October 2024

Connection

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Important updates

A candid conversation about health care with the LGBTQ+ community

Fallon Health was proud to participate in Pride Worcester, an annual event that celebrates diversity and promotes inclusivity. As we live our mission—*improving health and inspiring hope*—it's important to listen and learn from the LGBTQ+ community directly. And our question—***"How can your health care providers make you feel more welcome or be more inclusive?"***—sparked valuable conversations with attendees who visited our table. With over 60 responses gathered, key themes included the need for providers to:

- Avoid assumptions and ask for pronouns
- Show respect for boundaries, feelings, and identities
- Provide privacy by asking parents to step out
- Ensure gender-inclusive bathrooms in offices
- Truly listen to patients and take concerns more seriously

These insights are being shared with Fallon Health leadership to spark deeper discussions and make real changes for our members and the communities we serve. By attending events like Pride, we're able to stay connected while working towards creating a more inclusive health care environment for all. ▮

Fallon Health HQ is moving

Fallon Health is moving its headquarters to 1 Mercantile Street in Worcester. The move will provide the organization with the space and resources it needs to accommodate its modern workforce and to support future business expansion. The move is scheduled to be completed by the end of October 2024. ▮

Prohibition on billing Medicare-Medicaid enrollees for Medicare cost-sharing

We remind all providers of the federal law which bars Medicare providers from collecting coinsurance or copayments from those enrolled in Qualified Medicare Beneficiaries (QMB) programs. Providers must either accept Fallon Health's payment as payment in full or bill MassHealth (Medicaid) for applicable QMB members.

Effective January 1, 2025, Fallon Medicare Plus™ QMB members' ID cards will reflect the same member cost share as non-QMB eligible members. Providers may use the following tools to confirm information regarding QMB members:

- Providers using the Fallon Health eligibility look-up tool will see this newly added language: "Qualified Medicare Beneficiaries (QMB): QMB status will not be reflected on Fallon Health member ID cards. Please review your records to ensure the patient responsibility amount is billed to MassHealth and not wrongfully collected."
- Providers using the 271-eligibility file will see the following messaging: EB*1*FAM*1*QM*PROGRAM NAME, example: EB*1*IND*1*QM*Medicare HMO
- Call into Fallon Health's provider service line to verify eligibility at 1-866-275-3247, prompt 1.

Future enhancements to Fallon Health's Provider Remittance Advice Statements and eligibility verification tools to identify QMB status are planned for release in the second quarter of 2025. ▮

What's new

Changes to prior authorization requirements

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

What you need to know:

- Providers must submit authorization requests in advance to ensure an authorization decision is received prior to the service date.
- If a prior authorization is not obtained in advance of the service, the claim will be denied.
- A provider appeal will only be granted for extenuating circumstances, such as an enrollment/eligibility mismatch or technology malfunctions.
- In the rare instance that a prior authorized surgical code needs to be changed or amended after the surgery, the provider appeal process should be utilized.

- For a continuation of services such as DME, or infusion, providers should submit additional clinical information prior to future service dates for authorization of continued services.
- Home care, oxygen services, hospice, and non-emergency transportation are currently excluded from this change to the prior authorization requirements. Please continue to follow the current process.
- Urgent and emergent inpatient admissions are excluded from this change to the prior authorization requirements.
- Our vendor partners are also making this change.

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

New Medicare Prescription Payment Plan—starting in 2025!

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

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

This applies to Fallon Health members in:

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

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

Annual Behavioral Health Wellness Examination

An annual Mental Health Wellness Examination is a new benefit available to members of MassHealth ACO plans and NaviCare®, effective July 1, 2024. The benefit became available to Community Care members on February 15, 2024.

A member can receive an annual Mental Health Wellness Examination from either a primary care provider or a behavioral health provider. The member may receive only one examination annually, but they can receive that examination from either type of provider.

An annual Mental Health Wellness Examination is intended to be a comprehensive mental health screening which is a separate service from an annual physical examination. The legislation that created the benefit defines an annual Mental Health Wellness Examination as follows:

- a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include:

- observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication; and
- age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews, and questions.

For Community Care, providers should bill using procedure code: 90791 (An integrated biopsychosocial assessment, including history, mental status and recommendations)

- **Diagnosis code: Z13.30 –** Encounter for screening examination for mental health and behavioral disorders, unspecified
- **Modifier: 33 –** to make clear that the evaluation is for preventive purposes and not an initial evaluation due to a particular presenting issue/illness, and to indicate that it is a service that is generally not subject to cost-sharing

For MassHealth ACO and NaviCare, providers should bill using:

- **Procedure code: 90791 –** Psychiatric diagnostic evaluation (An integrated biopsychosocial assessment, including history, mental status, and recommendations).
- **Primary diagnosis code: Z13.30 –** Encounter for screening examination for mental health and behavioral disorders, unspecified.

Providers must not use modifier 33 for claims billed to MassHealth or any MassHealth plan. Modifier 33 is a commercial modifier used in claims billed to commercial payers and is not recognized by the Centers for Medicare & Medicaid Services (CMS).

An annual Mental Health Wellness Examination is covered with no cost-sharing for all MassHealth ACO and NaviCare members, and for most Community Care members except Low Silver HSA plans. For Low Silver HSA members, an annual Mental Health Wellness Examination is subject to the deductible, then covered with no cost-sharing once the deductible has been met.

Magellan Rx Management name change

Magellan Rx Management is now Prime Therapeutics Management. The Medical Pharmacy portal URL has changed to *GatewayPA.com*. Please be sure to bookmark this new URL.

Please note: You do not need to register again to access the portal. Your current username (email address) and password will remain valid.

If you have any questions, please contact: *ProviderInquiry@PrimeTherapeutics.com*.

Fallon Health Medical Pharmacy Drug Wastage Program

Beginning February 1, 2025, for our Community Care and MassHealth ACO members, we will be partnering with Prime Therapeutics Management to launch a medical drug wastage program. As part of the prior authorization process, Prime Therapeutics Management will require dose rounding for infused drug products to the nearest lowest vial size if within +/- 10% of the original prescribed dose ("the Recommended Dose"), unless the following ***medical necessity*** criteria are met:

- Provider indicates the recommended dose may result in a suboptimal outcome due to one of the following:
  - Member's age is less than 18 years.
  - Member is partially responsive to the original prescribed dose.
  - Member previously demonstrated a suboptimal response to a lower rounded down dose.
  - Member has a history of rapidly fluctuating body weight (i.e., weight gain of at least 10% body weight in a one-month period within the past 6 months).
  - Member is clinically unstable and at high risk for hospitalization if the requested medication produces a suboptimal response.
  - Member is being treated for an oncology indication with a curative goal (i.e. adjuvant, neoadjuvant).
  - Member's laboratory values indicate that a dose reduction will result in a suboptimal response.
- All other reasons not referenced in this policy are **not considered medically necessary.**

The following drugs require dose rounding (i.e., reduction) for infused drug products to the nearest lowest vial size if within +/- 10% of the original prescribed dose.

