prostate, transperineal, ultrasound-guided (i.e., sextant) with MRI-fusion-guidance biopsy, first targeted lesion |
| **55711** | Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion |
| **55712** | Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion |
| **55713** | Biopsy, prostate, in-bore CT- or MRI-guided (i.e., sextant), with biopsy of additional targeted lesion(s), first targeted lesion |
| **55714** | Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion |
| **55715** | Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided targeted lesion (List separately in addition to code for primary procedure) |
| **55868** | Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with lymph node biopsy(ies) (limited pelvic lymphadenectomy) |
| **55869** | Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes |
| **77436** | Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting |
| **77437** | Surface radiation therapy; superficial, delivery, =150 kV, per fraction (e.g., electronic brachytherapy) |
| **77438** | Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction |

| Code | Description |
|---|---|
| **77439** | Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (List separately in addition to code for primary procedure) |
| **87182** | Susceptibility studies, antimicrobial agent; carbapenemase enzyme detection (e.g., Klebsiella pneumoniae carbapenemase [KPC], New Delhi metallo-beta-lactamase [NDM], Verona integron-encoded metallo-beta-lactamase [VIM]), multiplex immunoassay, qualitative, per isolate |
| **87183** | Susceptibility studies, antimicrobial agent; carbapenem resistance genes (e.g., blaKPC, blaNDM, blaVIM, blaOXA-48, blaIMP), amplified probe technique, per isolate |
| **87494** | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis and Neisseria gonorrhoeae, multiplex amplified probe technique |
| **87812** | Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B |
| **90481** | Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine; each additional component administered (List separately in addition to code for primary procedure) |
| **90482** | Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; 3 minutes up to 10 minutes |
| **90483** | Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; greater than 10 minutes up to 20 minutes |
| **90484** | Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; greater than 20 minutes |
| **91124** | Rectal sensation, tone, and compliance study (e.g., barostat) |
| **91125** | Anorectal manometry, with rectal sensation and rectal balloon expulsion test, when performed |
| **92628** | Evaluation for hearing aid candidacy, unilateral or bilateral, including review and integration of audiologic function tests, assessment, and interpretation of hearing needs (e.g., speech-in-noise, suprathreshold hearing measures), discussion of candidacy results, counseling on treatment options with report, and, when performed, assessment of cognitive and communication status; first 30 minutes |
| **92629** | Evaluation for hearing aid candidacy, unilateral or bilateral, including review and integration of audiologic function tests, assessment, and interpretation of hearing needs (e.g., speech-in-noise, suprathreshold hearing measures), discussion of candidacy results, counseling on treatment options with report, and, when performed, assessment of cognitive and communication status; each additional 15 minutes (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **92631** | Hearing aid selection services, unilateral or bilateral, including review of audiologic function tests and hearing aid candidacy evaluation, assessment of visual and dexterity limitations, and psychosocial factors, establishment of device type, output requirements, signal processing strategies and additional features, discussion of device recommendations with report; first 30 minutes |
| **92632** | Hearing aid selection services, unilateral or bilateral, including review of audiologic function tests and hearing aid candidacy evaluation, assessment of visual and dexterity limitations, and psychosocial factors, establishment of device type, output requirements, signal processing strategies and additional features, discussion of device recommendations with report; each additional 15 minutes (List separately in addition to code for primary procedure) |
| **92634** | Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; first 60 minutes |
| **92635** | Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; each additional 15 minutes (List separately in addition to code for primary procedure) |
| **92636** | Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (e.g., verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; first 30 minutes |
| **92637** | Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (e.g., verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; each additional 15 minutes (List separately in addition to code for primary procedure) |
| **92638** | Behavioral verification of amplification including aided thresholds, functional gain, speech-in-noise, when performed (List separately in addition to code for primary procedure) |
| **92639** | Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure) |
| **92641** | Hearing device verification, electroacoustic analysis |
| **92642** | Hearing assistive device, supplemental technology fitting services (e.g., personal frequency modulation [FM]/digital modulation [DM] system, remote microphone, alerting devices) |

| Code | Description |
|---|---|
| **92930** | Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch |
| **98979** | Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes |
| **98984** | Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period |
| **98985** | Remote therapeutic monitoring (e.g., therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period |
| **99445** | Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period |
| **99470** | Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes |
| **A4295** | Intermittent urinary catheter; straight tip, hydrophilic coating, each |
| **A4296** | Intermittent urinary catheter; coude (curved) tip, hydrophilic coating, each |
| **A4297** | Intermittent urinary catheter; hydrophilic coating, with insertion supplies |
| **C9176** | Tc-99m from domestically produced non-heu mo-99, [minimum 50 percent], full cost recovery add-on, per study dose |

| Code | Description |
|---|---|
| **G0568** | Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies (list separately in addition to the advanced primary care management code) |
| **G0569** | Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment (list separately in addition to advanced primary care management code) |
| **G0570** | Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team (list separately in addition to advanced primary care management code) |
| **G0571** | Intraoperative nerve(s) cryoablation for post-surgical pain relief (list separately in addition to code for primary service) |

