Connection

July 2026

Important information for Fallon Health physicians and providers

In the July issue:

What's new

From fire drills to flow: A better approach to clinical data sharing

Fallon Health is introducing Clinical Connect, a new way to obtain clinical data from providers in a timelier and more predictable way. Clinical Connect is designed to reduce administrative burden while supporting quality and clinical documentation accuracy across our shared member population.

Powered by 1upHealth, Clinical Connect securely connects to your EHR and provides Fallon Health with read-only access to existing clinical data. This connection virtually eliminates the need for manual medical record requests from Fallon Health, reducing administrative burden without requiring new reporting.

Over time, the goal is fewer one-off medical record requests, fewer last-minute chart retrieval fire drills, and less disruption for clinical and administrative teams. Participation in Clinical Connect is provided at no cost to providers and includes implementation and ongoing support.

Providers who are curious about Clinical Connect or would like to learn more can reach out to their Provider Relations representative or contract manager to start an informal conversation about what this could look like for their organization. ■

New enhancement to ProAuth: Optional use of InterQual® level of care criteria

We are excited to share a new enhancement to ProAuth that is designed to further support providers and streamline the authorization process. ProAuth now includes the InterQual® Level of Care criteria currently used by Fallon Health.

This enhancement gives providers the option to apply InterQual criteria directly within ProAuth, helping create a more efficient, consistent, and transparent authorization experience.

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Why consider using InterQual in ProAuth?
While use of InterQual criteria within ProAuth will be optional, providers may benefit from adopting this functionality for several reasons:

- **Improved authorization efficiency**
  Aligning requests with InterQual Level of Care criteria can reduce back-and-forth communication and support faster authorization decisions.
- **Greater clarity and consistency**
  InterQual provides nationally recognized, evidence-based criteria that clearly outline clinical requirements, helping ensure requests are submitted with the appropriate level of supporting documentation.
- **Reduced administrative burden**
  Built-in criteria guidance can help minimize rework, follow-up requests, and delays related to incomplete or misaligned submissions.
- **Enhanced user experience**
  Integrating InterQual directly into ProAuth allows providers to reference criteria at the point of submission, making the process more intuitive and user-friendly.

Key details

- Use of InterQual Level of Care criteria within ProAuth is optional.
- This enhancement is designed to support more efficient and informed authorization submissions.

If you have questions or would like additional information, please contact your Provider Relations representative. ■

Important updates

Medicare GLP-1 bridge: What providers should know

The Centers for Medicare & Medicaid Services (CMS) is expanding access to certain GLP-1 medications for people with Medicare Part D through the Medicare GLP-1 Bridge short-term demonstration starting July 1, 2026 through December 31, 2027.

The Medicare GLP-1 Bridge will operate outside of Medicare Part D plan coverage and use a central processor to manage prior authorization, claims processing, and pharmacy payment. The Medicare GLP-1 Bridge is for patients who are not eligible to receive a GLP-1 drug through their Part D plan and do not have type 2 diabetes, moderate-to-severe sleep apnea, or fatty liver disease. Providers should be aware that:

- The GLP-1 Bridge operates separately from Part D
- Prior authorization will be required through the CMS-designated process

For more information visit: Medicare GLP-1 Bridge | CMS.

Fallon MassHealth ACO July 2026 drug list summary update

MassHealth evaluates the prior authorization (PA) status for drugs on an ongoing basis and updates the MassHealth Drug List accordingly. This summary update document identifies changes to the MassHealth Drug List for the rollout, effective July 1, 2026.

Additional information about these agents may be available within the MassHealth Drug List at mass.gov/druglist.

Additions

a. Effective July 1, 2026, the following newly marketed drugs have been added to the MassHealth Drug List:
   - buspirone capsule – **PA; A90**
   - Enbumyst (bumetanide nasal spray) – **PA**
   - escitalopram capsule – **PA**
   - Exdensur (depemokimab-ulaa) – **PA; MB**
   - Exxua (gepirone) – **PA**
   - Forzinity (elamipretide) – **PA**
   - Hyrnuo (sevabertinib) – **PA**
   - Inluriyo (imlunestrant) – **PA**
   - Javadin (clonidine oral solution) – **PA**
   - Komzifti (ziftomenib) – **PA**
   - Lasix Onyu (furosemide on-body infusor) – **PA**
   - Lopressor (metoprolol immediate-release 12.5 mg tablet) – **PA**
   - Lopressor (metoprolol immediate-release oral solution) – **PA**
   - Pokonza (potassium chloride oral solution) – **PA**
   - potassium chloride 40 mEq powder packet – **PA; A90**
   - Rybrevant Faspro (amivantamab/hyaluronidase-lpuj) – **PA; MB**
   - Unloxcyt (cosibelimab-ipdl) – **PA; MB**
   - Veltassa (patiromer 1 g packet) – **PA ≥ 18 years and PA > 4 unit/day**
   - Voyxact (sibeprenlimab-szsi) – **PA**

Change in prior authorization status

a. Effective July 1, 2026, the following antitubercular agent will require PA.
   - cycloserine – **PA; A90**

b. Effective July 1, 2026, the following hematinic agent will require PA.
   - Velphoro (sucroferric oxyhydroxide) – **PA**

c. Effective July 1, 2026, the following hormone agent will require PA.

- desmopressin acetate 1.5 mg/mL nasal spray – **PA**

d. Effective July 1, 2026, the following hereditary cardiovascular agent will no longer require PA within newly established quantity limits.
- Entresto (sacubitril/valsartan tablet) – **PA > 2 units/day**

e. Effective July 1, 2026, the following cardiovascular agent will no longer require PA.
- clonidine patch; **A90**

f. Effective July 1, 2026, the following cardiovascular agent will no longer require PA within updated age limits.
- Inzirqo (hydrochlorothiazide suspension) – **PA ≥ 13 years**

g. Effective July 1, 2026, the following cardiovascular agents will require PA.
- Exforge HCT (amlodipine/valsartan/hydrochlorothiazide) – **PA; M90**
- Inspra (eplerenone) – **PA; M90**
- quinidine sulfate – **PA; M90**

h. Effective July 1, 2026, the following insulin agent will no longer require PA.
- Humulin N (insulin NPH)

i. Effective July 1, 2026, the following insulin agent will require PA.
- Novolin N (insulin NPH) – **PA**

New or revised therapeutic tables

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Updated MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred Over Generic Drug List has been updated to reflect recent changes to the MassHealth Drug List.

a. Effective July 1, 2026, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List.
   - Belbuca (buprenorphine buccal film) – **PA; BP**
   - Endometrin (progesterone vaginal insert) – **PA; BP**
   - Humulin N (insulin NPH); **BP**
   - Incruse (umeclidinium); **BP, A90**
   - Lumigan (bimatoprost 0.01% ophthalmic solution); **BP, M90**
   - Qvar Redihaler (beclomethasone inhaler) – **PA; BP**
b. Effective July 1, 2026, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List.
   - Fabior (tazarotene foam) – **PA**

Updated MassHealth 90-day initiative

The MassHealth 90-day Initiative has been updated to reflect recent changes to the MassHealth Drug List.

a. Effective July 1, 2026, the following agents may be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below:
   - Incruse (umeclidinium); **BP, A90**
   - Lumigan (bimatoprost 0.01% ophthalmic solution); **BP, M90**
b. Effective July 1, 2026, the following agents will no longer be allowed or mandated to be dispensed in up to a 90-day supply, as indicated below:
   - Revlimid (lenalidomide) – **PA; BP**
   - Samsca (tolvaptan) – **PA**

Updated MassHealth Over-the-Counter Drug List

The MassHealth Over-the-Counter Drug List has been updated to reflect recent changes to the MassHealth Drug List.

Effective July 1, 2026, the following agents were removed from the MassHealth Over-the-Counter Drug List.

- cherry syrup*
- gelatin capsule, empty*
- hydrophilic ointment*, A90
- Ora-Plus suspending vehicle*
- Ora-Sweet oral syrup*
- Ora-Sweet-SF oral syrup*
- simple syrup*

Updated MassHealth Supplemental Rebate/Preferred Drug List

The MassHealth Supplemental Rebate/Preferred Drug List has been updated to reflect recent changes to the MassHealth Drug List.

a. Effective July 1, 2026, the following biological agents will be added to the MassHealth Supplemental Rebate/Preferred Drug List:
   - Fasenra (benralizumab) [PD] – **PA**
   - Nemluvio (nemolizumab-ilto) [PD] – **PA**

b. Effective July 1, 2026, the following topical immunosuppressant agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List:
   - Vtama (tapinaro) [PD] – **PA**

Deletions

a. The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer:
   a. Androgel (testosterone 1.62% gel packet) – **PA**
   b. Androgel (testosterone 1% gel packet) – **PA**
   c. Beqvez (fidanacogene elaparvovec-dzkt) – **PA; CO**
   d. Cymbalta (duloxetine 20 mg, 30 mg, 60 mg capsule) – **PA < 6 years; #, A90**
   e. Exservan (riluzole film) – **PA**
   f. Namenda (memantine titration pack) – **PA < 6 years and PA > 49 units/28 days; A90**
   g. Namenda XR (memantine extended-release) – **PA < 6 years and PA > 1 unit/day; #, A90**
   h. Prozac (fluoxetine 10 mg, 20 mg, 40 mg capsule, solution) – **PA < 6 years; #, A90**
   i. Qtern (dapagliflozin/saxagliptin) – **PA**
   j. Rilutek (riluzole tablet); **#, A90**
   k. Roctavian (valoctocogene roxaparvovec-rvox) – **PA; CO**
   l. Trecator (ethionamide)

b. MassHealth does not pay for drugs that are manufactured by companies that have not signed rebate agreements with the U.S. Secretary of Health and Human Services. The following drugs have been removed from the MassHealth Drug List:
   - Qlosi (pilocarpine 0.4% ophthalmic solution) – **PA**
   - Vizz (aceclidine ophthalmic solution) – **PA**

Abbreviations, acronyms, and symbols

This designates a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.