This medical policy will apply to the following drugs:

Code	Drug
J9264	Abraxane
J3262	Actemra IV
J0791	Adakveo
J9042	Adcetris
J0172	Aduhelm
J9305	Alimta
Q5126	Alymsys
J9118	Asparlas
J1426	Amondys-45
J9035	Avastin
J0881	Aranesp
Q5121	Avsola
J9999	Avzivi
J9032	Beleodaq
J0490	Benlysta IV
J9039	Blincyto

Code	Drug
J9046	Bortezomib
J9048	Bortezomib
J9049	Bortezomib
J9051	Bortezomib
J9064	Cabazitaxel
J2786	Cinqair
J1448	Cosela
J9308	Cyramza
J9348	Danyelza
J9145	Darzalex
J9063	Elahere
J9269	Elzonris
J9176	Empliciti
J9358	Enhertu
J9055	Erbitux
J1305	Evkeeza

Code	Drug
J1428	Exondys-51
J0641	Fusilev
J9331	Fyarro
J0223	Givlaari
J1447	Granix
J0599	Haegarda
J9179	Halaven
J9355	Herceptin
J9999	Hercessi
J9347	Imjudo
Q5103	Inflectra
J9198	Infugem
J9043	Jevtana
J9354	Kadcyla
J0642	Khapzory
J9047	Kyprolis
J0174	Leqembi
J3263	Loqtorzi
J9313	Lumoxiti
J9353	Margenza
J0888	Mircera
J9349	Monjuvi
Q5107	Mvasi
J1442	Neupogen
Q5110	Nivestym
J2796	Nplate
J9205	Onivyde
J0222	Onpattro
J0224	Oxlumo
J9258	Paclitaxel Albumin-Bound
J9259	Paclitaxel Albumin-Bound
J9177	Padcev
J0208	Pedmark
J9322	pemetrexed (bluepoint)
J9297	pemetrexed (Sandoz)
J9314	pemetrexed (Teva)
J9323	pemetrexed ditromethamine (Hospira)
J9296	pemetrexed (Accord)
J9294	pemetrexed (Hospira)
J9297	pemetrexed (Sandoz)
J9999	pemetrexed (Zydus)

Code	Drug
J9324	Pemrydi RTU
J9309	Polivy
J9204	Poteligeo
J0885	Procrit/Epogen
J0896	Reblozyl
Q5125	Releuko
J1745	Remicade
Q5104	Renflexis
Q5106	Retacrit
Q5123	Riabni
J9312	Rituxan
J0596	Ruconest
Q5119	Ruxience
J9021	Rylaze
J9227	Sarclisa
J1602	Simponi_ARIA
J2860	Sylvant
J9262	Synribo
J3055	Talvey
J9022	Tecentriq
J9380	Tecvayli
J3241	Tepezza
J9273	Tivdak
Q5133	Tofidence
J9033	Treanda
J9317	Trodelvy
Q5115	Truxima
J3590	Tyenne IV
J9381	Tzield
J9999	Unituxin
J9303	Vectibix
Q5129	Vegzelma
J1427	Viltepso
J1429	Vyondys-53
J9228	Yervoy
J9352	Yondelis
J9400	Zaltrap
Q5101	Zarxio
J9223	Zepzelca
Q5118	Zirabev
J9359	Zynlonta

Fallon Health MassHealth ACO pharmacy formulary updates

Updates are effective October 1, 2024, for Fallon Health's MassHealth ACOs—Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative.

Guidelines	Guideline update description
Acute lymphoblastic leukemia, single agent therapies	• Besponsa CU: expanded age to pediatric patients ≥ 1 year of age
Anesthetics – topical	• QA: add lidocaine OTC 4% patches as covered; Ztlido CU - to include lidocaine 4% patch as LCA
Angiogenesis inhibitors	• QA: Dx of cervical cancer CU: add paclitaxel and carboplatin as LCA option • Avastin CU for dx of HCC – remove Child Pugh Class A • Cyramza CU for dx of NSCLC – remove used in combination with Tagrisso and add Tagrisso and Vizimpro as LCA option
Anti-acne and rosacea products	• Anti-Acne and Rosacea QA: add Cabtreo requiring PA following PA criteria for Combination Topical Agents, Update age limit to oral and topical retinoid agents (isotretinoin, tretinoin) and one sulfacetamide agent to PA required for ≥21 years of age; Criteria update to oral isotretinoin agents (regarding diagnosis and acceptable trials); Add Atralin, Cleocin T lotion, Fabior, Onexton gel pump and Retin -A Micro to BOGL
Antibiotics – oral	• Antibiotics Oral QA: add non-rebate criteria to Xenleta (currently non rebate), Add Tetracycline 250 mg and 500 mg tablets to PA; CU for Xifaxan for diagosis of SIBO to align with consensus guidelines; CU to Likmez
Antibiotics – vaginal	• Add Vandazole to PA matching criteria with other branded products
Anticonvulsants	• Update appendix for new PBHMI rule verbiage QA: • Add Libervant to PA within age and QLs; add Xcopri 25 mg strength to PA; Xcopri CU for off-label peds dx - remove age criteria; remove POS for Lamictal XR and Lamictal ODT for stability; Briviact vial, Cerebyx, Vimpat vial, Keppra injection, valproate injection, phenobarbital injection updated to MB; Diastat brand name obsolete; Qudexy XR added to BOGL
Antiretroviral agents	• Add PA to fosamprenavir; remove Selzentry from BOGL; remove obsolete agents: Invirase (saquinavir), Norvir (ritonavir solution), brand Sustiva, Temixys
Atidarsagene autotemcel (Lenmeldy)	• NDR: add Lenmeldy to PA, CO, MB
Benzodiazepines and other antianxiety agents	• Add flurazepam with PA criteria matching current quazepam criteria, remove flurazepam trial from current Quazepam criteria and from Restoril (temazepam 2.5 mg); CU for Benzo polypharmacy for Sleep diagnosis