**Effective January 1, 2026,** the following codes will be configured as *deny vendor liable* for all lines of business:

| Code | Description |
|---|---|
| **0600U** | Infectious disease (wound infection), identification of 65 organisms and 30 antibiotic resistance genes, wound swab, real-time PCR, reported as positive or negative for each organism |
| **0601U** | Infectious disease (periprosthetic joint infection), analysis of 11 biomarkers (alpha defensins 1â€"3, C-reactive protein, microbial antigens for Staphylococcus [SPA, SPB], Enterococcus, Candida, and C. acnes, total nucleated cell count, percent neutrophils, RBC count, and absorbance at 280 nm) using immunoassays, hematology, clinical chemistry, synovial fluid, and diagnostic algorithm reported as a probability score |
| **0602U** | Endocrinology (diabetes), insulin (INS) gene methylation using digital droplet PCR, insulin, and C-peptide immunoassay, serum, Hemoglobin A1c immunoassay, whole blood, algorithm reported as diabetes-risk score |
| **0603U** | Drug assay, presumptive, 77 drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS), results reported as positive or negative |
| **0604U** | Allergy and immunology (chronic recurrent angioedema), 4 bradykinin peptides, liquid chromatography and tandem mass spectrometry (LC-MS/ MS), whole blood, quantitative |
| **0605U** | Allergy and immunology (hereditary alpha tryptasemia), DNA, analysis of TPSAB1 gene copy number variation using digital PCR, whole blood, results reported with genotype-specific interpretation of alpha-tryptase copy number and algorithmic classification as normal or abnormal |
| **0606U** | Hematology (red cell membrane disorders), RBCs, osmotic gradient ektacytometry, whole blood, quantitative |
| **0607U** | Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations |
| **0608U** | Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations |
| **0609U** | Oncology (prostate), immunoassay for total prostate-specific antigen (PSA) and free PSA, serum or plasma, combined with clinical features, algorithm reported as a probability score for clinically significant prostate cancer |
| **0610U** | Infectious disease (antimicrobial susceptibility), phenotypic antimicrobial susceptibility testing of positive blood culture using microfluidic sensor technology to quantify bacterial growth response to multiple antibiotic types, reporting categorical susceptibility (susceptible, susceptible dose dependent, intermediate, resistant), minimum inhibitory concentration, and interpretive comments |
| **0611U** | Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result |

| Code | Description |
|---|---|
| **0612U** | Oncology (liver), analysis of over 1,000 methylated regions, cell-free DNA from plasma, algorithm reported as a quantitative result |
| **0613U** | Oncology (urothelial carcinoma), DNA methylation and mutation analysis of 6 biomarkers (TWIST1, OTX1, ONECUT2, FGFR3, HRAS, TERT promoter region), methylation-specific PCR and targeted next-generation sequencing, urine, algorithm reported as a probability index for bladder cancer and upper tract urothelial carcinoma |
| **64567** | Percutaneous electrical nerve field stimulation, cranial nerves, without implantation |
| **81354** | Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of structural and copy number variants, optical genome mapping (OGM) |
| **92288** | Screening dark adaptation measurement (e.g., rod recovery intercept time), with interpretation and report |
| **97007** | Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education |
| **97008** | Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period |
| **97009** | Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure) |
| **G0660** | Team remote e/m new pt 10mins |
| **G0661** | Team remote e/m new pt 20mins |
| **G0662** | Team remote e/m new pt 30 mins |
| **G0663** | Team remote e/m new pt 45mins |
| **G0664** | Team remote e/m new pt 60mins |
| **G0665** | Team remote e/m est. pt 10mins |
| **G0666** | Team remote e/m est. pt 15mins |
| **G0667** | Team remote e/m est. pt 25mins |
| **G0668** | Team remote e/m est. pt 40mins |
| **G9871** | Behavioral counseling for diabetes prevention, online, 60 minutes |
| **M1426** | Encounters conducted via telehealth |
| **M1427** | Documentation of medical reason(s) for performing a bone scan (including documented pain related to prostate cancer, salvage therapy, other medical reasons) |
| **M1428** | Patients who have bilateral absence of eyes any time during the patient's history through the end of the measurement period |
| **M1429** | Retinal exam finding with evidence of retinopathy in left, right or both eyes with severity level documented |
| **M1430** | Retinal exam finding without evidence of retinopathy in both eyes with severity level documented (in measurement year or in the prior year) |
| **M1431** | Encounters conducted via telehealth |
| **M1432** | Encounters conducted via telehealth |
| **M1433** | Patient on oral chemotherapy on or within 30 days before denominator eligible encounter |