MB This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting.

***** The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without PA.

PA Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the provider to receive reimbursement. Note: PA applies to both the brand-name and the FDA "A"-rated generic equivalent of listed product.

A90 Allowable 90-day supply. Dispensing up to a 90-day supply is allowed. May not include all strengths or formulations. Quantity limits and other restrictions may apply.

BP Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

M90 Mandatory 90-day supply. After dispensing up to a 30-day supply initial fill, dispensing in a 90-day supply is required. May not include all strengths or formulations. Quantity limits and other restrictions may also apply.

PD Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class. ■

Weight loss drug coverage change for MassHealth ACO members, effective July 1, 2026

Beginning July 1, 2026, MassHealth will no longer pay for medications used for weight loss only. This means that Fallon Health MassHealth ACO members will no longer be able to fill weight-loss medications starting on July 1, 2026.

If Fallon Health MassHealth ACO members need to stay on a weight-loss medication for a medical reason other than weight loss alone, they must have their provider submit a new prior authorization (PA) request.

Effective July 1, 2026, Wegovy® (semaglutide) will be the sole preferred medication to treat **ALL** other medically accepted conditions. The following conditions may be reasons for coverage of Wegovy (semaglutide):

- Moderate to severe obstructive sleep apnea
- Certain liver conditions
- A history of a heart attack, stroke, or symptomatic peripheral artery disease

All requests for members younger than 21 will be reviewed for medical necessity in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. ■

Caring for NaviCare® members? We have resources to support you

If your practice cares for Fallon Health NaviCare members, we're here to support you with the tools and information needed to deliver high-quality, coordinated care.

NaviCare is Fallon Health's integrated program designed to support individuals, over the age of 65 within the service area, with complex medical and behavioral health needs. Whether you serve as a primary care provider (PCP) or a participating specialist, understanding the program and your role is essential to ensuring a seamless experience for your patients.

To support your practice, Fallon Health offers a self-guided training presentation that includes:

- An overview of the NaviCare program
- Member benefits and covered services
- Provider responsibilities and expectations
- Model of Care requirements, including care coordination and collaboration
- Key resources and education, including:
    - Long-Term Services and Supports (LTSS)
    - Accessibility and accommodations
    - Alcohol and substance use disorder support
    - Fall prevention tools
    - Cultural competency resources
    - And more

This training serves as both a helpful refresher for current providers and a valuable onboarding resource for new staff.

We encourage you and your team to review this resource to stay informed and aligned with program expectations.

If you have questions or would like additional support, please contact your Provider Relations representative—we're here to assist you. ■

Update on ACO contract timeline

We want to share an important update regarding the current Accountable Care Organization (ACO) contract period.

The existing ACO contract was scheduled to conclude on **December 31, 2027.** The state has recently notified us that it anticipates **extending the current ACO contracts through December 31, 2028.** This one-year extension is intended to allow additional time for planning and implementation of the next 1115 Demonstration Waiver.

At this time, we are continuing to review this announcement and will assess any potential operational or programmatic impacts.

For our current ACO partners, this update is expected to mean **business as usual for an additional year**, with no immediate changes to existing arrangements.

We will continue to keep you informed as more information becomes available and appreciate your continued partnership and collaboration. ■

Product spotlight

Healthy Homes available to MassHealth ACO members

Healthy Homes is a MassHealth Health-Related Social Needs (HRSN) Supplemental Service available to qualified Medicaid members enrolled in Berkshire Fallon Health Collaborative, Fallon Health-Atrius Health Care Collaboration, and Fallon 365 Care. Like food and nutrition supports offered through HRSN, Healthy Homes addresses nonmedical factors that impact health, and—in this case—the home environment.

Healthy Homes supports members with **asthma, COPD, or other heart or lung conditions** whose home environment may be contributing to health symptoms.

What services are available

Eligible members may receive home-based items or environmental remediation services at no cost, including:

- Air conditioners, air purifiers, fans, humidifiers, or dehumidifiers
- HEPA filters and HEPA vacuums
- Cleaning supplies and pest-control products
- Hypoallergenic mattresses and linens
- Curtains or blinds
- Medication refrigerators and sharps containers
- Environmental remediation, such as mold removal, carpet removal, pest eradication, vent cleaning, hazardous waste removal, or heavy cleaning/chore services

These supports are intended to **reduce environmental triggers**, improve safety, and help members better manage chronic conditions in their homes.

How to refer:

- ACO partner care teams may refer members directly
- Providers who identify a potential Healthy Homes need may contact the Fallon Health Related Social Needs (HRSN) Central Team Inbox cp.referrals@fallonhealth.org to initiate coordination and determine eligibility.

Healthy Homes complements Fallon Health's other HRSN food and housing-related supports, helping address root causes that impact health outcomes beyond traditional clinical care. ■

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 member's goals and the benefits that are part of their care plan. Benefits may include, but are not limited to, in-home supportive services such as homemakers, the Personal Care Attendant (PCA) program, adult day health care, group adult care, and adult foster care. Each member's care plan is unique to meet their needs.

Benefits that all NaviCare members receive include:

- **An entire 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 with whom to communicate to have the best information possible for each NaviCare member. Care Team members visit and assess members in their homes with the members' 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 1-way rides to the pharmacy.
- Mileage reimbursement for friends and family who give rides when pre-approved.
- 100 1-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 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 benefit** is set aside for them to buy healthy food. To learn more, contact Fallon Health.
- 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.

**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.*

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 from 8 a.m. to 8 p.m., Monday through Friday (7 days a week, Oct. 1 through 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. ■

Additional program to support NaviCare implemented: Substance Use Disorder (SUD) support

Fallon Health has launched a comprehensive Substance Use Disorder care coordination program designed to strengthen partnership with inpatient and residential SUD treatment facilities and improve continuity of care for members during admission and through discharge planning. The program establishes a single, consistent point of contact for all SUD facilities, creating a streamlined and reliable communication pathway between Fallon Health and treatment providers.

This model promotes bi-lateral, real-time communication to support clinical collaboration, address barriers early, and ensure discharge planning is informed, timely, and aligned with each member's needs, benefits, and aftercare options. By centralizing communication during high-risk transitions of care, Fallon Health aims to reduce gaps in follow-up, support safe transitions, and improve recovery-focused outcomes.

The program is supported by a dedicated SUD Care Manager, who serves as a subject-matter expert on SUD treatment resources across the state and works closely with the liaison role to support members post-discharge. Together, these roles reinforce coordinated care planning, proactive outreach, and connection to appropriate levels of ongoing treatment and community-based supports—ensuring members receive comprehensive, individualized care across the full continuum. ■

NaviCare Model of Care success

Compassionate advocacy in action—how our Model of Care transforms the member experience at an Adult Day Health (ADH)

At the heart of our work is a deep commitment to advocacy, thoughtful benefit coordination, and a dignity-driven, culturally responsive approach to supporting every member. Recent conversations with participants at Eagle Adult Day Health illustrate how the NaviCare model of care comes to life—thanks in large part to the efforts of dedicated team members like Viola, a NaviCare Navigator, who visits the facility monthly, and the broader care team that supports her work.

During our first SCO Consumer Advisory meeting of the year, participants shared powerful feedback that reflects not only their satisfaction with their benefits, but the meaningful improvements they've experienced in their daily lives.

Members expressed deep appreciation for the wide range of services available to them, noting how seamless and supportive the experience feels. They described the scheduling process as

smooth, communication as clear and helpful, and their interactions with staff as respectful and culturally attuned. Many emphasized how grateful they are to have Viola as their Navigator, especially because she speaks their native language and helps them understand and navigate their benefits with clarity and patience.

One especially impactful story came from a member whose husband lives with Parkinson's disease. Before joining Eagle ADH, he spent most of his days in bed, disengaged and sleeping. After being welcomed into the program—with compassion, patience, and encouragement from the program director—he began attending regularly. Today, he never misses a day. This renewed engagement has not only improved his sense of purpose and daily activity but also brought meaningful relief and support to his wife, who is also his primary caregiver.

Another participant shared that he believes he has lived longer than anyone else in his family thanks to the health care services he receives. He credited the coordination, consistency, and guidance that Viola provides as key factors in maintaining his health and quality of life.

Participants at Eagle ADH described the program as a "second home," a place where they feel welcomed, respected, and understood. They spoke about daily routines, group conversations, and friendships that have become an important part of their lives. Family members, too, have noticed positive changes in their loved ones since joining the program.

Throughout the rollout of these services, the Navigator remained in close, consistent communication with the member, adjusting the frequency and scheduling of supports to ensure the care plan truly met her needs. Through education, collaboration, and strong relationship-building—conducted in the member's primary language—the Navigator helped ensure consistent oversight for her complex medical conditions.

The result? The member continues to live safely at home. She feels reassured, supported, and more connected, and she is once again enjoying life. She has expressed deep gratitude for the care and support she has received.

