July 2024

Connection

Important information for Fallon Health physicians and providers

In the July issue:

Important updates

Changes to prior authorization requirements

Effective January 1, 2025, to align with industry practice, Fallon Health 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 enrollment/ eligibility mismatch or technology malfunctions.
- For a continuation of services such as DME, home health, or infusion, providers should submit additional clinical information prior to future service dates for authorization of continued services.

Please refer to our Procedure Code Look-up Tool as a resource for which codes require prior authorization.

Understanding this may require changes to provider workflows, we are providing ample notice to allow sufficient time for preparation. If you have questions about this change, please contact your Provider Relations representative.

Fallon Health member language and/or alternate format preferences

In 2024, the Centers for Medicare & Medicaid Services (CMS) put out a Final Rule that states that once a Medicare Advantage plan learns of a member's primary language and/or need for an alternate format, the plan must provide required materials in that language, and/or accessible format, as long as the member remains enrolled in the plan or until they request that the plan provide required materials in a different manner.

Please notify us if you learn that the primary spoken or written language is anything other than English or there is a need for an alternate format for one of our members. Send a ***secure*** email to *ContactCustomerService@fallonhealth.org* or fax it to 1-508-368-9966, and include the member's name, ID number, and language/alternate format preference.

Deadline for MassHealth ACO first-time claim and corrected claim submissions

Each year Fallon Health is required to submit encounter data to the State of Massachusetts for all ACO members. The information submitted includes final encounter data from claims with service dates from the previous year.

To meet this requirement, all claims for dates of service (DOS) between April 1, 2023 and December 31, 2023 **must be submitted by July 27, 2024.** Submission of claims by this deadline will ensure the information will be provided to the state within the required timeframe.

Please note timely filing limits apply.

Information about submitting first-time claims and claim corrections:

- First-time claims must be submitted within 120 days of the DOS, unless your contract states otherwise.
- Claim corrections must be submitted within 120 days from the most recent Remittance Advise Summary (RAS).
    - All paper claim corrections must be submitted with a completed *Request for Claim Review form*.
    - All electronic claim corrections must be submitted with a frequency code 7 or bill type 7.
    - Corrected claims must include all services/lines on the claim, not just the corrected line.

Please reach out to your Provider Relations Representative with questions.

Helpful clarifications to the provider appeal process

While Fallon Health doesn't currently offer second level appeals on the same issue, we want to reinforce that providers may submit a second appeal on the same claim for a different issue. For instance, if a claim is appealed due to a member enrollment issue and is subsequently paid, the provider may then submit a second appeal (e.g., regarding payment on specific billing codes). Provider Appeals must be sent using a *Request for Claim Review form* and must be accompanied by all supporting documentation.

CAQH: Action needed

Fallon Health partners with Council for Affordable Quality Healthcare for validation of provider directory information. Please see below for specific tasks you must complete.

- If you do not complete the attestation of the provider information, please share this information with those who do.
- Please continue to share the Connection newsletter with the staff updating CAQH, as this is where Fallon Health shares important updates.
- Indicate and accept that Fallon Health is an insurer you do business with, as this will allow Fallon to access the provider and accept information and updates through this process.

Once you are enrolled in the CAQH process:

- Review and attest to the provider information in the CAQH Provider Directory Management Solution every 90 days, to keep information current.
- If you do not attest, you will be considered a non-responder—this will prompt calls to your office.
- If you make an update in CAQH, you must attest—again—for the information to be shared with the health plans.
- If you do not indicate Fallon Health as a health plan that you participate with, this will prompt outreach calls to your office.

If there are any questions about this process, reach out to your Provider Relations representative.

For more information about the CAQH Directory Management process, visit *HCAS*.