Guidelines	Guideline update description
Brand name and non-preferred generic drugs	• Remove Selzentry from BOGL • Quarterly anticipated generics document: add Nucynta, Nucynta ER, Finacea (azelaic acid foam), Horizant (gabapentin), Complera (emtricitabine, rilpivirine, tenofovir) to BOGL; remove Xerese from BOGL Remove Onglyza from BOGL per RB email confirmation Add Olux- E to BOGL Remove Bystolic from BOGL, add # Derm QA reviewed/ approved by JB email 6/25/24; add Condylox gel to BOGL
Complement inhibitors and miscellaneous immunosuppressive agents	• Voydeya NDR: add Voydeya to PA • CU for all complement inhibitors – remove meningococcal vaccine requirement; also remove this requirement from stability criteria • Ultomiris new approved indication for NMOSD • Soliris CU for NMOSD – add Ultomiris as step through trial • Add Fabhalta to PA • Empaveli CU for PNH – add criteria points for: name of diagnosis, prescriber specialist, LCA with Soliris or Ultomiris • Add Zilbrysq to PA (for gMG diagnosis criteria) • Approval criteria update for gMG: add criteria point requiring severe disease or trial of IVIG or plasmapheresis with glucocorticoids
Corticosteroids – topical	• Capex (fluocinolone) shampoo (non- rebate) add into criteria with other scalp agents in the guideline (agent currentl; Remove PA requirement for: Olux-E® (clobetasol propionate) 0.05% emulsion foam, Desonide lotion, 3) hydrocortisone valerate ointment; Add Olux- E to BOGL
COVID-19 treatments and prophylaxis	• Lagevrio NDR: add Lagevrio to PA with QL; add QL to Paxlovid • Pemgarda NDR: add Pemgarda to PA and MB
Dermatological agents (Topical chemo/genital wart therapy)	• Condylox® (podofilox) 0.5% gel add to BOGL; PA criteria added to the MHDL for both Ameluz® and Levulan Kerastick®
Duchenne muscular dystrophy disease modifying agents	• Elevidys CU
Enfortumab vedotin-ejfv (Padcev)	• Criteria update: Keytruda/Padcev for Ulcerative Colitis
Erythropoiesis-stimulating agents (ESAs)	• QA: Remove Epogen step through requirement for Retacrit, add Retacrit as a step through requirement for Procrit® in addition to Epogen
Gamma-aminobutyric acid (GABA) analogs	• Add Horizant to BOGL GABA analogs QA: remove Horizant from PA; Gralise CU to include Horizant as LCA Anticonvulsants QA - move Lyrica and Gabapentin into GL
Glycopyrrolate agents	• CU: remove step through Dartisla from Cuvposa , add brand Robinul and Robinul Forte

Guidelines	Guideline update description
GnRH analogues	• QA: Add leuprolide 22.5 mg vial to PA with dx of advanced prostate cancer, GID • And Lupron depot ped 45 mg to PA with dx of CPP, GID • Fensolvi and Supprelin LA changed to MB • Dx of advanced prostate cancer, GID, ovarian suppression/preservation CU – Lupron to include clinical rationale for use instead of Eligard • Dx of advanced prostate cancer CU – Orgovyx to include step through Eligard
Immune globulin	• Add Alyglo (non-rebate) requiring PA
Isocitrate dehydrogenase (IDH) inhibitors	• Criteria update for Tibsovo (ivosidenib): add approval criteria for the expanded indication for MDS
Lung cancer agents	• Lung cancer update: CU for Tagrisso for diagnosis of Adjuvant Treatment for Stage IB to IIIA NSCLC, add criteria for expanded indication of First-Line Treatment of Locally Advanced or Metastatic NSCLC, CU for Rybrivant for expanded labeling, CU for Alecensa: add criteria for expanded indication of non-small cell lung cancer
Oncology immunotherapies	• Criteria updates for: Keytruda for cervical cancer, Opdivo for UC, Opdivo/ Keytruda for HCC.
Oncology interferon agents	• Criteria update for Besremi based on NCCN recommendations
Opioid dependence and reversal agents	• CU for Brixadi, CU for Opvee to include quantity limits, remove PA for ≤ 24 mg/day for buprenorphine/naloxone tablets; update to account for accumulated doses within dose limits; CU to buprenorphine high dose
Pediatric Behavioral Health Medication Initiative (PBHMI)	PBHMI QA • Criteria updates to the following sections: antipsychotic polypharmacy, antidepressant polypharmacy, mood stabilizer polypharmacy, benzodiazepine polypharmacy, drugs in member less than 6 years of age, Atomoxetine or Qelbree (viloxazine) in member <6 years of age, Cerebral stimulant or alpha2 agonist medication in member <3 years of age, and Hypnotics (both types, two different criteria sets) in member <6 years of age. • Change cutoff for PA for new start on antipsychotics to <10 years of age; criteria update. • Add prazosin to PBHMI for interclass polypharmacy and in members <6 years of age. Prazosin will not require PA if outside of the age restriction or as an individual agent. • Change current 4+ polypharmacy rule to: 4+ polypharmacy only if one of the agents is: antipsychotic, benzo, divalproex/valproate, lithium, or TCA; 5+ polypharmacy for any agents designate Aptiom as seizure-only med Antidepressant QA: add Aplenzin to PA, add amoxapine to PA, remove Pexeva as drug obsolete Antipsychotics QA: remove lurasidone and paliperidone tablets from PA, manage with QL only; increase QL for risperidone tablets and olanzapine tablets

Guidelines	Guideline update description
Pulmonary hypertension (PH) agents	• Winrevair NDR add requiring PA QA: add Opsynvi to PA
Resmetirom (Rezdiffra)	• NDR: add Rezdiffra to PA
Rituximab agents	QA: • Include DLBCL, BL, and BLL as part of diagnosis • Dx of pediatric NHL and B-AL – remove requested agent will be used in combination with LMB
RSV prophylaxis agents	• QA; Synagis CU for all indications to require step through with Beyfortus; Synagis verbiage update
Targeted immunomodulators	• NDR; add Omvoh to PA;
Thrombocytopenic agents	• Alvaiz NDR: add to PA; CU to Doptelet, Nplate and Tavalisse - update LCA verbiage of Promacta to eltrombopag to allow trial of Alvaiz
Topical hyperhidrosis agents	• Adjust the PA criteria of Qbrexza® to clearly identify that Botox® can be bypassed in certain situations due to the invasiveness of the treatment
Vaccines	• RSV clinical update: add mRESVIA - PA < 60 years of age; expanded indication for Arexvy expanding use in adult patients 50 to 59 years of age

CU = criteria update **DX** = diagnosis **NDR** = new drug review **PA** = prior authorization
LCA = lower cost alternative **QA** = quality analysis **BOGL** = brand over generic list
MB = medical benefit

Product spotlight

NaviCare – Model of Care training

NaviCare utilizes both Medicare and Medicaid covered benefits and services to help our members function at the safest level in the most appropriate setting. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. Eligible members cannot have any other comprehensive health insurance, except Medicare. NaviCare is available in every county in Massachusetts, except for Nantucket and Dukes.