These stories reflect the profound personal impact our care model—and the people who carry it out—can have. They demonstrate how our work supports independence, enhances wellbeing, and uplifts both members and their families in ways that truly matter. ■

Important reminders

Reminder: Required documentation for provider appeals

To help ensure timely and accurate review, please remember that all **provider appeals must be submitted with a completed Request for Claim Review Form.**

When submitting a provider appeal, the form should:

- Identify the appeal as a **payer policy dispute** (clinical and/or payment).
- Include comments that clearly explain the **reason for the appeal and the purpose of the review request.**

Appeals submitted without this form—particularly those involving **multi-line claims without explanation**—are challenging to review, as the Plan does not have sufficient information to understand the basis of the appeal.

To avoid delays or returned submissions, please ensure the **form is fully completed and included** with all provider appeals. Appeals received without the required form may be returned or rejected as incomplete.

Thank you for your partnership in helping streamline the review process. ■

What you should know about the Health Outcomes Survey (HOS)

Fallon Health is committed to partnering with our providers to deliver the best possible patient experiences and outcomes. Each year a random sampling of Fallon Medicare Plus™ and NaviCare members are surveyed about their experience with their providers, health care services, and their health plan through the HOS.

The HOS is a tool for assessing the health and well-being of Medicare beneficiaries enrolled in Medicare Advantage (MA) health plans and is an important aspect of the CMS 5-Star Quality Rating Program. Since you, the provider, are a critical component of the patient's experience, we have highlighted 3 specific HOS measures where your actions can influence results and outcomes. As a reminder, HOS surveys are conducted from August to October each year.

The role you—the provider—can play in impacting the HOS

Key focus areas. HOS scores can be impacted by focusing on areas that clinicians and clinical staff directly influence that can both positively impact survey ratings and improve health:

- *Key HOS measures providers are poised to influence:*
    - Improving Bladder Control
    - Reducing the Risk of Falling
    - Monitoring Physical Activity

Recommended strategies and interventions: Improving Bladder Control

Improving Bladder Control is a HOS measure in the annual Medicare Part C Star Ratings. It assesses urinary incontinence management among Medicare members aged 65 and older who reported urine leakage in the past 6 months. Suggestions include:

- **Screening and assessment**
  Regularly screen patients for urinary incontinence.
  Assess the severity, frequency, and impact of symptoms on daily life.
- **Education and lifestyle modifications**
  Educate patients about bladder health, including dietary habits, fluid intake, and pelvic floor exercises. Encourage lifestyle modifications such as weight management, avoiding bladder irritants (e.g., caffeine, alcohol), and timed voiding.
- **Behavioral interventions**
  Recommend bladder training techniques, including scheduled voiding, and urge suppression strategies. Provide guidance on pelvic floor muscle exercises (Kegels) to improve bladder control.
- **Pharmacological interventions**
  Consider medications (e.g., anticholinergics) for urge incontinence. Evaluate risks and benefits based on individual patient needs.
- **Referral to specialists**
  Refer patient to urologists, urogynecologists, or pelvic health specialists for further evaluation and management.

Evidence suggests that personalized care plans tailored to each patient's needs are essential for improving bladder control and overall quality of life.

Recommended strategies and interventions: Reducing the Risk of Falling

Regularly screen patients aged 65 or older for fall risk. Assess the severity, frequency, and impact of balance and walking problems. Educate patients about fall prevention strategies:

- Proper footwear.
- Home safety modifications (e.g. removing tripping hazards).
- Exercise programs (e.g., strength training, balance exercises).
- Evaluate medications that may increase fall risk (e.g. sedatives, antihypertensives), adjust medications as needed.
- Encourage regular physical activity to improve strength and balance.
- Collaborate with other healthcare professionals (e.g., physical therapists, occupational therapists) to address fall risk comprehensively.

Personalized interventions can significantly reduce fall risk and improve patient safety.

Recommended strategies and interventions: Monitoring Physical Activity

- Regularly discuss exercise with patients during visits.
- Assess their current physical activity levels.
- Provide tailored advice to start, increase, or maintain physical activity.
- Encourage patients to engage in regular exercise.
- Refer patients to physical therapists or exercise specialists, if necessary.

Promoting physical activity contributes to overall health and well-being.

For more details about the HOS survey, specific measures, or the CMS 5-Star Quality Rating Program, please contact your Provider Relations representative. ■

Accessibility and accommodations for Fallon Health members

Fallon Health is committed to ensuring that all members can access covered services without unnecessary barriers. Providers play a vital role in supporting accessibility and reasonable accommodations for individuals with disabilities and other access needs.

Provider expectations

In accordance with federal and state requirements, including the Americans with Disabilities Act (ADA), providers are expected to offer reasonable accommodations that support member access to care. Examples may include:

- Accessible entrances, restrooms, and exam rooms
- Use of accessible medical equipment when available
- Communication supports such as interpreters or materials in alternative formats
- Reasonable scheduling or visit modifications based on individual needs

Providers should respond promptly and respectfully to both one-time and ongoing accommodation requests to support continuity of care.

Accurate accessibility information

Up-to-date provider directory information helps members identify offices and service locations that can meet their accessibility needs. Providers are responsible for notifying Fallon Health of changes related to:

- Physical accessibility of offices or facilities
- Communication or accommodation services offered
- Any updates that may affect member access to care

Timely responses to outreach requests help ensure directory accuracy.

Working together

Fallon Health engages providers on accessibility through onboarding, training, and routine provider services activities. When accessibility concerns are identified, providers may be contacted for clarification or updates as part of ongoing compliance and quality efforts.

Questions or updates?

Providers with questions or updates related to accessibility or accommodations should contact their Provider Relations representative. Your partnership helps ensure equitable, respectful access to care for all Fallon Health members. ■

Doing business with us

Action needed: Provider payment transition to Zelis Payments Network

Fallon Health is transitioning provider payment processing from PaySpan to Zelis, effective September 1, 2026. At this point, you should have received a letter from Fallon Health and Zelis separately, indicating next steps for you to avoid a payment disruption.

What this means for providers

- In partnering with Zelis, we're excited to offer you more efficiency and choice in how you receive claims payments and remittance data.
- Zelis is a recognized leader in modernizing health care payments. Through this new partnership, you'll gain access to their premium payments experience, ZAPP Edge, providing payments, data, and performance insights from 550+ payers in a single portal.
- You can also choose to receive your payments through virtual credit or use cost-free options that include Fallon Health ePayment Center or paper checks.
- If you wish to change the method by which you receive payments from Fallon Health through Zelis, use the contact information below to indicate your decision.
    - Zelis Payment Network (ZAPP Edge, VCC, Check): 1-877-828-8770
    - ePayment Center (ACH): 1-855-774-4392

Important

We encourage you to share this information with your finance or revenue cycle teams sooner rather than later to ensure your organization has plenty of time to evaluate the option that best meets your needs.

Support

Fallon Health and Zelis will work directly with providers to answer questions and document payment selections. ■

Coming soon in 2026—expanding provider portal capabilities

We are excited to share that we will be expanding portal capabilities later in 2026 to include provider data change forms. Once available, users will be able to **submit provider enrollment transactions directly through the Provider Portal** using standardized electronic forms.

These enhancements are designed to:

- Improve data quality through standardized submissions
- Support quicker turnaround times for processing
- Enhance communication and transparency throughout the process

More details to come soon.

Reminder: The fastest way to update an existing enrollment continues to be attesting through CAQH. Maintaining accurate provider information is a shared responsibility—and a critical one. ■

Stay connected with your Provider Relations representative

At Fallon Health, we are committed to supporting your practice and ensuring you have the resources you need to work effectively with us. All contracted providers are assigned a dedicated Provider Relations Representative who serves as your primary point of contact.

Your representative is available to assist with a variety of needs, including:

- Questions about Fallon Health products and plans
- Guidance on doing business with Fallon Health
- Education or refresher training for your staff
- Support navigating policies, processes, and updates

We encourage you to reach out whenever you need assistance—our team is here to help.
In addition, Fallon Health offers a wide range of online resources to support your practice, without needing a username and password.

Visit fallonhealth.org/en/providers to access tools and information such as:

- **Provider Manual** – Comprehensive guidance on claims submission, referrals, prior authorization requirements, plan details, plan specific requirements, and more
- **Provider Lookup Tool** – Easily verify network participation
- **Procedure Code Lookup Tool** – Determine if a service requires prior authorization

These resources are designed to make it easier for you and your staff to find the information you need quickly and efficiently. If you have questions or need support, don't hesitate to contact your Provider Relations representative—we're here to partner with you.

If you do not know who your Provider Relations representative is, you can email askfchp@fallonhealth.org. ■

Quality focus

Closing HEDIS care gaps together

Fallon Health is committed to partnering with you to close care gaps and improve patient outcomes across your population.

Targeted measures:

- Diabetes care: HbA1c control, retinal eye exam, nephropathy screening
- Hypertension: Blood pressure control
- Cancer screenings: Breast, colorectal, and cervical

Support available to your practice:

- Gaps in Care reports identifying patients due for services
- Lab results through Fallon Health-sponsored programs with Quest Diagnostics

New colorectal screening: Cologuard

Fallon Health is expanding access to Cologuard, a noninvasive, at-home screening option that can support gap closure for your Medicare and NaviCare patients.