Behavioral health needs in an inpatient setting

Fallon Health will reimburse hospitals for behavioral health services provided to members of **Summit ElderCare®, Fallon Health-Atrius Health Care Collaborative (FACC), Berkshire Fallon Health Collaborative (BFHC), Fallon 365 Care,** and **NaviCare.**

Pursuant to MCE Bulletins 107 and 110, providers may bill HCPCS code S9485 as described below for **Summit ElderCare, FACC, BFHC, Fallon 365 Care,** and **NaviCare:**

- **S9485** (Crisis intervention mental health services, per diem)

Billing guidance:

- **BH crisis evaluations (S9485) delivered in the emergency department**
  - Rendered in accordance with Standards for Behavioral Health Evaluations in RY24 Acute Hospital RFA (Appendix I).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - No more than one unit per day, no more than once per acute hospital stay.

- **BH crisis evaluations (S9485) delivered in the medical/surgical setting**
  - Rendered in accordance with Standards for Behavioral Health Crisis Evaluations in RY24 Acute Hospital RFA (Appendix I).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - No more than one unit per day, no more than once per acute hospital stay.
- **BH crisis management (S9485 with V1 or V2) delivered in emergency department**
  - Rendered in accordance with Standards for Behavioral Health Crisis Management in RY24 Acute Hospital RFA (Appendix K).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - No more than one unit per day.
  - BH Crisis Management (S9485 with V1 or V2) cannot be billed on same day as BH Crisis Evaluation (S9485).
  - S9485 with V1 cannot be billed on same day as S9485 with V2.
- **BH crisis management (S9485 with V1 or V2) delivered in the medical/surgical setting**
  - Rendered in accordance with Standards for Behavioral Health Crisis Management in RY24 Acute Hospital RFA (Appendix K).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - No more than one unit per day.
  - BH Crisis Management (S9485 with V1 or V2) cannot be billed on same day as BH Crisis Evaluation (S9485).
  - S9485 with V2 cannot be billed on same day as S9485 with V1.
- **G2213** (Initiation of medication for treatment of opioid use disorder in the emergency dept.)
- **H2015 HF** (Paraprofessional or peer specialist in the essentials of substance use disorder)

Billing guidance:

- **MOUD (G2213) delivered in the emergency department**
  - Rendered in accordance with Standards for Initiation of Medication for the Treatment of Opioid Use Disorder in RY24 Acute Hospital RFA (Appendix M).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - G2213 is an add-on code to be billed with evaluation and management visit codes used in the ED setting (99281-99285).
  - MOUD (G2213) is not separately reimbursed when delivered in the Medical/Surgical Setting.

- **RSN (H2015-HF) delivered in the emergency department**
  - Rendered in accordance with Standards for Recovery Support Navigators in RY24 Acute Hospital RFA (Appendix N).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - RSN services must be billed with the procedure code and modifier.
- **RSN (H2015-HF) delivered in the medical/surgical setting**
  - Rendered in accordance with Standards for Recovery Support Navigators in RY24 Acute Hospital RFA (Appendix N).
  - Claim submitted to Fallon Health.
  - The hospital is the billing entity, not the individual provider.
  - Claim must be billed on 837I (UB).
  - RSN services must be billed with the procedure code and modifier.

For Community Care, providers may bill HCPCS codes:

- **S9485** (Crisis intervention mental health services, per diem)
- **T1004** (Services of a qualified nursing aide, up to 15 minutes)

If you have questions, please call your Fallon Health Provider Relations representative.

What's new

Starting July 1, 2024, Manny Lopes will assume the role of President and CEO of Fallon Health

A seasoned executive with experience across the health care industry, Lopes most recently served as Interim CEO of Fenway Health, one of the first health care organizations in the country to specifically address the health care needs of the LGBTQ+ community. Prior to that, he was the Executive Vice President of Public Markets and Government Relations for Blue Cross Blue Shield of Massachusetts (BCBSMA) with responsibilities for the company's Medicare division, achieving growth through innovation while also improving consumer experience and health outcomes.

Before joining BCBSMA, Lopes was the President and CEO of East Boston Neighborhood Health Center, a large, nationally recognized primary care provider and insurer that offers a Program of All-Inclusive Care for the Elderly and a Senior Care Options plan, both core programs in Fallon Health's portfolio.