| Code | Description |
|---|---|
| **M1434** | Patient on oral chemotherapy on or within 30 days after denominator eligible encounter |
| **M1435** | Patient on oral chemotherapy during the performance period |
| **M1436** | Encounters conducted via telehealth |
| **M1437** | Encounters conducted via telehealth |
| **M1438** | Time last known well to hospital arrival less than or equal to 3.5 hours (<= 210 minutes) |
| **M1439** | Significant ocular conditions that impact the visual outcome of surgery |
| **M1440** | Encounters conducted via telehealth |
| **M1441** | Encounter corresponds to initial diagnosis of sleep apnea or first contact with sleep apnea diagnosed patient |
| **M1442** | Encounters conducted via telehealth |
| **M1443** | Encounters conducted via telehealth |
| **M1444** | Delivery at < 39 weeks of gestation |
| **M1445** | Postpartum care visit before or at 12 weeks of giving birth |
| **M1446** | Patients who died any time prior to the end of the measure assessment period |
| **M1447** | Patients with an active diagnosis of bipolar disorder any time prior to the end of the measure assessment period |
| **M1448** | Patients with an active diagnosis of personality disorder any time prior to the end of the measure assessment period |
| **M1449** | Patients with an active diagnosis of schizophrenia or psychotic disorder any time prior to the end of the measure assessment period |
| **M1450** | Patients who received hospice or palliative care service any time during denominator identification period or the measure assessment period |
| **M1451** | Patients with an active diagnosis of pervasive developmental disorder any time prior to the end of the measure assessment period |
| **M1452** | Patient ever had a diagnosis of dementia |
| **M1453** | Patients with a pre-operative visual acuity better than 20/40 |
| **M1454** | New cied |
| **M1455** | Replaced or revised cied |
| **M1456** | Patient had a heart transplant |
| **M1457** | Patient had a diagnosis of asthma with any contact during the current or prior performance period or had asthma present on an active problem list any time during the performance period |
| **M1458** | Patient died prior to the end of the performance period |
| **M1459** | Patient was in hospice or receiving palliative care services at any time during the performance period |
| **M1460** | Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure |
| **M1461** | Patient diagnosis for chronic hepatitis c |
| **M1462** | Patients with clinical indications for imaging of the head |
| **M1463** | Documentation of at least two attempts to follow up with patient within 180 days of treatment |
| **M1464** | No documentation of at least two attempts to follow up with patient within 180 days of treatment |