Key benefits for your patients and practice:

- Screening interval of **every 3 years**, reducing the need for annual testing
- **Higher single-test sensitivity than FIT** (approximately 92% vs 74%), increasing the likelihood of detecting cancer with each test
- Improved detection of advanced precancerous lesions to support earlier intervention
- Convenient, at-home option that may improve patient gap closure

Results will be shared with your practice to support follow-up and care coordination.

For more information, please contact Dawn Little, Director of Quality, at dawn.little@fallonhealth.org.

Thank you for your continued partnership in delivering high-quality, patient-centered care. ■

Clinical practice guidelines update

Our clinical practice guidelines are available. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

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

- Standards of Care in Diabetes – 2026
- 2026 MHQP Pediatric Preventive Care Guidelines
- 2026 MHQP Adult Preventive Care Guidelines
- 2026 MHQP Perinatal Preventive Care Guidelines
- GOLD Initiative for Chronic Obstructive Lung Disease Pocket Guide to COPD Diagnosis Management and Prevention 2026 Pocket Guide
- Elder Abuse and Neglect—A guide to help assess elderly patients for abuse and neglect
- CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022
- 2020 Asthma Management Guidelines At-A-Glance
- 2020 Asthma Management Guidelines
- 2025 ACC/AHAHFSA Guideline for the Management of Heart Failure
- Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain-United States, 2022
- 2025 Child and Adolescent Immunization Schedule by Age—Recommendations for 18 Years or Younger
- 2025 Adult Immunization Schedule by Age—Recommendations for Ages 19 Years or Older ■

How providers can support better Medicare Health Outcomes Survey (HOS) results

Each year, some Fallon Health Medicare members are asked to complete the Medicare Health Outcomes Survey (HOS)—a CMS-required survey that looks at changes in members' physical and mental health over time. While members complete the survey themselves, providers play an important role in helping ensure survey responses accurately reflect members' real health status and care experiences.

Why the HOS matters to Fallon Health and to providers

The HOS results are used by CMS to evaluate how well Medicare Advantage plans support members' ability to function physically and emotionally as they age. These results contribute to Medicare quality ratings, which directly affect plan resources, care management programs, and provider support initiatives.

When the HOS results accurately reflect members' health and functional status, Fallon Health can:

- Identify where members need more support
- Invest in targeted programs that help members maintain independence
- Strengthen care coordination and population health efforts

What providers can do to help

1. **Reinforce the importance of honest responses**
   If a patient mentions receiving a HOS survey, encourage them to answer questions honestly and based on their current abilities—not what they think someone wants to hear. Honest responses help Fallon understand what is working well and where additional support may be needed.

2. **Normalize conversations about function and daily living**
   The HOS focuses on members' ability to perform everyday activities, such as walking, climbing stairs, dressing, and managing daily tasks. Providers who routinely ask about these topics help members feel comfortable acknowledging limitations, leading to survey responses that better align with clinical reality.

3. **Encourage participation—especially for vulnerable members**
   Members with chronic conditions, mobility challenges, or cognitive limitations may be less likely to complete surveys without encouragement. Providers and office staff may remind members that participation is voluntary but valuable, reassure them that responses are confidential, and offer help understanding questions if requested—while ensuring answers remain the member's own.

4. **Support accurate reporting of mental and emotional health**
   The HOS includes questions related to emotional well-being. Normalizing conversations about mood, stress, and mental health during visits can help members feel more comfortable responding accurately on the survey.

To protect the integrity of the survey, providers should not:

- Tell members how to answer specific questions
- Complete the survey for a member without the member present
- Discourage participation

Working together to improve outcomes

The Health Outcomes Survey is one of the few tools CMS uses to measure how members' health changes over time. Through everyday interactions, providers help ensure that HOS results tell the right story—supporting Fallon Health's efforts to improve care and outcomes for Medicare members.

For questions about the HOS survey or Fallon Health's quality initiatives, please contact your Fallon Health Provider Relations representative. ■

Personalized Wellness Mailer – what you should know

Beginning in September 2026, Fallon Health members will receive a Personalized Wellness Mailer designed to support conversations between providers and patients during office visits.
The mailer includes a personalized checklist of recommended preventive screenings, tests, vaccines, and condition-specific care, based on available information.

For members with diabetes, the mailer may include reminders related to A1c testing, kidney health evaluations, annual eye exams, and medication therapy.
The mailer also highlights supportive benefits such as telehealth services, medication delivery options, Fallon Health Navigator support, and in-home health evaluations.

Providers may see patients referencing this mailer during visits beginning in September. Reviewing it together can help identify potential gaps in care and support shared decision-making. ■

Coding Corner

Update to 835 Electronic Remittance Advice (ERA)

Fallon Health will be implementing a minor update to the 835 Electronic Remittance Advice (ERA). This update maintains current functionality while introducing a small enhancement keeping in line with industry EDI standards and compliance requirements.

What's changing

- A new reference identifier will be added to the Provider Level Balance (PLB) segment.
- This identifier will link to the Transaction Identifier (TRN02) associated with the payment.
    - For payments: the identifier will reflect the check number.
    - For non-payment notifications: the identifier will include a combination of the date, fund ID, and provider NPI.

What's not changing

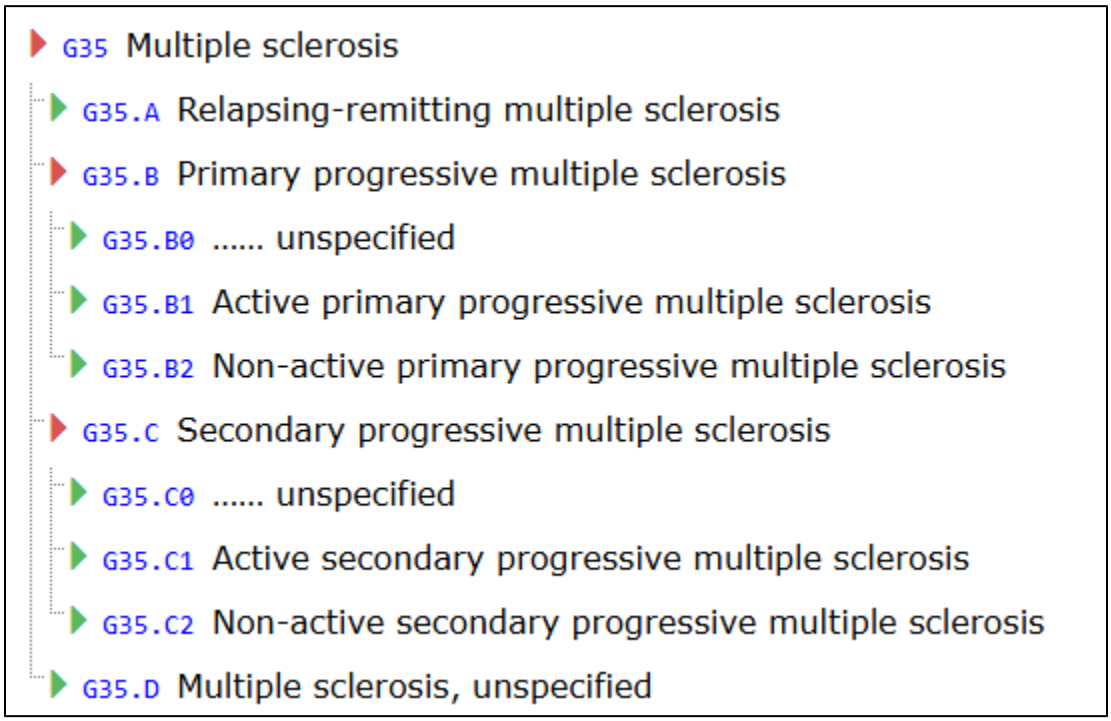
- There are **no changes** to how PLB amounts are calculated or reported.
- PLB adjustments (such as negative balances, withholds, interest, refunds, and advance payments) will continue to be reported at the payment level.
- Provider payment calculations and reporting logic remain the same.
- There are **no changes** to paper Remittance Advice Statements (RAS).

Provider impact

This is a minimal, technical enhancement that will not affect how provider systems process 835 files today. ■

Changes to Multiple Sclerosis (MS) codes

In 2026, the ICD-10 code for Multiple Sclerosis (MS) has significant changes. G35 is no longer valid and has been replaced with the following specific subcodes:



Claims using the old G35 code after October 1, 2025 will be rejected, so it's important to use language that illustrates the specificity of the condition so that accurate codes are utilized for billing and documentation. ■

Upcoming claims editing enhancements—effective September 2026

To continue improving accuracy and compliance in claims processing, several new edits will be implemented in September 2026. These updates are designed to align with AMA, CMS, and ICD-10 guidelines and industry best practices. Below is an overview of the new rules.