Fallon Health has announced construction of its newest Summit ElderCare Program of All-Inclusive Care for the Elderly (PACE) center in Dartmouth, Massachusetts

The center, which is pending regulatory review, will serve as the central hub for PACE services in Southeastern Massachusetts. PACE is a national model of care offering a full range of coordinated health and wellness services to largely older adults so that they can age with dignity in their home or community.

Summit ElderCare uses a collaborative approach to care planning, called the Interdisciplinary Team (IDT). The IDT is comprised of providers (MD/DO and NP/PA), nurses, social workers, physical and occupational therapists, dieticians, health aides, recreation staff, home care and transportation coordinators, and site administrator. This approach to care is the gold standard for complex and frail older adults who wish to avoid nursing home placement.

"At Summit ElderCare, our providers can visit with participants and their families without worrying about restricted schedules," said Dr. Jean Jaoude, Vice President and Medical Director of Summit ElderCare." We can focus solely on patients' needs and quality of life. And we work collaboratively with an interdisciplinary team of physical and occupational therapists, dietitians, nurses, social workers, health aides, pharmacists, and others to ensure the best care for our participants."

Fallon Health has received approval from the Massachusetts Executive Office of Health and Human Services (EOHHS) to file an application with the Centers for Medicare & Medicaid Services (CMS) seeking authorization to build the PACE facility in Dartmouth. If approved, it would open in 2025. Fallon Health is hiring several health care professionals in this location. To learn more, please visit fallonhealth.org/en/careers.

Fallon Health MassHealth ACO pharmacy formulary updates

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

Name	Update
Amyloidosis therapies	• Wainua (eplontersen) added to pharmacy benefit requiring prior authorization.
Antidepressants	• Aplenzin (bupropion hydrobromide ER) added to pharmacy benefit requiring prior authorization with quantity limit of 1 tablet per day. • Preferred drug designation added to Zurzuvae.
Anti-diabetic agents	• Zituvio (sitagliptin) added to pharmacy benefit requiring prior authorization with quantity limit of 1 tablet per day.
Antifungals – oral and injectable	• Noxafil suspension was removed from brand over generic list.
Anti-obesity agents	• Wegovy criteria was updated to include new cardiovascular indication.

Name	Update
Anti-viral agents	• Valcyte powder for oral suspension was added with prior authorization and brand preferred over generic, quantity limit of 18 ml per day. • Removed prior authorization on Denavir and add to brand preferred over generic. • Quantity limit of 1 tablet per day was added to Prevymis (letermovir).
Asthma and allergy monoclonal antibodies	• Dupixent criteria updated to include expanded age and weight for eosinophilic esophagitis expanded age indication. • Xolair expanded indication for IgE-mediated food allergy.
Beta thalassemia, Myelodysplastic Syndrome and Sickle Cell agents	• Lyfgenia (lovotibeglogene autotemcel) was added to Fallon Medical Benefit and carve out.
Breast cancer therapies	• Truqap (capivasertib) added to pharmacy benefit with prior authorization
Butalbital containing agents	• Butalbital/ASA/caffeine 50/325/40 capsule prior authorization removed, quantity and age limit remain • Expanded indications for migraines within quantity limit
Cenergermin (Oxervate)	• Updated approval duration to 3 months
Duchenne muscular dystrophy agents	• Exondys, Amondys, Viltepso, and Vyondus update approval duration to 6 months
Immune suppressants topical	• Zoyvre foam added with prior authorization to pharmacy benefit • Zoyvre cream updated age to 6 years old from 12 years
Immunotherapy oral	• Grastek criteria update, remove trial with Oralair
Inflammatory bowel agents	• Delzicol add prior authorization and remove from brand over generic • Mesalamine 800mg delayed release add prior authorization
JAK inhibitors for myelofibrosis	• Add Ojjaara (momelotinib) to pharmacy benefit with prior authorization • Jakafi and Vonjo, update criteria to include Polycythemia vera diagnosis
Lung cancer agents	• Augtyro (repotricetinib) added to pharmacy benefit with prior authorization
Medical foods	• L-methylfolate will be covered with a quantity limit of 1 tablet per day
Methotrexate agents	• Jyalmvo (methotrexate 2mg/mL oral solution) add to pharmacy benefit with prior authorization
NSAIDS – injectable, intranasal, and oral	• Indomethacin suppository add prior authorization • Coxanto (oxaprozin capsule) add to pharmacy benefit with prior authorization
Otic agents	• Ciprofloxacin/dexamethasone added prior authorization