| Code | Description |
|---|---|
| **M1465** | Patient follow up more than 180 days after treatment |
| **M1466** | Patient had a lumbar fusion on the same date as the discectomy/laminectomy procedure |
| **M1467** | Patients with an existing diagnosis of lynch syndrome |
| **M1468** | Patient received recommended doses of hepatitis b vaccination based on age |
| **M1469** | Patient has a history of hepatitis b illness or received a hepatitis b surface antigen, hepatitis b surface antibody, or total antibody to hepatitis b core antigen test with a positive result any time before or during the measurement period |
| **M1470** | Documentation of medical reason(s) for not administering hepatitis b vaccine (e.g., prior anaphylaxis due to the hepatitis b vaccine) |
| **M1471** | Documentation that patient is a Medicare fee-for-service beneficiary and without additional supplementary insurance coverage for whom hep b vaccination is not reimbursable under current Medicare part b coverage rules |
| **M1472** | Patient did not receive recommended doses of hepatitis b vaccination based on age |
| **M1473** | Patient situations, at any point during the denominator identification period, where the patient's functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools, such as delirium, dementia, intellectual disabilities, and pervasive and specific development disorders |
| **M1474** | Patients with diagnosis of dementia |
| **M1475** | Patients with diagnosis of Huntington's disease |
| **M1476** | Patients with diagnosis of cognitive impairment or Alzheimer's disease |
| **M1477** | Diagnosis of delirium |
| **M1478** | Psychoactive substance abuse |
| **M1479** | Patients whose functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools such as delirium, dementia, intellectual disabilities, and pervasive and specific development disorders |
| **M1480** | Patients whose functional capacity or motivation (or lack thereof) to improve may impact the accuracy of results of validated tools such as delirium, dementia, intellectual disabilities, and pervasive and specific development disorders |
| **M1481** | Patients receiving hospice or palliative care or who died during the measurement period |
| **M1482** | Positive/detectable hepatitis c virus quantitative or qualitative rna test result during the denominator identification period |
| **M1483** | Patients who achieve sustained virological response as identified by an hcv rna test (cpt 87522) or (cpt 87521) with a negative/undetectable hcv rna result that occurred 20 weeks to 12 months after the first positive/detectable hcv rna test result within the denominator identification period |
| **M1484** | Patients who did not have a repeat hcv rna labs performed for medical reasons documented by clinician (e.g., patient with limited life expectancy, delay in treatment of hcv related to treatment of hiv, hbv, hepatocellular carcinoma, decompensated cirrhosis) |

| Code | Description |
|---|---|
| **M1485** | Patients who did not achieve sustained virological response as identified by an hcv rna test (cpt 87522) or (cpt 87521) with a negative/undetectable hcv rna result that occurred 20 weeks to 12 months after the first positive/detectable hcv rna test result within the denominator identification period |
| **M1486** | Patients admitted to a skilled nursing facility (snf) during the period of evaluation |
| **M1487** | Patients in hospice in the year before or during the period of evaluation |
| **M1488** | Patients with a diagnosis for dementia in the year before or during the period of evaluation |
| **M1489** | Patient status documented |
| **M1490** | Patient status not documented |
| **M1491** | Receiving esrd mcp dialysis services by the provider during the performance period |
| **M1492** | Patients who did not report a fall |
| **M1493** | Documentation of falls not performed due to medical reasons (e.g., syncope, vertigo and related disorders, restless leg syndrome, tourette syndrome/tic disorder, back pain, concussion/mild traumatic brain injury (mtbi), cervical dystonia, or epilepsy) |
| **M1494** | Patients that reported a fall since the last visit |
| **M1495** | Patients that reported a fall occurred who had a plan of care for falls documented or patients that did not report a fall |
| **M1496** | Patients that had a fall who did not have a plan of care for falls documented or do not have documentation of being assessed for falls |
| **M1497** | Documentation of falls not performed due to medical reasons (e.g., syncope, vertigo and related disorders, restless leg syndrome, tourette syndrome/tic disorder, back pain, concussion/mild traumatic brain injury (mtbi), cervical dystonia, or epilepsy) |
| **M1498** | Diagnostic radiology mips value pathway |
| **M1499** | Interventional radiology mips value pathway |
| **M1500** | Neuropsychology mips value pathway |
| **M1501** | Pathology mips value pathway |
| **M1502** | Podiatry mips value pathway |
| **M1503** | Vascular surgery mips value pathway |

**Effective January 1, 2026,** the following codes will be configured as *experimental and investigational without prior authorization* for all lines of business, except MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative), which will be *deny vendor liable*:

| Code | Description |
|---|---|
| **0988T** | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous and subfascial |
| **0989T** | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous and subfascial |
| **0990T** | Transcervical instillation of biodegradable hydrogel materials, intrauterine |
| **0991T** | Cystourethroscopy, with low-energy lithotripsy and acoustically actuated microspheres, including imaging |
| **0992T** | Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat without concurrent computed tomography (CT) scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional |
| **0993T** | Noninvasive assessment of cardiac risk derived from augmentative software analysis of perivascular fat with concurrent computed tomography scan of the heart, including patient-specific clinical factors, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure) |
| **0994T** | Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; percutaneous |
| **0995T** | Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic roadmapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; open |
| **0996T** | Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed |
| **0997T** | Precuneus magnetic stimulation; treatment planning using magnetic resonance imaging-guided neuronavigation to determine optimal location, dose, and intensity for magnetic stimulation therapy, derived from evoked potentials from single pulses of electromagnetic energy recorded by 64-channel electroencephalogram, including automated data processing, transmission, analysis, generation of treatment parameters with review, interpretation, and report |