1. **Patient is not new to this provider**
   A patient is considered **new** only if they have not received any professional service from you (or another provider in your group of the same specialty) within the last **3 years.** If you bill a new patient E/M code for a patient who has had an E/M visit with the same specialty in your group during the prior 3 years, the new patient E/M will be denied. **Applies to: CMS-1500 claims.**

2. **Sequela Dx code billed as primary Dx**
   A sequela code reports a residual condition after the acute injury/illness has resolved. When reporting sequela, typically submit two diagnosis codes: (1) the current residual condition first, and (2) the sequela ("late effect") code second. Claim lines will be denied if a sequela code is billed as the primary/first diagnosis or as the only diagnosis on the line. **Applies to: UB-04 claims and CMS-1500 claim lines.**

3. **Mutually exclusive Excludes1 diagnosis codes**
   An Excludes1 note means the two diagnosis codes should not be reported together because the conditions cannot occur at the same time (for example, congenital vs. acquired forms). This edit will deny the claim line when an Excludes1 code combination is billed on the same line. **Applies to: CMS-1500 claim lines.**

4. **Inappropriate sequencing order for Code First diagnosis**
   Some ICD-10-CM conditions require reporting an underlying etiology and one or more manifestations. When a diagnosis code includes a Code First note, the underlying condition must be sequenced before the manifestation. This edit will deny claim lines when a manifestation code is billed ahead of its required underlying (etiology) code. **Applies to: UB-04 claims and CMS-1500 claim lines.**

5. **Missing Code First diagnosis code**
   For conditions with an underlying cause and related manifestations, ICD-10-CM provides sequencing instructions using Use additional code (at the etiology code) and Code first (at the manifestation code). If a manifestation code is billed, the required underlying (Code First) diagnosis must also be present and sequenced first when applicable. This edit will deny claim lines when a manifestation diagnosis is submitted without an appropriate designated Code First (etiology) diagnosis code on the line. **Applies to: UB-04 claims and CMS-1500 claim lines.**

6. **Inconsistent multiple laterality diagnosis codes submitted**
   Some ICD-10-CM codes include laterality (left, right, or bilateral). Do not bill conflicting laterality codes from the same subcategory for the same service. This edit will deny claim lines when inconsistent laterality diagnosis codes from the same subcategory are submitted together for the same procedure/service. **Applies to: UB-04 claims and CMS-1500 claim lines.**

7. **Procedure submitted with an inappropriate anatomical modifier**
   Use anatomical modifiers with CPT/HCPCS codes only when they are allowed for the procedure. This edit will deny claim lines when a procedure code is billed with a disallowed anatomical modifier. **Applies to: UB-04 and CMS-1500 claim lines.**

   - **Coronary modifiers:** LC, LD, LM, RC, RI
   - **Finger modifiers:** FA, F1, F2, F3, F4, F5, F6, F7, F8, F9
   - **Toe modifiers:** TA, T1, T2, T3, T4, T5, T6, T7, T8 & T9

- **Side body modifiers:** LT, RT
- **Eyelid modifiers:** E1, E2, E3 & E4

Upcoming claims editing enhancements—effective November 2026

Medicare Advantage NCD/LCD claim edits
Fallon Health follows CMS guidance, including applicable National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). When these policies restrict or define coverage, claims that do not meet NCD or LCD criteria will be denied in accordance with Medicare regulations. ■

Coding updates

Effective June 17, 2025, the following codes are configured as *covered with prior authorization* for Medicare HMO, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (e.g., electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters

Effective October 28, 2025, the following codes are configured as *covered with prior authorization* for Medicare HMO, NaviCare, and Summit ElderCare PACE:

Code	Description
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision

	and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system

Effective January 1, 2026, the following code will *deny vendor liable* for MassHealth ACO (BFHC, FACC, Fallon 365 Care):

Code	Description
15016	APP SKN CL SSP AGRF T/A/L EA

Effective January 1, 2026, the following codes will be *payable with prior authorization* for MassHealth ACO (BFHC, FACC, Fallon 365 Care):

Code	Description
64567	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

Effective January 1, 2026, the following code is *deny vendor liable* for MassHealth ACO (BFHC, FACC, Fallon 365 Care):

Code	Description
70471	Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing

Effective January 1, 2026, the following code is *covered with prior authorization* for MassHealth ACO (BFHC, FACC, Fallon 365 Care):

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

Effective September 1, 2026, the following codes will *deny vendor liable* for Fallon Medicare Plus and NaviCare with CMS Admin "I", and MassHealth ACO:

Code	Description
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)
A0394	ALS specialized service disposable supplies; IV drug therapy
A0398	ALS routine disposable supplies
A0420	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)

Effective September 1, 2026, the following codes will *not be covered* for Fallon Medicare Plus and NaviCare, and *deny vendor liable* for MassHealth ACO:

Code	Description
A4611	Battery, heavy-duty; replacement for patient-owned ventilator
A4612	Battery cables; replacement for patient-owned ventilator
A4613	Battery charger; replacement for patient-owned ventilator

Effective September 1, 2026, the following codes will *deny vendor liable* for Fallon Medicare Plus and NaviCare with CMS Admin "I", Summit ElderCare PACE, and Community Care:

Code	Description
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

Effective September 1, 2026, the following code will be configured *deny vendor liable* for Community Care:

Code	Description
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
0935T	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components

Effective September 1, 2026, the following codes will *not be covered* for Fallon Medicare Plus and Community Care:

Code	Description
E0445	Oximeter device for measuring blood oxygen levels noninvasively
A4606	Oxygen probe for use with oximeter device, replacement

Effective September 1, 2026, the following codes will change from *covered with prior authorization* to *deny vendor liable* for all lines of business, except MassHealth ACO (BFHC, FACC, Fallon 365 Care), which is already *deny vendor liable*:

Code	Description
A9291	Prescription digital cognitive and/or behavioral therapy, FDA cleared, per course of treatment
A9292	Prescription digital visual therapy, software-only, FDA cleared, per course of treatment

Effective September 1, 2026, the following codes will *deny vendor liable* for all lines of business:

Code	Description
E0787	External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing
A4226	Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week

Effective September 1, 2026, the following code will *deny vendor liable* for all lines of business (pass-through status expired):

Code	Description
C1886	Catheter, extravascular tissue ablation, any modality (insertable)

Effective September 1, 2026, the following codes will *require prior authorization* for all lines of business:

Code	Description
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming

Effective September 1, 2026, the following code is *not covered* for Summit ElderCare PACE and NaviCare:

Code	Description
A4520	Incontinence garment, any type, (e.g., brief, diaper), each

Effective September 1, 2026, the following codes will *require prior authorization* for all lines of business:

Code	Description
29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)
29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)
29916	Arthroscopy, hip, surgical; with labral repair

Effective September 1, 2026, the following code will *deny vendor liable* for all lines of business:

Code	Description
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung)

Effective September 1, 2026, the following code will *require prior authorization* for Fallon Medicare Plus, NaviCare, Community Care, and Summit ElderCare PACE:

Code	Description
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each

Effective September 1, 2026, the following codes will *deny vendor liable* for all lines of business:

Code	Description
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components
C1607	Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system
S9453	Smoking cessation classes, nonphysician provider, per session

Effective September 1, 2026, the following code will *deny vendor liable* for Fallon Medicare Plus, NaviCare, and Summit ElderCare PACE:

Code	Description
C1898	Lead, pacemaker, other than transvenous vdd single pass

Effective September 1, 2026, the following codes will *deny vendor liable* for Community Care:

Code	Description
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only
C1824	Generator, cardiac contractility modulation (implantable)
C1898	Lead, pacemaker, other than transvenous vdd single pass

Effective September 1, 2026, the following codes will *not be covered* for all lines of business, except MassHealth ACO, which will remain *vendor liable*:

Code	Description
G0255	Current perception threshold / sensory nerve conduction test (SNCT), per limb, any nerve
G0282	Electrical stimulation (unattended) to one or more areas for wound care (not otherwise specified)
G0295	External electrocardiographic (ECG) continuous rhythm monitoring with recording and storage (typically wearable patch monitoring)
G0428	Cardiac rehabilitation program, typically involving monitored exercise and education for heart disease patients (unspecified setting/session)
G9013	Care coordination services provided by non-physician staff to support patient management and treatment planning
G9014	Coordination and communication of patient care activities, including interdisciplinary care management support
G9147	Outpatient intravenous insulin treatment (OIVIT), guided by laboratory measurements

Effective September 1, 2026, the following code will *be covered with prior authorization* for all lines of business, except MassHealth ACO, which will remain *vendor liable*:

Code	Description
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

Effective September 1, 2026, the following codes will *deny vendor liable* for Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
C1765	Adhesion barrier
C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1768	Graft, vascular
C1769	Guide wire
C1770	Imaging coil, magnetic resonance (insertable)
C1771	Repair device, urinary, incontinence, with sling graft
C1772	Infusion pump, programmable (implantable)
C1773	Retrieval device, insertable (used to retrieve fractured medical devices)
C1776	Joint device (implantable)
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
C1778	Lead, neurostimulator (implantable)
C1779	Lead, pacemaker, transvenous vdd single pass
C1780	Lens, intraocular (new technology)
C1781	Mesh (implantable)
C1782	Morcellator
C1783	Ocular implant, aqueous drainage assist device
C1784	Ocular device, intraoperative, detached retina
C1785	Pacemaker, dual chamber, rate-responsive (implantable)
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1787	Patient programmer, neurostimulator
C1788	Port, indwelling (implantable)
C1789	Prosthesis, breast (implantable)
C1813	Prosthesis, penile, inflatable
C1814	Retinal tamponade device, silicone oil
C1815	Prosthesis, urinary sphincter (implantable)
C1816	Receiver and/or transmitter, neurostimulator (implantable)
C1890	No implantable/insertable device used with device-intensive procedures