Name	Update
Targeted immunomodulators	• Bimzelx (bimekizumab-bkzx) added to pharmacy benefit with prior authorization • Velsipity (etrasimod) added to pharmacy benefit with prior authorization
Xphozah (tenapanor)	• New guideline, Xphozah (tenapanor) added to pharmacy benefit with prior authorization
Vitamin D analogs	• Sorilux remove from brand over generic
Brand name and non-preferred generics	• Proair and Proventil removed from brand over generic • Delzicol removed from brand over generic • Prezista removed from brand over generic • Lexiva removed from brand over generic

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. NaviCare is available in every county in Massachusetts, except 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. 140 one-way trips per calendar year to places including grocery stores, gyms, and churches, within a 30-mile radius of the member's home. Transportation may be arranged two business days in advance by calling our transportation vendor, CTS at 1-833-824-9440. The member or caregiver can arrange transportation. Fallon Health Navigators are also available to assist. Members or their caregivers can also qualify for mileage reimbursement for covered trips provided by friends and family.
- 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. They also have a Silver Sneakers™ gym membership.
- Up to $848 per year on the Save Now card, to purchase food, health, and personal care items. Purchases can be made over the phone, at stores like CVS Pharmacy, Family Dollar, and Walmart, or online with free home delivery.

- Outpatient behavioral health services (Covered through our contracted providers. No authorization required).
- Covered prescription drugs and certain approved OTC drugs and items. Members may receive a 100-day supply of medications via mail order.
- Vision care and eyeglasses ($570 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 doctor or other plan provider must get prior authorization 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.
- 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.

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.

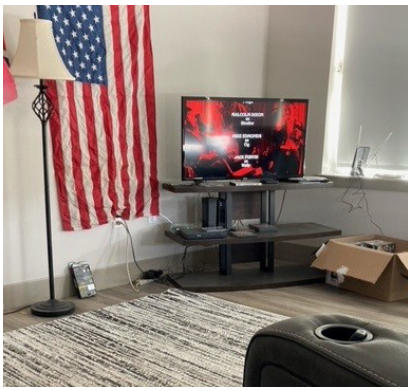
To refer a patient to NaviCare, or learn more about eligibility criteria, call 1-877-255-7108.

NaviCare – Model of Care success

The Fallon Health NaviCare team consistently offers support to members during transitions.

In an earlier Connection, we spotlighted the compassionate intervention by a Fallon Health NaviCare team, who swiftly came to the aid of ten seniors from an assisted living facility in the Berkshires that was deemed uninhabitable. These elders faced imminent risk and required urgent relocation. Promptly responding to the crisis, the NaviCare team met at the facility, seamlessly integrating each resident into the NaviCare SCO plan, and within a mere two months, secured new residences for all.

The final resident to vacate the premises did so with a heavy heart, saying goodbye to what had been his home for numerous years. Despite his initial hesitance, he recognized the necessity of the move. In the interim, he was accommodated at a long-term care facility, awaiting a permanent solution. His Navigator, having established a trusting relationship, provided much-needed emotional support and motivation during this period. As a veteran, the member had specific needs for a handicap-accessible living space. His Navigator diligently helped to maintain his connection with Veteran Affairs throughout this period of change.



After a patient wait, the member was overjoyed to be offered a newly constructed, handicap-accessible apartment. However, he felt he did not deserve such a generous space. Concerns about furnishing and affording his new apartment also surfaced. The NaviCare team stepped in once more, referring him to MATCH—a program that aids eligible MassHealth members in establishing stable community living arrangements. Thanks to MATCH's assistance, the resident managed to secure his new home, complete with essential furniture, household supplies, and a custom rug to accommodate his wheelchair.