| Code | Description |
|---|---|
| **0998T** | Precuneus magnetic stimulation; personalized treatment delivery of magnetic stimulation therapy to a prespecified target area derived from analysis of evoked potentials within the precuneus, utilizing magnetic resonance imaging-based neuronavigation, with management, per day |
| **0999T** | Autologous muscle cell therapy, harvesting of muscle progenitor cells, including ultrasound guidance, when performed |
| **1000T** | Autologous muscle cell therapy, administration of muscle progenitor cells into the urethral sphincter, including cystoscopy and post-void residual ultrasound, when performed |
| **1001T** | Autologous muscle cell therapy, injection of muscle progenitor cells into the external anal sphincter, including ultrasound guidance, when performed |
| **1002T** | Air displacement plethysmography, whole-body composition assessment, with interpretation and report |
| **1003T** | Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (e.g., first carpometacarpal total joint) |
| **1004T** | Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (e.g., contact group[s], gain, bandpass filters) by physician or other qualified health care professional; without programming |
| **1005T** | Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (e.g., contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, first 15 minutes face-to-face time with physician or other qualified health care professional |
| **1006T** | Electronic analysis of implanted sub-scalp continuous bilateral electroencephalography monitoring system (e.g., contact group[s], gain, bandpass filters) by physician or other qualified health care professional; with programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure) |
| **1007T** | Electroencephalogram from implanted sub-scalp continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording without video |
| **1008T** | Remote monitoring of sub-scalp implanted continuous bilateral electroencephalography monitoring system, device fitting, initial set-up, and patient education in wearing of system and use of equipment |
| **1009T** | Remote monitoring of a sub-scalp implanted continuous bilateral electroencephalography monitoring system, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, up to 30 days of recording without video |

| Code | Description |
|---|---|
| **1010T** | Computerized ophthalmic analysis of monocular eye movements using retinal-based eye-tracking without spatial calibration, including fixation, microsaccades, drift, and horizontal saccades, when performed, unilateral or bilateral, with interpretation and report |
| **1011T** | Photobiomodulation (PBM) therapy of oral cavity, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device |
| **1012T** | Motorized ab interno trephination of sclera (sclerostomy), or trabecular meshwork (trabeculostomy), 1 or more, including injection of antifibrotic agents, when performed |
| **1013T** | Laparoscopy, surgical, implantation or replacement of lower esophageal sphincter neurostimulator electrode array and neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver, including cruroplasty and/or electronic analysis, when performed |
| **1014T** | Laparoscopic revision or removal, lower esophageal sphincter neurostimulator electrodes |
| **1015T** | Revision or removal, lower esophageal sphincter neurostimulator pulse generator or receiver |
| **1016T** | Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; intraoperative, with programming |
| **1017T** | Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, without reprogramming |
| **1018T** | Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of waveform, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements), lower esophageal sphincter neurostimulator pulse generator/transmitter; subsequent, with reprogramming |
| **1019T** | Lymphovenous bypass, including robotic assistance, when performed, per extremity |
| **1020T** | Raman spectroscopy of 1 or more skin lesions, with probability score for malignant risk derived by algorithmic analysis of data from each lesion |
| **1021T** | Active thoracic irrigation (separate procedure) |
| **1022T** | Percutaneous tissue displacement, any method, including imaging guidance; intra-abdominal/pelvic structures (List separately in addition to code for primary procedure) |

| Code | Description |
|---|---|
| **1023T** | Percutaneous tissue displacement, any method, including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure) |
| **1024T** | Percutaneous tissue displacement, any method, including imaging guidance; soft tissue (List separately in addition to code for primary procedure) |
| **1025T** | Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification |

**Effective January 1, 2026,** the following codes will be configured as *experimental and investigational without prior authorization* for all lines of business:

| Code | Description |
|---|---|
| **43889** | Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed |
| **47384** | Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous |
| **52443** | Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy, when performed |
| **55877** | Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous |
| **64654** | Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (i.e., total system), and intraoperative interrogation and programming |
| **64655** | Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only |
| **64656** | Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only |
| **64657** | Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator |
| **64658** | Removal of baroreflex activation therapy (BAT) modulation system; lead only |
| **64659** | Removal of baroreflex activation therapy (BAT) modulation system; pulse generator only |
| **64728** | Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance |

| Code | Description |
|---|---|
| **93145** | Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); without programming |
| **93146** | Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming, including optimization of tolerated therapeutic level setting |
| **C7566** | Arthrodesis, interphalangeal joints, with or without internal fixation, with autografts (includes obtaining grafts) |
| **C7567** | Bronchoscopy, rigid or flexible, including fluoroscopic guidance when performed, **with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)**, with computer-assisted image-guided navigation |
| **C7568** | Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, **with intravascular doppler velocity and/or pressure** derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress |
| **C7569** | Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report |
| **C7570** | Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation 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 (list separately in addition to code for primary procedure) |
| **C7571** | Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with percutaneous transluminal coronary lithotripsy |