C1891	Infusion pump, non-programmable, permanent (implantable)
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
C1897	Lead, neurostimulator test kit (implantable)
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
C1900	Lead, left ventricular coronary venous system
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive
C2613	Lung biopsy plug with delivery system
C2614	Probe, percutaneous lumbar discectomy
C2615	Sealant, pulmonary, liquid
C2617	Stent, non-coronary, temporary, without delivery system
C2618	Probe/needle, cryoablation
C2619	Pacemaker, dual chamber, non rate-responsive (implantable)
C2620	Pacemaker, single chamber, non rate-responsive (implantable)
C2621	Pacemaker, other than single or dual chamber (implantable)
C2622	Prosthesis, penile, non-inflatable
C2623	Catheter, transluminal angioplasty, drug-coated, non-laser
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components
C2625	Stent, non-coronary, temporary, with delivery system
C2626	Infusion pump, non-programmable, temporary (implantable)
C2627	Catheter, suprapubic/cystoscopic
C2628	Catheter, occlusion
C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser
C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, cool-tip
C2631	Repair device, urinary, incontinence, without sling graft
C2637	Brachytherapy source, non-stranded, ytterbium-169, per source

C2644	Brachytherapy source, cesium-131 chloride solution, per millicurieC1716

Effective September 1, 2026, the following codes will *deny vendor liable* for Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
C1740	Leadless electrode, transmitter, battery (all implantable), for sequential left ventricular pacing
C1747	Endoscope, single use (i.e., disposable), urinary tract, imaging/illumination device (insertable)
C1748	Endoscope, single use (i.e. disposable), upper gi, imaging/illumination device (insertable)
C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)
C1750	Catheter, hemodialysis/peritoneal, long-term
C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
C1752	Catheter, hemodialysis/peritoneal, short-term
C1753	Catheter, intravascular ultrasound
C1754	Catheter, intradiscal
C1755	Catheter, intraspinal
C1756	Catheter, pacing, transesophageal
C1757	Catheter, thrombectomy/embolectomy
C1758	Catheter, ureteral
C1759	Catheter, intracardiac echocardiography
C1760	Closure device, vascular (implantable/insertable)
C1761	Catheter, transluminal intravascular lithotripsy, coronary
C1762	Connective tissue, human (includes fascia lata)
C1763	Connective tissue, non-human (includes synthetic)
C1817	Septal defect implant system, intracardiac
C1818	Integrated keratoprosthesis
C1819	Surgical tissue localization and excision device (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1821	Interspinous process distraction device (implantable)
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system

C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller
C1830	Powered bone marrow biopsy needle
C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)
C1839	Iris prosthesis
C1840	Lens, intraocular (telescopic)
C1874	Stent, coated/covered, with delivery system
C1875	Stent, coated/covered, without delivery system
C1876	Stent, non-coated/non-covered, with delivery system
C1877	Stent, non-coated/non-covered, without delivery system
C1878	Material for vocal cord medialization, synthetic (implantable)
C1880	Vena cava filter
C1881	Dialysis access system (implantable)
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
C1883	Adapter/extension, pacing lead or neurostimulator lead (implantable)
C1884	Embolization protective system
G2000	Blinded administration of convulsive therapy procedure, either electroconvulsive therapy (ECT, current covered gold standard) or magnetic seizure therapy (MST, non-covered experimental therapy), performed in an approved IDE-based clinical trial, per treatment session
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed
27216	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
27217	Open treatment of anterior pelvic bone fracture and/ or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)
27218	Open treatment of posterior pelvic bone fracture and/or dis-location, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

Effective September 1, 2026, the following codes will *deny vendor liable* for all lines of business:

Code	Description
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)
C1889	Implantable/insertable device, not otherwise classified

Effective September 1, 2026, the following code will *not be covered* for Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral

Effective September 1, 2026, the following code will *require prior authorization* for all lines of business:

Code	Description
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

Effective September 1, 2026, the following codes will *require prior authorization* for MassHealth ACO:

Code	Description
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
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
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)
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
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

Effective September 1, 2026, the following codes will *deny vendor liable* for MassHealth ACO:

Code	Description
81416	EXOME SEQUENCE ANALYSIS
81415	EXOME SEQUENCE ANALYSIS
81425	GENOME SEQUENCE ANALYSIS
81426	GENOME SEQUENCE ANALYSIS
86364	TISS TRNSGLTMNASE EA IG CLAS
83521	IG LIGHT CHAINS FREE EACH
86258	DGP ANTIBODY EACH IG CLASS
88374	M/PHMTRC ALYS ISHQUANT/SEMIQ
88321	MICROSLIDE CONSULTATION
86381	MITOCHONDRIAL ANTIBODY EACH
81432	HRDTRY BRST CA-RLATD DSORDRS
81268	CHIMERISM W/COMP TO BASELINE W/CELL SELECTION EA
88331	PATH CONSULT INTRAOP, 1 BLOC
86580	TB INTRADERMAL TEST
88377	M/PHMTRC ALYS ISHQUANT/SEMIQ
80179	DRUG ASSAY SALICYLATE
86015	ACTIN ANTIBODY EACH
80503	PATH CLIN CONSLTJ SF 5-20
86077	PHYSICIAN BLOOD BANK SERVICE
81411	AORTIC DYSFUNCTION/DILATION
88364	NSITU HYBRIDIZATION (FISH)
81460	WHOLE MITOCHONDRIAL GENOME
81430	HEARING LOSS SEQUENCE ANALYS
81595	CARDIOLOGY HRT TRNSPL MRNA

86037	ANCA TITER EACH ANTIBODY
81465	WHOLE MITOCHONDRIAL GENOME
86036	ANCA SCREEN EACH ANTIBODY
81435	HEREDITARY COLON CANCER
83529	ASAY OF INTERLEUKIN-6 (IL-6)
86231	EMA EACH IG CLASS
81410	AORTIC DYSFUNCTION/DILATION
82653	EL-1 FECAL QUANTITATIVE
88323	MICROSLIDE CONSULTATION
81431	HEARING LOSS DUP/DEL ANALYS
86078	PHYSICIAN BLOOD BANK SERVICE
81259	HBA1/HBA2 FULL GENE SEQUENCE
88332	PATH CONSULT INTRAOP ADDL
86363	MOG-IGG1 ANTB FLO CYTMTRY EA
88329	PATH CONSULT INTROP
86596	VOLTAGE-GTD CA CHNL ANTB EA
88325	COMPREHENSIVE REVIEW OF DATA
86052	AQUAPORIN-4 ANTB CBA EACH
86053	AQAPRN-4 ANTB FLO CYTMTRY EA
80220	DRUG ASY HYDROXYCHLOROQUINE
81328	SLCO1B1 GENE COM VARIANTS
81417	EXOME RE-EVALUATION
86362	MOG-IGG1 ANTB CBA EACH
80504	PATH CLIN CONSLTJ MOD 21-40
81230	CYP3A4 GENE COMMON VARIANTS
80505	PATH CLIN CONSLTJ HIGH 41-60
86051	AQUAPORIN-4 ANTB ELISA
88369	M/PHMTRC ALYSISHQUANT/SEMIQ
84600	ASSAY OF VOLATILES

Effective September 1, 2026, the following codes will *deny vendor liable* for MassHealth ACO:

Code	Description
80506	DVL FOR ACO EFFECTIVE 9/1/26
81175	DVL FOR ACO EFFECTIVE 9/1/26
81176	DVL FOR ACO EFFECTIVE 9/1/26
81247	DVL FOR ACO EFFECTIVE 9/1/26
81283	DVL FOR ACO EFFECTIVE 9/1/26
81313	DVL FOR ACO EFFECTIVE 9/1/26
81334	DVL FOR ACO EFFECTIVE 9/1/26
81346	DVL FOR ACO EFFECTIVE 9/1/26
81349	DVL FOR ACO EFFECTIVE 9/1/26
81412	DVL FOR ACO EFFECTIVE 9/1/26
81427	DVL FOR ACO EFFECTIVE 9/1/26
81434	DVL FOR ACO EFFECTIVE 9/1/26
81437	DVL FOR ACO EFFECTIVE 9/1/26
81440	DVL FOR ACO EFFECTIVE 9/1/26
81448	DVL FOR ACO EFFECTIVE 9/1/26
81470	DVL FOR ACO EFFECTIVE 9/1/26
81471	DVL FOR ACO EFFECTIVE 9/1/26
81490	DVL FOR ACO EFFECTIVE 9/1/26
81493	DVL FOR ACO EFFECTIVE 9/1/26
81504	DVL FOR ACO EFFECTIVE 9/1/26
81520	DVL FOR ACO EFFECTIVE 9/1/26
81523	DVL FOR ACO EFFECTIVE 9/1/26
81525	DVL FOR ACO EFFECTIVE 9/1/26
81535	DVL FOR ACO EFFECTIVE 9/1/26
81536	DVL FOR ACO EFFECTIVE 9/1/26
81538	DVL FOR ACO EFFECTIVE 9/1/26
81540	DVL FOR ACO EFFECTIVE 9/1/26
81560	DVL FOR ACO EFFECTIVE 9/1/26
86932	DVL FOR ACO EFFECTIVE 9/1/26

88366	DVL FOR ACO EFFECTIVE 9/1/26
88373	DVL FOR ACO EFFECTIVE 9/1/26
88375	DVL FOR ACO EFFECTIVE 9/1/26
89337	DVL FOR ACO EFFECTIVE 9/1/26