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

NaviCare benefits that all members receive include:*

- Unlimited transportation to medical appointments. And, 130 one-way trips per calendar year to other locations including grocery stores, fitness facilities, religious services, homes of family or friends, and more, within a 30-mile radius of the member's home. Transportation should be arranged 2 business days in advance by calling our transportation vendor, Coordinated Transportation Solutions (CTS), at 1-833-824-9440. The member or caregiver can arrange transportation. Fallon Health Navigators are also available to assist. Members' friends and family can receive reimbursement for mileage of pre-approved rides.
- Up to $400 per year in fitness reimbursements for new fitness trackers, like a Fitbit or Apple Watch, and/or a membership in a qualified health club or fitness facility.
- Up to $1,100 per year on the Save Now card, to purchase health care items. Purchases can be made at stores like CVS Pharmacy, Family Dollar, and Walmart, or by phone or online with free home delivery.
- Outpatient behavioral health services (Covered through our contracted providers. No authorization required.)
- Covered prescription drugs and certain approved OTC drugs and items. Members may receive a 100-day supply of medications via mail order.
- Vision care and eyeglasses ($403 annual eyewear allowance, up to 2 pairs of glasses per year)
- Hearing aids (and batteries)
- Dental care, including dentures. For comprehensive dental, including endodontics, extractions, oral surgery services in a provider's office (except for the removal or exposure of impacted teeth), periodontics, prosthodontics, restorative services, and other oral/maxillofacial surgery services to be covered, the member's doctor or other plan provider must get prior authorization (approval in advance) from the plan. 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, up to $900. (Prior authorization for medical necessity is required.)
- Diabetic services and supplies. In addition to Freestyle Libre monitors, additional glucometers may be covered. (Previously, only Freestyle Libre monitors were covered). Also, Medtronic non-therapeutic or adjunctive continuous glucose monitors may be obtained at network DME providers.
- An entire Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as coordinated care plans to reference and other Care Team members to communicate with to have the best information possible for each NaviCare patient.

** Benefit amounts are effective January 1, 2025.*

Care Team members and their roles include:

Navigator

- Educates patients about benefits and services
- Educates patients about—and obtains their approval for—their care plan
- Assists in developing patient's care plan
- Helps patients make medical appointments and access services
- Informs Care Team when patient has a care transition

Nurse Case Manager or Advanced Practitioner

- Assesses clinical and daily needs
- Teaches about conditions and medications
- Helps patients get the care they need after they're discharged from a medical facility

Primary Care Provider (PCP)

- Provides overall clinical direction
- Provides primary medical services including acute and preventive care
- Orders prescriptions, supplies, equipment, and home services
- Documents and complies with advance directives about the patient's wishes for future treatment and health care decisions
- Receives patient's care plan and provides input when needed

Geriatric Support Services employed by local Aging Service Access Points (ASAPs)
(if patient is living in own home)

- Evaluates need for services to help patients remain at home and coordinates those services
- Helps patients with MassHealth paperwork
- Connects patients with helpful resources

Behavioral Health Case Manager *(as needed)*

- Identifies and coordinates services to support patients' emotional health and well-being
- Supports your patients through transition to older adulthood
- Helps connect patients with their Care Team, and patients' behavioral health providers and substance-use counselors, if present

Clinical pharmacist *(as needed)*

- Visits patients after care transition to perform a medication reconciliation and teaches them proper medication use.

PCPs are welcome to provide input to their patient's care plan at any time by contacting the NaviCare Enrollee Service Line at 1-877-700-6996 or by speaking directly with the NaviCare Navigators and/or Nurse Case Managers who may be embedded in your practices. If you are interested in having a Navigator and/or Nurse Case Manager embedded in your practice, please contact us at 1-877-700-6996.

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

NaviCare – Model of Care Success

Fallon Health care transition support

After a member is discharged from the hospital or a skilled nursing facility, our NaviCare Transition of Care (TOC) Nurse Case Managers (NCM) ensure a smooth transition back to the community. This proactive approach helps prevent fragmented care and avoidable hospital readmissions.

Within 7 days of discharge, the TOC NCM completes an assessment, followed by additional outreach from the member's Navigator 2 weeks later to ensure proper recovery. This assessment focuses on key elements such as Primary Care Provider (PCP) follow-up and medication reconciliation, supporting members through their recovery process.

Recently, we assisted a member with end-stage COPD who had frequent hospital visits due to exacerbations. During TOC outreach, our NaviCare TOC NCM discussed the member's quality of life and care goals. The member wished to remain comfortable at home. By coordinating with the member, her family, her primary care provider, and our NaviCare team, we facilitated hospice care, allowing her to stay home, surrounded by loved ones, without frequent hospital trips.

Some members with frequent ER visits or hospital stays lack adequate support systems, knowledge, or have untreated mental illnesses. Our transition team collaborates with members to identify their care goals and motivate them to make and adhere to plans to better achieve these goals.

One member, facing mental illness, loneliness, and a new diagnosis, received comprehensive support and education from our transition team. The TOC NCM emphasized crucial lifestyle changes, helped schedule follow-up medical appointments, and involved our behavioral health case manager. Consequently, the member accepted a medication dispenser to improve compliance. Additionally, to assist with caring for his three cats and reduce fall risk, the team arranged a heavy chore service to declutter and clean his home.

Our transition team takes great satisfaction in helping members optimize their health outcomes, reduce avoidable disruptions, and achieve their goals. ▮

Important reminders

CAQH directory updates

Fallon Health partners with Health Care Administrative Solutions (HCAS) and uses the Council for Affordable Quality Healthcare (CAQH) Directory Management system for validation of provider directory information. Providers (or an authorized person on their behalf) should be using the CAQH Directory Management system and attesting to your information regularly—every 90 days.

Fallon Health can receive your CAQH directory information automatically. We encourage you to make demographic updates directly in CAQH in lieu of sending faxes and emails. This will save time and allow your information to be updated in our system faster and in a more automated manner.

Demographic updates include:

- Practice address
- Phone number
- Fax number
- Panel status

Exceptions:

- "Pay to"/Type 2 NPI updates (these require an updated W-9)
- New providers (these require an HCAS form with appropriate supporting documentation)
- Specialty updates

New information

Within the next several weeks, should Fallon Health receive information that is part of the above exceptions list, you will receive an email from us explaining what is needed to process your request. The email will go to the CAQH user who made the update. It will be that person's responsibility to ensure the supporting documentation is subsequently sent to Fallon Health. Without this supporting documentation the update will not be made.

For CAQH training and user guides please use this *link*.

If you are unable to use the CAQH Directory Management system, any forms or updates sent to Fallon Health should be emailed to *providerdataupdates@fallonhealth.org*.