Upon a recent follow-up visit, the NaviCare team was pleased to see the member making a smooth transition in his new home. He expressed how happy he was, feeling like a 'king' in his new recliner.

The Navigator reflected on the gratification derived from helping the member find and transition to his new home—serving as a testament to the team's unwavering commitment to exceeding expectations for those they serve.

Important reminders

What you should know about HOS

Fallon Health is committed to partnering with our providers to deliver 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, healthcare services, and their health plan through the **Health Outcomes Survey (HOS).**

HOS is 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 Five-Star Quality Rating Program. Since you, the provider, are a critical component of the patient's experience, we have highlighted three specific HOS measures where your actions can influence results and outcomes. As a reminder, HOS surveys are administered from August to October each year.

The role for you—the provider—can play in impacting 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: 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 six 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 ages 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 Rating Program, please contact your Provider Relations Representative.

Medication reconciliation post discharge

Fallon Health reimburses providers for medication reconciliation within 30 days of inpatient discharge for Fallon Medicare Plus and NaviCare members. To receive reimbursement for medication reconciliation when transitional care CPT codes are not applicable, documentation must be:

- Conducted by clinician: MD, DO, PA, NP, RN, or clinical pharmacist.
- Notated in chart the hospitalization and name of the facility.
- Billed with CPT® code 1111F

Doing business with us

Primary Care Physician (PCP) referrals for NaviCare and Fallon Medicare Plus

When a PCP seeks to refer a NaviCare or Fallon Medicare Plus member for specialty care services, a referral is entered into ProAuth, Fallon Health's referral and authorization tool. A PCP referral is not required when a PCP is sending a patient to a specialist within their health care option (HCO). Health care options are provider groups that often share a contractual relationship. To confirm if a specialist is in the same HCO as a PCP, please reference the HCO code listed in the *Provider Look-up Tool*.

Provider tools registration

User accounts are terminated after 180 days of inactivity. If your account was terminated and you would like to reinstate your account, please sign up by completing the *online registration form*.

Notifications of provider terminations

It is essential Fallon Health be informed 60 days in advance of a provider termination. Please submit this information to us to ensure members are informed in a timely manner. If the provider is a primary care physician, please ensure the member is reassigned to another physician within the practice to allow for appropriate continuity of care.

Quality Focus

Clinical Practice Guidelines update

Fallon Health's Clinical Practice Guidelines are available *here*.

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:

Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain-United States, 2022

Transitions of Care (TRC) HEDIS® measure

HEDIS measures are widely used. These best practices are intended to help identify opportunities to improve and standardize processes for capturing the following information necessary to improve patient outcomes.

The TRC measure assesses the percentage of discharges for Medicare members 18 years of age and older who experienced each of the following:

1. **Notification of inpatient admission.** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
    - Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received.
2. **Receipt of discharge information.** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). The outpatient medical record at a minimum must include:
    - The practitioner responsible for the member's care during the inpatient stay
    - Procedures or treatment provided
    - Diagnoses at discharge
    - Current medication list
    - Testing results, or documentation of pending tests or no tests pending
    - Instructions for patient care post-discharge
3. **Patient engagement after inpatient discharge.** Documentation in the outpatient medical record of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
4. **Medication reconciliation post-discharge.** Documentation in the outpatient medical record of medication reconciliation on the date of discharge through 30 days after discharge (31 total days), or CPT code 1111F.

Coding Corner

Injection of anesthetic agent(s) and/or steroid (nerve block) for diagnostic or therapeutic purposes (CPT 64400-64455)

Effective for dates of service on or after September 1, 2024, the first two (2) nerve blocks in a 12-month period do not require prior authorization. Any subsequent nerve blocks during the 12-month period will require prior authorization.