Effective September 1, 2026, the following codes will *deny vendor liable* for Medicare HMO, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
80321	Alcohols biomarkers; 1or 2
80322	Alcohols biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamines; 3 or 4
80326	Amphetamines; 5 or more
80327	Anabolic steroids; 1 or 2
80328	Anabolic steroids; 3 or more
80329	Analgesics, non-opioid; 1 or 2
80330	Analgesics, non-opioid; 3-5
80331	Analgesics, non-opioid; 6 or more
80332	Antidepressants, serotonergic class; 1 or 2
80333	Antidepressants, serotonergic class; 3-5
80334	Antidepressants, serotonergic class; 6 or more
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 6 or more
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1-3
80340	Antiepileptics, not otherwise specified; 4-6
80341	Antiepileptics, not otherwise specified; 7 or more
80342	Antipsychotics, not otherwise specified; 1-3
80343	Antipsychotics, not otherwise specified; 4-6

80344	Antipsychotics, not otherwise specified; 7 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80350	Cannabinoids, synthetic; 1-3
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids synthetic; 7 or more
80353	Cocaine
80355	Gabapentin, non-blood
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4
80364	Opioids and opiate analogs; 5 or more
80366	Pregabalin
80367	Propoxyphene
80368	Sedative hypnotics (non-benzodiazepines)
80369	Skeletal muscle relaxants; 1 or 2
80370	Skeletal muscle relaxants; 3 or more
80371	Stimulants, synthetic
80372	Tapentadol
80374	Stereoisomer (enantiomer) analysis, single drug class
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more

Effective September 1, 2026, the following code will *require prior authorization* for all lines of business:

Code	Description
J1440	Fecal microbiota, live – jslm, 1 mL billed as 150 mL

Effective July 1, 2026, the following code will be configured as *covered with prior authorization* for Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and *deny vendor liable* for MassHealth ACO and Community Care:

Code	Description
0648U	Oncology (solid tumor), targeted genomic sequencing analysis, to detect deletions, insertions, and substitutions in 42 genes, copy number amplifications in 10 genes, and fusions and splice variants in 18 driver genes from DNA and RNA extracted from formalin-fixed paraffin-embedded (FFPE) tissue

Effective July 1, 2026, the following codes will be configured as *deny vendor liable* for all lines of business (experimental and investigational):

Code	Description
1026T	Transvaginal laser photobiomodulation therapy of pelvis, provided by a physician or other qualified health care professional
1027T	Percutaneous insertion or replacement of neurostimulation catheter via left subclavian or left jugular vein into the superior vena cava, with verification of capture of phrenic nerves, mapping and programming, and delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning when performed, including imaging guidance
1028T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, with repositioning and verification of left phrenic nerve capture, per session
1029T	Mapping and programming of neurostimulation catheter with delivery of transvenous phrenic neurostimulation therapy in ventilated patients, without catheter repositioning, per session
1030T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (e.g., final anatomic representation [FAR]), cumulative time for up to 30 days; initial 30 minutes
1031T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (e.g., final anatomic representation [FAR]), cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)

1032T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (e.g., final anatomic representation [FAR]) and digital simulation, cumulative time for up to 30 days; initial 60 minutes
1033T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (e.g., final anatomic representation [FAR]) and digital simulation, cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)
1034T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), digital simulation, and computational analyses (eg, computational fluid dynamics, finite element analysis), cumulative time for up to 30 days; initial 90 minutes
1035T	Creation of digital 3D model from surface mesh files of patient-specific anatomy (eg, final anatomic representation [FAR]), digital simulation, and computational analyses (eg, computational fluid dynamics, finite element analysis), cumulative time for up to 30 days; each additional 30 minutes (List separately in addition to code for primary procedure)
1036T	Noninvasive hemodynamic assessment with pulmonary pressures and ejection fraction when performed, including passive acquisition of acoustic and electrical signals, augmentative algorithmic analysis, and generation of a clinical report with review, interpretation, and clinical integration by a physician or other qualified health care professional
1037T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant pancreatic tissue, including imaging guidance
1038T	Autologous muscle cell therapy, injection(s) of muscle progenitor cells into the tongue, including esophagoscopy, when performed
1039T	Connectomic analysis of previously performed multi-modal brain magnetic resonance imaging (MRI) requiring physician or other qualified health care professional (QHP) analysis of software- and physician-generated structural and functional maps for integration of cortical grey matter correlation based on resting-state functional MRI and mapping of white matter connectivity based on diffusion-weighted MRI relative to brain regions, with physician or other QHP interpretation and report
1040T	Bronchoscopy, flexible, with bronchial cryotherapy, 1 lung, including trachea, when performed
1041T	Augmentative algorithmic analysis of encephalographic waveforms to identify the source and propagation of epileptiform activity, including artifact reduction with analysis of 3D localization of spike sources throughout the examination, 3D animations over time of high-amplitude event locations, high-frequency activity locations, and temporal relationships among locations, with interpretation and report by physician or other qualified health care professional, related to a previously performed electroencephalogram (EEG)
1042T	Implantation of absorbable urologic scaffold for prostatic urethra restoration of reconstructed bladder neck and urethral anastomosis (List separately in addition to code for primary procedure)

1043T	Quantitative magnetic resonance, without imaging, for analysis of liver tissue, including assessment of 1 or more parameters (eg, proton density fat fraction [PDFF], water diffusion, T1-water relaxation time), with automatically generated report
1044T	Harvest of full-thickness skin for autologous heterogeneous skin-construct graft, including direct closure of donor site; first 5 sq cm or less
1045T	Harvest of full-thickness skin for autologous heterogeneous skin-construct graft, including direct closure of donor site; each additional 5 sq cm, or part thereof (List separately in addition to code for primary procedure)
1046T	Autologous heterogeneous skin-construct graft application, trunk, arms, legs; first 50 sq cm or less, or 0.5% of body area of infants and children
1047T	Autologous heterogeneous skin-construct graft application, trunk, arms, legs; each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
1048T	Autologous heterogeneous skin-construct graft application, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 50 sq cm or less, or 0.5% of body area of infants and children
1049T	Autologous heterogeneous skin-construct graft application, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 50 sq cm, or each additional 0.5% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
1050T	Insertion, subcutaneous heart failure decompensation monitor, containing sensors that measure, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds
1051T	Removal of subcutaneous heart failure decompensation monitor
1052T	Interrogation device evaluation(s), (in person or remote) up to 30 days, insertable subcutaneous heart failure decompensation monitor, analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report, review and interpretation by a physician or other qualified health care professional
1053T	Programming device evaluation (in person or remote) of subcutaneous heart failure decompensation monitor, with analysis of physiologic parameters, including, at a minimum, heart rate, impedance, respiration rate, physical activity, heart sounds, with generation of a report and review and interpretation by a physician or other qualified health care professional

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

Code	Description
0631U	Oncology (solid tumor), DNA, sequence analysis of 15 genes including BRCA1 and BRCA2 for identification of clonal hematopoiesis, blood, reported as tumor-derived or nontumor-derived
0632U	Red blood cell antigen (fetal RhD gene analysis), multiplex polymerase chain reaction (PCR) and next-generation sequencing (NGS) of circulating cell-free

	DNA (cfDNA), plasma from pregnant individuals known to be RhD negative, reported as detected or not detected
0633U	Obstetrics (single-gene noninvasive prenatal test), cell-free DNA (cfDNA), next-generation sequencing (NGS) analysis of 1 or more targets (eg, CFTR, SMN1, HBB, HBA1, HBA2) to identify paternally inherited pathogenic variants and to determine fetal inheritance of maternal mutation, using maternal blood sample, algorithm reported as a fetal risk score
0634U	Oncology (breast cancer), cell-free DNA (cfDNA), evaluation of 11 ESR1 variants (E380Q, S463P, L536R, Y537C, Y537N, Y537S, D538G, V422del, L536H, L536P, Y537D) using droplet digital PCR (ddPCR), plasma, reported as positive or negative
0635U	Autoimmune (atopic dermatitis), mRNA, next-generation sequencing (NGS), gene expression profiling of 487 genes, noninvasive skin-surface scraping, algorithm reported as likelihood of response to therapy
0636U	Babesia (Babesiosis), antibody detection of 20 recombinant protein groups, by immunoassay, IgG
0637U	Babesia (Babesiosis), antibody detection of 20 recombinant protein groups, by immunoassay, IgM
0638U	Bartonella (Bartonellosis), antibody detection of 32 recombinant protein groups, by immunoassay, IgG
0639U	Bartonella (Bartonellosis), antibody detection of 32 recombinant protein groups, by immunoassay, IgM
0640U	Oncology (leptomeningeal metastases), tumor cell selection, identification, detection and enumeration based on differential CD318(CDCP1), SUSD2, CD340(erbB2/HER2), HGFR/cMET, FOLR1, EGFR, N cadherin, MUC1, EpCAM, and TROP2 antibody biomarkers, cerebrospinal fluid, reported as detection and quantification of tumor cells
0641U	Oncology (minimal residual disease [MRD]), tumor DNA, next-generation sequencing (NGS), using formalin-fixed paraffin-embedded (FFPE) tissue and blood samples, initial (baseline) assessment
0642U	Oncology (minimal residual disease [MRD]), tumor DNA, next-generation sequencing (NGS), whole blood, comparison to previously performed analyses, reported as trend in circulating tumor DNA (ctDNA) level
0643U	Oncology (genitourinary cancer), cell-free circulating tumor DNA (ctDNA), 200 genes, next-generation sequencing (NGS), interrogation for single-nucleotide variants (SNVs), insertions/deletions, gene rearrangements, copy number alterations, and tumor mutation burden, using urine, identify and report mutations with clinical actionability
0644U	Oncology (leukemia), minimal residual disease (MRD) detection for rearrangements, blood or bone marrow, personalized assay design and baseline quantification