If you have any questions, please contact your Provider Relations Representative. ▮

Reducing instances of foregone care for Community Care members

Fallon Health's Community Care plans include preventive care with no member cost sharing. Patients can make the most of their plan with regular checkups and screenings for things like breast cancer, cervical cancer, and colon cancer. If you have patients interested in learning more about their preventive care with no member cost sharing, they can call Fallon Health's Customer Service at 1-800-868-5200 (TRS 711) to get more information. ▮

Botox coding reminder

Coding reminder due to MassHealth identification of providers billing Botox Cosmetic NDCs.

Fallon Health does not cover the use of Botox (onabotulinumtoxinA) for cosmetic procedures. All providers are reminded to NOT use National Drug Codes (NDCs) that are established by the FDA for Botox Cosmetic.

Do not use: BOTOX Cosmetic (onabotulinumtoxinA) single-dose vial in the following sizes: 50 Units: NDC 0023-3919-50 100 Units: NDC 0023-9232-01

Fallon Health does cover Botox for chronic migraine or spastic related disorders as defined in our "Drugs and Biologic payment policy". The "Post-Service Claims Edit (PSCE) payment policy" for Botox Medical can be found under the Medical Pharmacy Formulary on *fallonhealth.org*.

The correct NDCs associated with Medical Botox administration (J0585) BOTOX (onabotulinumtoxinA) are: single-dose vials (100 Units) NDC 0023-1145-01 and (200 Units) NDC 0023-3921-02. All other coding requirements must be met for payment. ▮

Medication Therapy Management at Community Health Centers

If community health centers are providing Medication Therapy Management to NaviCare members using CPT codes 99605, 99606, or 99607, the pharmacist must be enrolled with Fallon Health. ▮

MassHealth regulations with the 340B Drug Pricing Program

In accordance with MassHealth Managed Care Entity Bulletin 114, and consistent with the policies outlined in MassHealth All Provider Bulletin 366 and All Provider Bulletin 390, providers must ensure that any high-cost drugs (list below) which are authorized by the plan and dispensed to a MassHealth ACO member, shall not be sourced from the purchased 340B Drug Pricing Program supply.

If, and to the extent, that the provider is not responsible for the invoice cost of the high-cost drug, Fallon Health will not be responsible for payment of the invoice cost of such drug. Separate reimbursement for the drug, is subject to the provider being charged for and paying for the product. Proof of purchase and incurred cost for the drug product shall be provided by the provider upon request from Fallon Health. A drug product invoice from the manufacturer shall serve as proof of purchase and incurred cost for the product.

- Abecma (idecabtagene vicleucel)
- Breyanzi (lisocabtagene maraleucel)
- Carvykti (ciltacabtagene autoleucel)
- Hemgenix (etranacogene dezaparvovec)
- Kymriah (tisagenlecleucel)
- Luxturna (voretigene neparvovec)
- Skysona (elivaldogene autotemcel)
- Tecartus (brexucabtagene autoleucel)
- Yescarta (axicabtagene ciloleucel)
- Zolgensma (onasemnogene abeparvovec-xioi)
- Zynteglo (betibeglogene autotemcel) ▮

Doing business with us

Ordering provider reminder

It is essential that when ordering, providers are aware of covered lab codes and those that require prior authorization. As previously mentioned, there will be no retrospective authorization allowed after January 1, 2025. This includes any laboratory testing that requires prior authorization such as genetic testing.

Please note CPT code 80050, General Health Panel, is not covered for Fallon Medicare Plus and Community Care, effective January 1, 2025. Please refer to the Medicare physician fee schedule for the appropriate specific test to order. ▮

Quality Focus

Disease Management Program empowers your patients

The Fallon Health Disease Management Program is a proactive, patient-centered program for individuals diagnosed with chronic diseases—including asthma, diabetes, chronic obstructive pulmonary disease (COPD), cardiac disease or heart failure. It reinforces standards of care by providing health education, health coaching, and self-management skills. We work toward empowering your patients to take a more active role in improving and maintaining their health.

We welcome referrals for your patients, our Fallon Health members, to our Disease Management Program and look forward to working with you. For more information or to make a referral, please call our team at 1-800-333-2535, ext. 69898, Monday through Friday from 8:30 a.m. to 5 p.m. You also may use our *Disease Management/Health Promotions Referral Form*.

Access to complex case management

Another program we offer to your patients who need a lot of care and resources is the Complex Case Management Program. You may refer a patient to this program if they have a "critical event or diagnosis"—for example, a car accident, a fall that results in serious injury, cancer, or serious health decline. We'll do a brief assessment to confirm eligibility.

Our nurse case managers and social workers coordinate their care in collaboration with caregivers and you. We want to help ensure that your patients receive all the appropriate services and have access to all the resources needed to resolve their health issues in the best way possible.

For more information, or to ask about enrolling in the program, you may call us at 1-800-333-2535, ext. 78002 (TRS 711), Monday–Friday, 8:30 a.m.–5:00 p.m. Or you may use our *Case Management Referral Form*.

Thank you for your referrals.

Important links to information about care

Our Clinical Practice Guidelines are available *here*.

We hope you'll take the time to explore the guidelines on *fallonhealth.org* to learn how we work with you and your patients to ensure the quality and safety of clinical care. If you'd like to receive a copy of this information, please call Provider Relations at 1-866-275-3247, option 4.

- **Clinical criteria for utilization care services.** Fallon Health uses national, evidence-based criteria reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care. Criteria are available *here* or as a paper copy upon request.

- **Learn more about our quality programs.** Fallon Health is proud of its long history of quality accomplishments, including our accreditation from the National Committee for Quality Assurance. A detailed description of our quality programs, goals, and outcomes is available *here*. We also welcome suggestions from our physicians about specific goals or projects that may further improve the quality of our care and services.
- **Know our members' rights.** Fallon Health members have the right to receive information about an illness, the course of treatment, and prospects for recovery in terms that they can understand. They have the right to actively participate in decisions regarding their own health and treatment options, including the right to refuse treatment. View a complete list of *Fallon Health members' rights and responsibilities*. ▮

Utilization Management (UM) incentives

Fallon Health affirms the following:

- Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage.
- Fallon Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization. ▮

Practitioner rights

Practitioners have the right to review information submitted to support their credentialing application unless the disclosure of certain information or the source of information is prohibited by law, contract, or agreement with the entity that provided the information to Fallon Health. They also have the right to correct erroneous information submitted by another party for use in the credentialing process and receive the status of their credentialing or recredentialing. ▮

Coding Corner

Correction

We incorrectly indicated that the following codes would be *deny vendor liable* for NaviCare in the April Connection newsletter. Please note we have made corrections, and these codes remain covered services for NaviCare. All claims were reprocessed accordingly. These codes will continue to be *deny vendor liable* for Fallon Medicare Plus due to the Medicare Physician Fee Schedule Status Indicator I (not valid for Medicare purposes).