**Effective January 1, 2026,** the following codes will be configured as *experimental and investigational with prior authorization* for all lines of business, except MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative), which will be *deny vendor liable*:

| Code | Description |
|---|---|
| **37262** | Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure) |
| **37279** | Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure) |

**Effective January 1, 2026,** the following DENTAL codes will be configured as *NOT covered* for all lines of business, and *NOT payable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative):

| Code | Description |
|---|---|
| **D0426** | collection, preparation, and analysis of saliva sample-point-of-care |
| **D0461** | testing for cracked tooth |
| **D1720** | influenza vaccine administration |
| **D5909** | maxillary guidance prosthesis with guide flange |
| **D5930** | maxillary guidance prosthesis without guide flange |
| **D5938** | resection prosthesis, maxillary complete removable |
| **D5939** | resection prosthesis, mandibular complete removable |
| **D5940** | resection prosthesis, maxillary partial removable |
| **D5941** | resection prosthesis, mandibular partial removable |
| **D5942** | resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch |
| **D5943** | resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch |
| **D5944** | resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch |
| **D5945** | resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch |
| **D5946** | resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch |

| Code | Description |
|---|---|
| **D5947** | resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch |
| **D5948** | resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch |
| **D5949** | resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch |
| **D6196** | removal of an indirect restoration on an implant retained abutment |
| **D9128** | photobiomodulation therapy - first 15 minute increment, or any portion thereof |
| **D9129** | photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof |
| **D9936** | cleaning and inspection of occlusal guard - per appliance |

**Effective January 1, 2026,** the following DENTAL code will be configured as *NOT covered* for Fallon Medicare Plus and Community Care, and *covered without prior authorization* for NaviCare and PACE, It will be configured as *NOT payable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative):

| Code | Description |
|---|---|
| **D6049** | scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure |

**Effective January 1, 2026,** the following DENTAL code will be configured as *NOT covered* for Fallon Medicare Plus and Community Care, and *covered with prior authorization* for NaviCare and PACE, It will be configured as *NOT payable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative):

| Code | Description |
|---|---|
| **D6280** | implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments-per arch |

**Effective January 1, 2026,** the following DENTAL codes will be configured as *covered without prior authorization* for all lines of business, and *NOT payable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative):

| Code | Description |
|---|---|
| **D5877** | duplication of complete denture - maxillary |
| **D5878** | duplication of complete denture - mandibular |

**Effective January 1, 2026,** the following DENTAL codes will be configured as *covered with prior authorization* for all lines of business, and *NOT payable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative):

| Code | Description |
|---|---|
| **D9224** | administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof |
| **D9225** | administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof |
| **D9244** | in-office administration of minimal sedation - single drug-enteral |
| **D9245** | administration of moderate sedation - enteral |
| **D9246** | administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof |
| **D9247** | administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof ■ |