0645U	Oncology (leukemia), minimal residual disease (MRD) detection for rearrangements, based on digital PCR, blood or bone marrow, reported as not detected or detected with estimated abundance
0646U	Oncology (molecular residual disease), whole genome sequence analysis, cell-free DNA, whole blood, and formalin-fixed paraffin-embedded (FFPE) tumor tissue DNA, baseline assessment
0647U	Oncology (molecular residual disease), whole genome sequence analysis, cell-free DNA (cfDNA), whole blood, assessment utilizing patient-specific tumor information, reported as negative or percent circulating tumor DNA (ctDNA)
0649U	Neurology (Alzheimer disease), DNA, targeted next-generation sequencing (NGS) of AD-1 and AD-2 target regions, whole blood, prognostic algorithmic analysis, reported as categorization of cognitive status
0650U	Drug metabolism (adverse drug reactions and drug response), genotyping of 9 genes (ie, CYP2D6, CYP2C19, G6PD, SLCO1B1, HLA-B*58:01, NAT2, CYP2C9, VKORC1, ABCG2), reported as metabolizer status and transporter function
0651U	Oncology (hereditary cancer), genomic DNA, 55 hereditary cancer pre-dispositioned genes, next-generation sequencing (NGS) and digital multiplex ligation-dependent probe amplification for variants, small indels (<40 base pairs), using saliva, whole blood or nail clipping, interpretive clinical report with variant classification
0652U	Drug metabolism (adverse drug reactions), DNA analysis of 13 genes by targeted genotyping, using saliva or buccal swab, reported as diplotype and metabolizer status
0653U	Nephrology (inherited kidney disorders), DNA, analysis of approximately 700 genes associated with inherited kidney diseases by exome sequencing, using whole blood, saliva, or nail clipping, reported as an interpretive clinical report classifying pathogenic and likely pathogenic variants
0654U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by western blot analysis, using cultured skin fibroblasts, diagnostic qualitative result
0655U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by spectrophotometric kinetic assay, using cultured skin fibroblasts, diagnostic quantitative result
0656U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 1 enzyme complex by radioactive activity assay, using cultured skin fibroblasts, diagnostic quantitative result
0657U	Rare diseases (constitutional/heritable disorders), rapid whole genome sequence analysis of comparator nuclear and mitochondrial DNA by next-generation sequencing (NGS), using blood or buccal sample, relevant variants reported with proband results
0658U	Rare diseases (constitutional/heritable disorders), rapid whole genome sequence analysis of nuclear and mitochondrial DNA by next-generation sequencing (NGS) for single-nucleotide variants (SNVs), insertions/deletions, copy number variants, uniparental disomy, and repeat expansions, using blood or buccal sample, identification and categorization of genetic variants

0659U	Rare diseases (constitutional/heritable disorders), ultrarapid whole genome sequence analysis of nuclear and mitochondrial DNA by next-generation sequencing (NGS) for single-nucleotide variants (SNVs), insertions/deletions, copy number variants, uniparental disomy, and repeat expansions, using blood or buccal sample, identification and categorization of genetic variants
90616	Influenza virus vaccine, trivalent (tIRV), mRNA, 37.5 mcg/0.38 mL dosage, for intramuscular use
90639	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 50 mcg/0.5 mL dosage, for intramuscular use
C1609	Vertebral device, motion-preserving, with screw fixation
G0574	Management of new patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services mush be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)
G0575	Management of established patient with dementia residing in an eligible residential care community, for use only in a medicare-approved cmmi model (services mush be furnished within a patient's eligible residential care community, including assisted living facilities, board and care homes, or other qualifying residential settings where dementia care services are provided)
G0669	Outcome-aligned payment (oap) for technology-enabled chronic care management of early cardio-kidney-metabolic (eckm) conditions (hypertension, or two or more of: dyslipidemia, obesity/overweight with central obesity marker, prediabetes); initial 12-month period; per month
G0670	Outcome-aligned payment (oap) for technology-enabled chronic care management of early cardio-kidney-metabolic (eckm) conditions (hypertension, or two or more of: dyslipidemia, obesity/overweight with central obesity marker, prediabetes); follow-on 12-month period; per month
G0671	Outcome-aligned payment (oap) for technology-enabled chronic care management of cardio-kidney-metabolic (ckm) conditions (one or more of: diabetes mellitus, chronic kidney disease stage 3a or 3b, atherosclerotic cardiovascular disease); initial 12-month period; per month
G0672	Outcome-aligned payment (oap) for technology-enabled chronic care management of cardio-kidney-metabolic (ckm) conditions (one or more of: diabetes mellitus, chronic kidney disease stage 3a or 3b, atherosclerotic cardiovascular disease); follow-on 12-month period; per month
G0673	Outcome-aligned payment (oap) for technology-enabled chronic care management of musculoskeletal (msk) conditions (chronic musculoskeletal pain); initial 12-month treatment period; per month
G0674	Outcome-aligned payment (oap) for technology-enabled chronic care management of behavioral health (bh) conditions (one or more of: depression, anxiety); initial 12-month period; per month
G0675	Outcome-aligned payment (oap) for technology-enabled chronic care management of behavioral health (bh) conditions (one or more of: depression, anxiety); follow-on 12-month period; per month

G0676	Standard co-management service payment for documented review of clinical updates from access participant managing cardio-kidney-metabolic conditions (early cardio-kidney-metabolic [eckm] or cardio-kidney-metabolic [ckm] track); per review
G0677	Standard co-management service payment for documented review of clinical updates from access participant managing musculoskeletal (msk) conditions; per review
G0678	Standard co-management-management service payment for documented review of clinical updates from access participant managing behavioral health (bh) conditions (depression, anxiety); per review
M0231	Intravenous infusion, tocilizumabbavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, includes infusion and post administration monitoring, first dose
M0232	Intravenous infusion, tocilizumabbavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, includes infusion and post administration monitoring, second dose
Q0234	Injection, tocilizumab-bavi, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation only, 1 mg

Payment policies

New policies – Effective September 1, 2026

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

- **Diagnosis Coding** – Policy origination.

Revised policies – Effective September 1, 2026

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

- **Non-Covered Services** – Updated code report (generated 07/02/2026).
- **Preventive Services** – Under Billing/coding guidelines, updated Breast Cancer Screening to include revenue codes, updated Abdominal Aortic Aneurysm (AAA) Screening to include coverage guidance and ICD-10-Diagnosis codes, updated Chlamydia and Gonorrhea Screening to include coverage guidance and ICD-10-Diagnosis codes, added new section for High-Intensity Behavioral Counseling to Prevent STIs for Fallon Medicare Plus, NaviCare and PACE Members, updated Tobacco Cessation Counseling to include coverage guidance and ICD-10-Diagnosis codes.
- **Early Intervention** – Under Policy, Guidelines for coverage of ABA services under early intervention (also referred to as EIBI), added Down Syndrome as a covered diagnosis effective January 1, 2026, under Billing/coding guidelines, updated instructions for billing for telehealth services.
- **Adult Day Health** – Updated reimbursement and billing/coding guidelines; removed telehealth provisions no longer applicable due to the end of the COVID-19 public health emergency).
- **Physical and Occupational Therapy Services** – Under Policy, updated extension of CMS flexibilities permitting physical therapists and occupational therapists to provide telehealth services through December 31, 2027; under Reimbursement, removed Multiple Procedure Payment Reduction for Outpatient Therapy Services, which is not being implemented at this time; updated Referral/notification/prior authorization requirements.
- **Speech-Language Therapy Services** – Under Policy, updated extension of CMS flexibilities permitting physical therapists and occupational therapists to provide telehealth services through December 31, 2027; under Reimbursement, removed Multiple Procedure Payment Reduction for Outpatient Therapy Services, which is not being implemented at this time; updated Referral/notification/prior authorization requirements.
- **Community Health Centers** – Under Reimbursement, added new sections for CPT/HCPCS codes 92137, 93896, T1023, V2600, V2610, V2615 and V2799; added new section for synchronous audio-video and audio-only telehealth visits using CPT codes 98000-98015 and brief synchronous communication (CPT 98016). ■

Medical policies

New policy – Effective July 1, 2026

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

- **Renal Denervation for Uncontrolled Hypertension**

Revised policies – Effective May 1, 2026

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

- **Autologous Chondrocyte Implantation**
- **Balloon Sinus Ostial Dilation**
- **Hip Arthroscopy for Femoroacetabular Impingement**
- **Lung Transplantation**
- **Bone-Anchored Hearing Aids**

Revised policies – Effective June 1, 2026

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

- **Fecal Microbiota Transplantation**
- **Varicose Veins of the Lower Extremities**
- **Zolgensma (onasemnogene abeparvovec-xioi)**
- **Skilled Nursing Facility Level of Care**
- **Hearing Aids for Community Care Members 21 Years of Age and Younger**
- **Radiofrequency Ablation of Uterine Fibroids**

Revised policies – Effective July 1, 2026

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

- **Luxturna (voretigene neparvovec-rzyl)**
- **Sacroiliac Joint Fusion**
- **Transurethral Waterjet Ablation of Prostate**
- **Corneal and Scleral Contact Lenses**
- **Urine Drug Testing**
- **Hospital Beds with Added Safety Enclosure**

Retired policy – Effective July 1, 2026

The following policy has been retired; details about the changes are indicated on the policies.

- **Fecal Calprotectin Testing** ■

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 1 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 2027. 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.

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