Code	Description
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64447	Injection(s), anesthetic agent(s); femoral nerve, including imaging guidance, when performed
64448	Injection(s), anesthetic agent(s); femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg Morton's neuroma) ▮

Changes for hearing aid codes – *correction*

In the April Connection newsletter, we indicated a subset of hearing aid codes would be set to not covered for Fallon Medicare Plus, Fallon Medicare Plus Central, and NaviCare, effective April 1, 2024. We erroneously included the following codes for NaviCare:

Code	Description
V5014	Repair/modification of hearing aid
V5160	Dispensing fee binaural
V5240	Disp fee contralateral binaural
V5241	Dispns fee monaurl hearing aid type

Please note that these codes remain covered for NaviCare members.

Prior authorization no longer required for psychological and neuropsychological testing

Effective April 1, 2024, members of Fallon Health's Community Care and MassHealth ACO plans—Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative—no longer need prior authorization (PA) for psychological and neuropsychological testing. The following services codes **will not** require PA:

Code	Description
96130	Psychological testing evaluation services by physician or other qualified healthcare professional
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, first hour
96136	Neuropsychological testing evaluation services by physician or other qualified health care professional, first 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96146	A single automated psychological or neuropsychological instrument that is administered via electronic platform
96131	Psychological testing evaluation services by physician or other qualified healthcare professional, each additional hour
96133	Neuropsychological testing, each additional hour
96137	Administration of two or more psychological or neuropsychological tests requiring an additional 30 minutes beyond the initial 30 minutes.
96139	Administration of two or more psychological or neuropsychological tests by technician requiring an additional 30 minutes beyond the initial 30 minutes.
96116	A physician or other qualified healthcare professional performs a face–to–face assessment of a patient's thinking, reasoning, and judgment.
96121	A physician or other qualified healthcare professional performs a face–to–face assessment of a patient's thinking, reasoning, and judgment, each additional hour

Use of EY modifier

The EY modifier is used to indicate that a physician's written order has not been received for home health and DME services.

Currently, Fallon Health is processing claims received with an EY modifier as informational. Please note prior authorization requirements still apply. To validate prior authorization requirements, you can use the following link: https://fallonhealth.org/providertools/ProcedureCodeLookup.

Coding updates

Effective July 1, 2024, the following codes will be *deny vendor liable* for MassHealth ACO (BFHC, FACC, Fallon 365 Care) only:

Code	Description
A9506	Graphite crucible for preparation of technetium tc 99m-labeled carbon aerosol, each
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation
C1606	Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope
Q4311	Acesso, per square centimeter
Q4312	Acesso ac, per square centimeter
Q4313	Dermabind fm, per square centimeter
Q4314	Reeva ft, per square cenitmeter
Q4315	Regenelink amniotic membrane allograft, per square centimeter
Q4316	Amchoplast, per square centimeter
Q4317	Vitograft, per square centimeter
Q4318	E-graft, per square centimeter
Q4319	Sanograft, per square centimeter
Q4320	Pellograft, per square centimeter
Q4321	Renograft, per square centimeter
Q4322	Caregraft, per square centimeter
Q4323	Alloply, per square centimeter
Q4324	Amniotx, per square centimeter
Q4325	Acapatch, per square centimeter
Q4326	Woundplus, per square centimeter
Q4327	Duoamnion, per square centimeter
Q4328	Most, per square centimeter
Q4329	Singlay, per square centimeter
Q4330	Total, per square centimeter
Q4331	Axolotl graft, per square centimeter
Q4332	Axolotl dualgraft, per square centimeter