# Payment policies

## Revised policies – Effective March 1, 2026

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

- **Non-Covered Services** – Updated code report (generated January 2, 2026).
- **Newborn Services** – Under reimbursement, updated section for Donor human milk and donor human milk-derived products to include for MassHealth ACO members effective October 15, 2025, in accordance with MassHealth Acute Inpatient Hospital Bulletin 205.
- **Inpatient Medical Review and Payment Policy** – Under policy, clarified the process for review of continuation of inpatient level of care (concurrent services) effective January 1, 2026; under Reimbursement, clarified the readmission review process effective January 1, 2026; added new section for Donor human milk and donor human milk-derived products for Community Care and MassHealth ACO members; under Billing/coding guidelines, removed section on Pharmaceutical waste, clarified DRG Coding and Clinical Validation section.
- **Adult Foster Care** – Under policy, added new section for Scope of Adult Foster Care (AFC) Services and Adult Foster Care Bulletin 34 which updates guidance for AFC providers related to admission and monthly visit requirements; added new definitions to the Definitions section; under Reimbursement, added new sections for Intake and Assessment Services and AFC Level I and Level II Services, clarified reimbursement for Medical Leave of Absence and Nonmedical Leave of Absence, and Alternative Caregiver Days; under Billing/coding guidelines, added new section for Telehealth Services pursuant to MassHealth Adult Foster Care Bulletin 34 (August 2025).
- **Serious Reportable Events and Provider Preventable Conditions** – Under policy, added new language stating that all providers delivering covered services to MassHealth ACO members are required to comply with all instructions set forth in All Provider Manuals Appendix V: MassHealth Billing Instructions for Provider Preventable Conditions, in accordance with ACPP Contract for RY 2026.
- **Claims Editing Software** – Under reimbursement, added new sections for Add-on code without base code, Medicare Advantage NCD and LCD claim edits, missing Modifier 26, and Modifier 78 without global procedure.
- **Preventive Services** – Under reimbursement, updated Breast Cancer Screening in accordance with Chapter 231 of the Acts or 2024, updated Fluoride Varnish Services for MassHealth ACO members in accordance with MassHealth Transmittal Letter ALL-252, updated Hepatitis C screening for Medicare members in accordance with Transmittal R13423CP, updated Colorectal Cancer Screening for Medicare members in accordance with Transmittal R13295CP, added new section for MassHealth Perinatal Depression Screening in accordance with MassHealth All Provider Bulletin 405.
- **Nurse Practitioner/Advanced Practice Registered Nurse** – Under definitions, added table clarifying when a Plan-Participating Collaborative Agreement is required.
- **Vision Services** – Under reimbursement, updated the amount the plan covers annually for contact lenses and eyeglasses for NaviCare members, added new section for Computerized Corneal Topography (CPT 92025).

- **Physical and Occupational Therapy Services** – Under policy, removed uUpdates related to coronavirus disease 2019 (COVID-19) for MassHealth ACO, NaviCare, and Summit ElderCare plan members, as no longer applicable and added new sections for Flexibilities After the End of the COVID-19 FPHE for MassHealth ACO members, and (2) CMS flexibilities for Medicare Advantage, NaviCare and PACE plan members; under Reimbursement, added new section for Multiple Procedure Payment Reductions for Outpatient Therapy Services; under Billing/coding guidelines, updated Therapy Modifiers section to include notification that effective for dates of service on or after April 1, 2026, the plan has implemented edits that will deny professional claims for services when they do not contain the appropriate therapy modifier (GP, GO, GN), regardless of the provider who furnishes them; under Billing/coding guidelines, added new section for Reporting of Service Units With HCPCS to include notification that, effective for dates of service on or after April 1, 2026, the plan has implemented edits, that will deny claims for "untimed" service codes billed with units exceeding the allowed units.
- **Speech Therapy Services** – Under reimbursement, added new section for Multiple Procedure Payment Reduction for Outpatient Therapy Services; under Billing/coding guidelines, updated Therapy Modifiers section and added new section for Reporting of Service Units with HCPCS.
- **Community Health Centers** – Under reimbursement, added new section for Breast Cancer Screening pursuant to Chapter 231 of the Acts or 2024, updated Fluoride Varnish Services for MassHealth ACO members in accordance with MassHealth Transmittal Letter ALL-252, added new section for Perinatal Depression Screening in accordance with MassHealth All Provider Bulletin 405, added new section for Definitive Drug Testing Billed on the Same Date of Service as Presumptive Drug Testing, added new section for Annual Behavioral Health Wellness Examinations, added new Section Update to T1015 – TH Modifier Use.
- **Drugs and Biologicals** – Under reimbursement, Part B/Medical Benefit Drugs Reimbursed under Medicare Payment Methodologies, clarified the use of the JW and JZ modifiers.