Code	Description
H0004	Alcohol and/or drug services
H0005	Alcohol and/or drug services
H0006	Alcohol and/or drug services
H0010	Alcohol and/or drug services

Code	Description
H0011	Alcohol and/or drug services
H0015	Alcohol and/or drug services
H0019	Alcohol and/or drug services
H0033	Oral med adm direct observe
H0046	Mental health service, nos
H2011	Crisis interven svc, 15 min
H2012	Behav hlth day treat, per hr
H2015	Comp comm supp svc, 15 min
H2016	Comp comm supp svc, per diem
H2036	A/d tx program, per diem
H0018	Alcohol and/or drug services ▮

Medicare MS-DRG annual update

Medicare MS-DRG V34 fee schedule of weights is effective October 1, 2024. For a list of new and invalid MS-DRG codes, effective for dates of service on or after October 1, 2024, please visit *CMS.gov*. ▮

ICD-10-CM and ICD-10-PCS annual code update

The annual update of the ICD-10-CM diagnosis and ICD-10-PCS procedure codes is effective October 1, 2024. An ICD-10-CM diagnosis code is required on all paper and electronic claims billed to Fallon Health. For a list of new and invalid ICD-10-CM and ICD-10-PCS codes, effective for dates of service on or after October 1, 2024, please visit *CMS.gov*. ▮

Documentation specificity

ICD-10 diagnosis codes must be reported to the greatest degree of specificity. To accomplish this goal, documentation should be as specific as possible.

If you mean…	Don't say…
Chronic obstructive asthma with acute exacerbation	COPD
Hypertensive heart disease with heart failure	Heart failure Hypertension
Lung cancer with metastasis to liver	Lung cancer Liver cancer
Alcohol dependence	Alcohol abuse
Dominant side hemiplegia due to CVA	History of CVA Hemiplegia
Diabetes with complications (Neuropathy, CKD, Skin Ulcer, etc.)	Diabetes
Major depressive disorder, recurrent severe without psychotic features	Depression
Opioid dependence managed with suboxone	History of opioid use ▮

Coding updates

Effective January 1, 2025, the following codes will be *deny vendor liable* for Summit ElderCare, Community Care, and *deny vendor liable* with CMS message "I" for Medicare Advantage (PSP and HMO) and NaviCare:

Code	Description
80373	DRUG SCREENING TRAMADOL
S8948	LOW-LEVEL LASER TRMT 15 MIN
80365	DRUG SCREENING OXYCODONE
80354	DRUG SCREENING FENTANYL
80320	DRUG SCREEN QUANTITATIVE ALCOHOLS
80349	DRUG SCREENING CANNABINOIDS NATURAL
76140	Consultation on X-ray examination made elsewhere, written report
99375	HOME HEALTH CARE SUPERVISION
S9470	Nutritional counseling, diet
S0285	Colonoscopy consultation performed prior to a screening colonoscopy procedure
S2342	Nasal endoscopy for post-operative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(ies), unilateral or bilateral

Effective January 1, 2025, the following codes will be *deny vendor liable* for Community Care, and *deny vendor liable* with CMS message "I" for Medicare Advantage (PSP and HMO):

Code	Description
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
90389	Tetanus immune globulin (TIg), human, for intramuscular use
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour

Effective January 1, 2025, the following codes will be *deny vendor liable* with CMS message "I" for Medicare Advantage (PSP and HMO):

Code	Description
S9485	Crisis intervention mental health services
S8948	LOW-LEVEL LASER TRMT 15 MIN

Effective January 1, 2025, the following code will require *plan prior authorization* for MassHealth ACO:

Code	Description
G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room

Effective January 1, 2025, the following code is *not covered* for Medicare Advantage (PSP and HMO) and Community Care consistent with Medicare physician-fee schedule. According to MPFS, this code has an indicator "N", which means *not covered*. Please refer to Medicare physician-fee schedule to bill appropriate code.

Code	Description
80050	GENERAL HEALTH PANEL

Effective January 1, 2025, the following code is *not covered* for Medicare Advantage (PSP and HMO) consistent with Medicare physician-fee schedule:

Code	Description
58300	Insertion of intrauterine device (IUD)

Effective December 1, 2024, the following code will require *plan prior authorization* for all lines of business:

Code	Description
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose

Effective December 1, 2024, the following code will be *not covered* for Fallon Medicare Plus, NaviCare, Summit ElderCare® PACE, and Community Care:

Code	Description
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium

Effective December 1, 2024, the following codes *will be covered* for Medicare Advantage plan members, including Fallon Medicare Plus and NaviCare HMO SNP (dual eligible Medicare/Medicaid) when the member is enrolled in Category B IDE study G150178 – the "PROTECT" Study. Prior authorization is required.

Code	Description
0587T	Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming and imaging guidance when performed, posterior tibial nerve
0588T	Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed

Code	Description
0589T	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 neurostimu-lation, detection algorithms, closed-loop parameters and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters
0590T	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 healthcare professional, posterior tibial nerve, 4 or more parameters

Effective December 1, 2024, the following codes will require *plan prior authorization* for all lines of business:

Code	Description
33202	Insertion of epicardial electrode(s); open incision (e.g., thoracotomy, median sternotomy, subxiphoid approach)
33203	Insertion of epicardial electrode(s); endoscopic approach (e.g., thoracoscopy, pericardioscopy)
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system

Effective December 1, 2024, the following codes will require *plan prior authorization* for all lines of business:

Code	Description
33975	Insertion of ventricular assist device; extracorporeal, single ventricle
33976	Insertion of ventricular assist device; extracorporeal, biventricular
33977	Removal of ventricular assist device; extracorporeal, single ventricle
33978	Removal of ventricular assist device; extracorporeal, biventricular
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass

Effective December 1, 2024, the following codes will require *plan prior authorization* for Medicare HMO, NaviCare, Summit ElderCare PACE, and Community Care:

Code	Description
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496	Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only

Effective December 1, 2024, the following codes will require *plan prior authorization* for all lines of business:

Code	Description
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64570	Removal of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

Effective October 1, 2024, the following codes will require *plan prior authorization* for all lines of business:

Code	Description
C9170	Injection, tarlatamab-dlle, 1 mg
J9329	Injection, tislelizumab-jsgr, 1mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg

Effective October 1, 2024, the following codes will be configured as *covered with prior authorization* for all lines of business, except for MassHealth ACO plans, which are *deny vendor liable*.