## New policies – Effective March 1, 2026

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

- **Annual Behavioral Health Wellness Examinations** – Policy origination
- **Co-Surgeon and Team Surgeon** – Policy origination ■

# Medical policies

## Revised policies – Effective November 1, 2025

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

- **Capsule Endoscopy**
- **Hypoglossal Nerve Stimulation**
- **Implantable Cardioverter Defibrillators**
- **Percutaneous Tibial Nerve Stimulation**
- **Trigger Point Injections**
- **Peripheral Nerve Stimulation**

## Revised policies – Effective December 1, 2025

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

- **Kymriah® (tisagenlecleucel)**
- **Long-Term Acute Care (LTAC)**
- **Sacral Nerve Stimulation for Urinary Incontinence**
- **Speech-Language Therapy Services**
- **Spine Surgery**

## Revised policies – Effective January 1, 2026

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

- **Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Technology**
- **External Breast Prostheses and Related Supplies (formerly Post-Mastectomy Surgery and Services)**
- **Lower Limb Prostheses**
- **Oral Appliances for Obstructive Sleep Apnea**
- **Skin Substitutes**
- **Surgery for Obstructive Sleep Apnea**
- **Transcutaneous Electrical Nerve Stimulation for Chronic Low Back Pain (formerly Transcutaneous Electrical Nerve Stimulation)**
- **Transurethral Waterjet Ablation of the Prostate** ■

# Our products*

## Medicare Advantage

**Fallon Medicare Plus HMO** – for Medicare beneficiaries across the state—from Boston to the Berkshires**.

4 plans to choose from:

- FMP Orange, Green, and Blue HMO plans
- FMP Saver No Rx HMO

***Service area includes all of Massachusetts except Dukes and Nantucket counties.*

**Fallon Medicare Plus Premier HMO** – for Medicare beneficiaries who receive coverage through an employer group or union.

- Service area includes Massachusetts as well as some cities and towns outside of the state.

## Medicare Supplement

**Fallon Medicare Plus Supplement** – for individual consumers who are Medicare-eligible. Can see any provider they choose who accepts Medicare. Three plans to choose from:

- FMP Supplement Core, FMP Supplement 1A, and FMP Supplement 1

## Individual and small group

**Community Care** – for the subsidized and unsubsidized individual and small group markets. Available on the Massachusetts Health Connector.

- Service area includes Berkshire, Bristol, Hampden, Middlesex, Plymouth, Suffolk, and Worcester counties, and part of Norfolk County.

## MassHealth ACO

**Berkshire Fallon Health Collaborative** – for MassHealth-eligible individuals who live in the Berkshire County service area.

- Partnership between Fallon Health and Partnership for Health in the Berkshires PHO, which includes Berkshire Health Systems, Inc., Community Health Programs, Inc., and the majority of Berkshire County community physician practices.

**Fallon 365 Care** – for MassHealth-eligible individuals who live in the service area that includes cities and towns in Worcester, Middlesex, Hampden, and Norfolk counties.

- Partnership between Reliant Medical Group, plus a small affiliate network of providers.

**Fallon Health-Atrius Health Care Collaborative** – for MassHealth-eligible individuals who live in the service area that includes cities and towns in Worcester, Middlesex, Essex, Suffolk, Norfolk, and Plymouth counties.

- Provider network consists of all Atrius Health, in addition to a small affiliate network of providers.

# Our products* *(continued)*

## PACE program

**Summit ElderCare** – Fallon Health's PACE (Program of All-Inclusive Care for the Elderly) provides medical care, social supports, adult day health, in-home services, transportation, and health insurance in one program—for people age 55 and older, who qualify for a nursing home level of care.

- Allows participants to stay in their homes and have social ties to their communities.
- Participants must live in the Summit ElderCare service area, available at fallonhealth.org/summit.

## Special Needs Plan

**NaviCare HMO SNP** – Fallon Health's Medicare Advantage Special Needs Plan (SNP) for people who have MassHealth Standard and Medicare Parts A and B.

Combines MassHealth (Medicaid) and Medicare benefits, including Medicare Part D prescription drug coverage. NaviCare members can't be enrolled in another health insurance plan, except Medicare and MassHealth. ■

**These are the products Fallon Health currently offers and they are not necessarily indicative of what you are contracted for with Fallon Health. Products may change for 2026. If you have questions regarding products you are contracted for, please contact your Provider Relations Representative.*

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

## Send information to:

Provider Relations
Fallon Health
1 Mercantile St., Ste. 400
Worcester, MA 01608

or

Email your Provider Relations Representative

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Manny Lopes
*President and CEO*

Lora Council, MD, MPH, MHCMI
*Senior Vice President and Chief Medical Officer*

Sean Murphy
*Chief Network Strategist*

Susan Keser
*Vice President, Network Development and Management*

***fallonhealth.org/providers***

## Questions?

**1-866-275-3247**

25-665-028 Rev. 00 12/25

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