Code	Description
0476U	Drug metabolism, psychiatry (e.g., major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis and reported phenotypes
0477U	Drug metabolism, psychiatry (e.g., major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis, including impacted gene-drug interactions and reported phenotypes
0478U	Oncology (non-small cell lung cancer), DNA and RNA, digital PCR analysis of 9 genes (EGFR, KRAS, BRAF, ALK, ROS1, RET, NTRK 1/2/3, ERBB2, and MET) in formalin-fixed paraffin-embedded (FFPE) tissue, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and reported as actionable detected variants for therapy selection
0479U	Tau, phosphorylated, pTau217
0480U	Infectious disease (bacteria, viruses, fungi, and parasites), cerebrospinal fluid (CSF), metagenomic next-generation sequencing (DNA and RNA), bioinformatic analysis, with positive pathogen identification
0481U	IDH1 (isocitrate dehydrogenase 1 [NADP+]), IDH2 (isocitrate dehydrogenase 2 [NADP+]), and TERT (telomerase reverse transcriptase) promoter (e.g., central nervous system [CNS] tumors), next-generation sequencing (single-nucleotide variants [SNV], deletions, and insertions)
0482U	Obstetrics (preeclampsia), biochemical assay of soluble fms-like tyrosine kinase 1 (sFlt-1) and placental growth factor (PlGF), serum, ratio reported for sFlt-1/PlGF, with risk of progression for preeclampsia with severe features within 2 weeks
0483U	Infectious disease (Neisseria gonorrhoeae), sensitivity, ciprofloxacin resistance (gyrA S91F point mutation), oral, rectal, or vaginal swab, algorithm reported as probability of fluoroquinolone resistance
0484U	Infectious disease (Mycoplasma genitalium), macrolide sensitivity (23S rRNA point mutation), oral, rectal, or vaginal swab, algorithm reported as probability of macrolide resistance
0485U	Oncology (solid tumor), cell-free DNA and RNA by next-generation sequencing, interpretative report for germline mutations, clonal hematopoiesis of indeterminate potential, and tumor-derived single-nucleotide variants, small insertions/deletions, copy number alterations, fusions, microsatellite instability, and tumor mutational burden
0486U	Oncology (pan-solid tumor), next-generation sequencing analysis of tumor methylation markers present in cell-free circulating tumor DNA, algorithm reported as quantitative measurement of methylation as a correlate of tumor fraction
0487U	Oncology (solid tumor), cell-free circulating DNA, targeted genomic sequence analysis panel of 84 genes, interrogation for sequence variants, aneuploidy-corrected gene copy number amplifications and losses, gene rearrangements, and microsatellite instability
0488U	Obstetrics (fetal antigen noninvasive prenatal test), cell-free DNA sequence analysis for detection of fetal presence or absence of 1 or more of the Rh, C, c, D, E, Duffy (Fya), or Kell (K) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected

Code	Description
0489U	Obstetrics (single-gene noninvasive prenatal test), cell-free DNA sequence analysis of 1 or more targets (e.g., CFTR, SMN1, HBB, HBA1, HBA2) to identify paternally inherited pathogenic variants, and relative mutation-dosage analysis based on molecular counts to determine fetal inheritance of maternal mutation, algorithm reported as a fetal risk score for the condition (e.g., cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia)
0490U	Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular-weight melanoma-associated antigen, CD34 and CD45 protein biomarkers, peripheral blood
0491U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor (ER) protein biomarker-expressing cells, peripheral blood
0492U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein biomarker-expressing cells, peripheral blood
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA
0494U	Red blood cell antigen (fetal RhD gene analysis), next-generation sequencing of circulating cell-free DNA (cfDNA) of blood in pregnant individuals known to be RhD negative, reported as positive or negative
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer
0496U	Oncology (colorectal), cell-free DNA, 8 genes for mutations, 7 genes for methylation by real-time RT-PCR, and 4 proteins by enzyme-linked immunosorbent assay, blood, reported positive or negative for colorectal cancer or advanced adenoma risk
0497U	Oncology (prostate), mRNA gene-expression profiling by real-time RT-PCR of 6 genes (FOXM1, MCM3, MTUS1, TTC21B, ALAS1, and PPP2CA), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a risk score for prostate cancer
0498U	Oncology (colorectal), next-generation sequencing for mutation detection in 43 genes and methylation pattern in 45 genes, blood, and formalin-fixed paraffin-embedded (FFPE) tissue, report of variants and methylation pattern with interpretation
0499U	Oncology (colorectal and lung), DNA from formalin-fixed paraffin-embedded (FFPE) tissue, next-generation sequencing of 8 genes (NRAS, EGFR, CTNNB1, PIK3CA, APC, BRAF, KRAS, and TP53), mutation detection
0500U	Autoinflammatory disease (VEXAS syndrome), DNA, UBA1 gene mutations, targeted variant analysis (M41T, M41V, M41L, c.118-2A>C, c.118-1G>C, c.118-9_118-2del, S56F, S621C)
0501U	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)
0502U	Human papillomavirus (HPV), E6/E7 markers for high-risk types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68), cervical cells, branched-chain capture hybridization, reported as negative or positive for high risk for HPV

Code	Description
0503U	Neurology (Alzheimer disease), beta amyloid (AÎ²40, AÎ²42, AÎ²42/40 ratio) and tau-protein (ptau217, np-tau217, ptau217/np-tau217 ratio), blood, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS), algorithm score reported as likelihood of positive or negative for amyloid plaques
0504U	Infectious disease (urinary tract infection), identification of 17 pathologic organisms, urine, real-time PCR, reported as positive or negative for each organism
0505U	Infectious disease (vaginal infection), identification of 32 pathogenic organisms, swab, real-time PCR, reported as positive or negative for each organism
0506U	Gastroenterology (Barrett's esophagus), esophageal cells, DNA methylation analysis by next-generation sequencing of at least 89 differentially methylated genomic regions, algorithm reported as likelihood for Barrett's esophagus
0507U	Oncology (ovarian), DNA, whole-genome sequencing with 5-hydroxymethylcytosine (5hmC) enrichment, using whole blood or plasma, algorithm reported as cancer detected or not detected
0508U	Transplantation medicine, quantification of donor-derived cell-free DNA using 40 single-nucleotide polymorphisms (SNPs), plasma, and urine, initial evaluation reported as percentage of donor-derived cell-free DNA with risk for active rejection
0509U	Transplantation medicine, quantification of donor-derived cell-free DNA using up to 12 single-nucleotide polymorphisms (SNPs) previously identified, plasma, reported as percentage of donor-derived cell-free DNA with risk for active rejection
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug
0512U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of MSI-high (MSI-H)
0513U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) and homologous recombination deficiency (HRD) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of each biomarker
0514U	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of adalimumab (ADL) levels in venous serum in patients undergoing adalimumab therapy, results reported as a numerical value as micrograms per milliliter (µg/mL)
0515U	Gastroenterology (irritable bowel disease [IBD]), immunoassay for quantitative determination of infliximab (IFX) levels in venous serum in patients undergoing infliximab therapy, results reported as a numerical value as micrograms per milliliter (Âµg/mL)
0516U	Drug metabolism, whole blood, pharmacogenomic genotyping of 40 genes and CYP2D6 copy number variant analysis, reported as metabolizer status
0517U	Therapeutic drug monitoring, 80 or more psychoactive drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally and maximally effective dose of prescribed and non-prescribed medications

Code	Description
0518U	Therapeutic drug monitoring, 90 or more pain and mental health drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally effective range of prescribed and non-prescribed medications
0519U	Therapeutic drug monitoring, medications specific to pain, depression, and anxiety, LC-MS/MS, plasma, 110 or more drugs or substances, qualitative and quantitative therapeutic minimally effective range of prescribed, non-prescribed, and illicit medications in circulation
0520U	Therapeutic drug monitoring, 200 or more drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally effective range of prescribed and non-prescribed medications
C9169	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram
C9171	Injection, pegulicianine, 1 mg
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose

Effective October 1, 2024, the following codes will be configured as *covered without prior authorization* for all lines of business except for MassHealth ACO plans, which are *deny vendor liable*.

Code	Description
A2027	Matriderm, per square centimeter
A2028	Micromatrix flex, per mg
A2029	Mirotract wound matrix sheet, per cubic centimeter
A9610	Xenon xe-129 hyperpolarized gas, diagnostic, per study dose
C8000	Support device, extravascular, for arteriovenous fistula (implantable)
L1653	Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, off the shelf
L1821	Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, off the shelf
Q4334	Amnioplast 1, per square centimeter
Q4335	Amnioplast 2, per square centimeter
Q4336	Artacent c, per square centimeter
Q4337	Artacent trident, per square centimeter
Q4338	Artacent velos, per square centimeter
Q4339	Artacent vericlen, per square centimeter
Q4340	Simpligraft, per square centimeter
Q4341	Simplimax, per square centimeter
Q4342	Theramend, per square centimeter
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter
Q4344	Tri-membrane wrap, per square centimeter
Q4345	Matrix hd allograft dermis, per square centimeter

Effective October 1, 2024, the following codes will be configured as *deny vendor liable* for all lines of business:

Code	Description
90624	Meningococcal pentavalent vaccine, Men B-4C recombinant proteins and outer membrane vesicle and conjugated Men A, C, W, Y-diphtheria toxoid carrier, for intramuscular use
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application
E0743	External lower extremity nerve stimulator for restless legs syndrome, each
E0767	Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories
E2513	Accessory for speech generating device, electromyographic sensor
E3200	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only
L1006	Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L8720	External lower extremity sensory prosthesis, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg
L8721	Receptor sole for use with l8720, replacement, each
P9027	Red blood cells, leukocytes reduced, oxygen/carbon dioxide reduced, each unit

Effective April 1, 2024, the following code *is covered* for MassHealth ACO, consistent with MassHealth Durable Medical Equipment Provider Manual Subchapter 6 update (Transmittal Letter DME-47). Prior authorization is required.

Code	Description
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type

Effective April 1, 2024, the following codes *are covered* for MassHealth ACO, NaviCare, and Summit ElderCare PACE, consistent with MassHealth Durable Medical Equipment Provider Manual Subchapter 6 update (Transmittal Letter DME-47). Prior authorization is required.

Code	Description
E0678	Non-pneumatic sequential compression garment, full leg
E0679	Non-pneumatic sequential compression garment, half leg
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure
E0681	Non-pneumatic compression controller without calibrated gradient pressure
E0682	Non-pneumatic sequential compression garment, full arm

Payment policies

Revised policies – Effective December 1, 2024

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

- **Non-covered services –** Updated code report (generated 10/02/2024).
- **Day Habilitation –** Updated clarifying the following: The one-time payments for Day Habilitation Admission Services (S5105) and Re-engagement Services (S5105 KZ) that are effective July 5, 2023 are excluded from the Plan's coverage of Day Habilitation; claims for such services shall be paid directly by MassHealth. Effective August 1, 2024, Day Habilitation providers must bill for Day Habilitation services using the code and modifier combinations as described in Subchapter 6 of the Day Habilitation Manual (MassHealth Day Habilititation Bulletin 33 October 2024). The new Day Habilitation Leveling Tool must be used when submitting requests for PA on or after September 1, 2024. The new Day Habilitation Leveling Tool will identify the member as Level 1, Level 2, Level 3, or Level 4. Day Habilitation providers may no longer obtain prior authorizations or claim payments for Individualized Staffing Supports (ISS) for dates of service on or after September 1, 2024.
- **Radiology/diagnostic imaging –** Under Reimbursement, clarified that calcium scoring (CPT 75571) is not covered service. Under Billing/coding guidelines, clarified that all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician or other qualified nonphysician practitioner who is treating the plan member for a specific medical problem and who uses the results in the management of the member's specific medical problem. On claims for diagnostic radiology services, sequence first the diagnosis, condition, or problem chiefly responsible for the request for radiological services.
- **Claims editing software –** Under Reimbursement, Multiple Procedure Payment Reduction, documented ranking for codes with no assigned RVU or an RVU of 0.00.
- **Ambulatory surgery (professional) –** Under Reimbursement, Multiple Procedure Payment Reduction, documented ranking for codes with no assigned RVU or an RVU of 0.00.

- **Modifier –** In the Level I CPT Modifiers table under Reimbursement, for Modifier 51, clarified codes with no assigned RVU or an RVU of 0.00 will not be excluded from ranking. Codes with no assigned RVU or an an RVU value 0.00 and will be ranked as secondary or subsequent procedures when reported with other procedures that have an RVU value higher than 0.00. If multiple procedures with no assigned RVU or an RVU of 0.00 are billed on the same claim, the codes are ranked by billed charges.

New policy – Effective December 1, 2024

- **Hemodialysis**

Retiring policy – Effective December 1, 2024

- **Retroactive authorization requests**

Medical policies

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

- **Vagus Nerve Stimulation**
- **Post-Mastectomy Surgery and Services**
- **Sacral Nerve Stimulation for Urinary Incontinence**
- **Trigger Point Injections**
- **Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy**
- **Spinal Cord Stimulation**

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

- **Oral Appliances for Obstructive Sleep Apnea**
- **Surgery for Obstructive Sleep Apnea**
- **Proton Beam Therapy**
- **Posterior Tibial Nerve Stimulation**
- **Ventricular Assist Devices**
- **Implantable Cardioverter Defibrillators**
- **Cochlear Implants**

Revised policies – Effective October 15, 2024 (annual review)

- **Speech Generating Devices**
- **Speech Therapy**
- **Transurethral Waterjet Ablation of Prostate**
- **Lower Limb Prostheses**
- **Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Systems**
- **Hypoglossal Nerve Stimulation**

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

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