Code	Description
Q4333	Ardeograft, per square centimeter
0020M	Oncology (central nervous system), analysis of 30000 DNA methylation loci by methylation array, utilizing DNA extracted from tumor tissue, diagnostic algorithm reported as probability of matching a reference tumor subclass
0450U	Oncology (multiple myeloma), liquid chromatography with tandem mass spectrometry (LC-MS/MS), monoclonal paraprotein sequencing analysis, serum, results reported as baseline presence or absence of detectable clonotypic peptides
0451U	Oncology (multiple myeloma), LC-MS/MS, peptide ion quantification, serum, results compared with baseline to determine monoclonal paraprotein abundance
0452U	Oncology (bladder), methylated PENK DNA detection by linear target enrichment-quantitative methylation-specific real-time PCR (LTE-qMSP), urine, reported as likelihood of bladder cancer
0453U	Oncology (colorectal cancer), cell-free DNA (cfDNA), methylation-based quantitative PCR assay (SEPTIN9, IKZF1, BCAT1, Septin9-2, VAV3, BCAN), plasma, reported as presence or absence of circulating tumor DNA (ctDNA)
0454U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
0455U	Infectious agents (sexually transmitted infection), Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis, multiplex amplified probe technique, vaginal, endocervical, gynecological specimens, oropharyngeal swabs, rectal swabs, female or male urine, each pathogen reported as detected or not detected
0456U	Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes, whole blood, with analysis of anti-cyclic citrullinated peptides (CCP) levels, combined with sex, patient global assessment, and body mass index (BMI), algorithm reported as a score that predicts nonresponse to tumor necrosis factor inhibitor (TNFi) therapy
0457U	Perfluoroalkyl substances (PFAS) (eg, perfluorooctanoic acid, perfluorooctane sulfonic acid), 9 PFAS compounds by LC-MS/MS, plasma or serum, quantitative
0458U	Oncology (breast cancer), S100A8 and S100A9, by enzyme-linked immunosorbent assay (ELISA), tear fluid with age, algorithm reported as a risk score
0459U	Î²--amyloid (Abeta42) and total tau (tTau), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology
0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes
0461U	Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with variant analysis, including impacted gene-drug interactions and reported phenotypes
0462U	Melatonin levels test, sleep study, 7 or 9 sample melatonin profile (cortisol optional), enzyme-linked immunosorbent assay (ELISA), saliva, screening/preliminary
0463U	Oncology (cervix), mRNA gene expression profiling of 14 biomarkers (E6 and E7 of the highest-risk human papillomavirus [HPV] types 16, 18, 31, 33, 45, 52, 58), by real-time nucleic acid sequence-based amplification (NASBA), exo- or endocervical epithelial cells, algorithm reported as positive or negative for increased risk of cervical dysplasia or cancer for each biomarker

Code	Description
0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result
0465U	Oncology (urothelial carcinoma), DNA, quantitative methylation-specific PCR of 2 genes (ONECUT2, VIM), algorithmic analysis reported as positive or negative
0466U	Cardiology (coronary artery disease [CAD]), DNA, genome-wide association studies (564856 single-nucleotide polymorphisms [SNPs], targeted variant genotyping), patient lifestyle and clinical data, buccal swab, algorithm reported as polygenic risk to acquired heart disease
0467U	Oncology (bladder), DNA, next-generation sequencing (NGS) of 60 genes and whole genome aneuploidy, urine, algorithms reported as minimal residual disease (MRD) status positive or negative and quantitative disease burden
0468U	Hepatology (nonalcoholic steatohepatitis [NASH]), miR-34a-5p, alpha 2-macroglobulin, YKL40, HbA1c, serum and whole blood, algorithm reported as a single score for NASH activity and fibrosis
0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants, duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance pattern that indicate uniparental disomy (UPD), and aneuploidy, fetal sample (amniotic fluid, chorionic villus sample, or products of conception), identification and categorization of genetic variants, diagnostic report of fetal results based on phenotype with maternal sample and paternal sample, if performed, as comparators and/or maternal cell contamination
0470U	Oncology (oropharyngeal), detection of minimal residual disease by next-generation sequencing (NGS) based quantitative evaluation of 8 DNA targets, cell-free HPV 16 and 18 DNA from plasma
0471U	Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations
0472U	Carbonic anhydrase VI (CA VI), parotid specific/secretory protein (PSP) and salivary protein (SP1) IgG, IgM, and IgA antibodies, enzyme-linked immunosorbent assay (ELISA), semiqualitative, blood, reported as predictive evidence of early SjÃƒÂ¶gren syndrome
0473U	Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden
0474U	Hereditary pan-cancer (eg, hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next-generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene
0475U	Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer

Effective July 1, 2024, the following code *will be covered without prior authorization* for all lines of business and will be *deny vendor liable for MassHealth ACO* (BFHC, FACC, and Fallon 365 Care) and Community Care:

Code	Description
C9901	Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components

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

Code	Description
G0519	Management of new patient-caregiver dyad with dementia, low complexity, for use in cmmi model
G0520	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model
G0521	Management of new patient-caregiver dyad with dementia, high complexity, for use in cmmi model
G0522	Management of a new patient with dementia, low complexity, for use in cmmi model
G0523	Management of a new patient with dementia, moderate to high complexity, for use in cmmi model
G0524	Management of established patient-caregiver dyad with dementia, low complexity, for use in cmmi model
G0525	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model
G0526	Management of established patient-caregiver dyad with dementia, high complexity, for use in cmmi model
G0527	Management of established patient with dementia, low complexity, for use in cmmi model
G0528	Management of established patient with dementia, moderate to high complexity, for use in cmmi model
G0529	In-home respite care, 4-hour unit, for use in cmmi model
G0530	Adult day center, 8-hour unit, for use in cmmi model
G0531	Facility-based respite, 24-hour unit, for use in cmmi model
G9037	Interprofessional telephone/internet/electronic health record clinical question/request for specialty recommendations by a treating/requesting physician or other qualified health care professional for the care of the patient (i.e. not for professional education or scheduling) and may include subsequent follow up on the specialist's recommendations; 30 minutes
G9038	Co-management services with the following elements: new diagnosis or acute exacerbation and stabilization of existing condition; condition which may benefit from joint care planning; condition for which specialist is taking a co-management role; condition expected to last at least 3 months; comprehensive care plan established, implemented, revised or monitored in partnership with co-managing clinicians; ongoing communication and care coordination between co-managing clinicians furnishing care
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL

Code	Description
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient-symptom profiling, with interpretation and report
0869T	Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional
0876T	Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula)
0877T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
0878T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure
0879T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission
0880T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report
0881T	Cryotherapy of the oral cavity using temperature regulated fluid cooling system, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device
0882T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure.)
0883T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure.)

Code	Description
0884T	Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed
0885T	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed
0886T	Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed
0887T	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure.)
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day
0893T	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion
0895T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment)
0896T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment) (List separately in addition to code for primary procedure.)
0897T	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report
0898T	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report

Code	Description
0899T	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure.)
0900T	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure.)

Effective July 1, 2024, the following codes *will be covered* for all lines of business:

Code	Description
90637	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage, for intramuscular use
90638	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage, for intramuscular use

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

Code	Description
J2267	Injection, mirikizumab-mrkz, 1 mg
J3247	Injection, secukinumab, intravenous, 1 mg
J3263	Injection, toripalimab-tpzi, 1 mg
J7171	Injection, adamts13, recombinant-krhn, 10 iu
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg

Effective September 1, 2024, the following code will be *not covered* for Medicare HMO, NaviCare, Summit ElderCare PACE, and Community Care only:

Code	Description
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical banded gastroplasty

Effective September 1, 2024, the following codes will be *deny vendor liable* for Medicare HMO, NaviCare, Summit ElderCare PACE, and Community Care only:

Code	Description
S2083	Periodic adjustment of gastric restrictive device after the global period
S2342	Nasal endoscopy for post-operative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(s), unilateral or bilateral

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

Code	Description
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung) for transplantation, living donor

Effective September 1, 2024, the following codes will be *not covered* for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, and Summit ElderCare PACE only:

Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

Effective September 1, 2024, the following codes will be *not covered* for Medicare Advantage only:

Code	Description
92591	Hearing aid examination and selection; binaural
92590	Hearing aid examination and selection; monaural
92551	Screening test, pure tone, air only
92015	Determine refractive state

Effective September 1, 2024, the following codes will be *not covered* for Medicare Advantage and Community Care only:

Code	Description
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92592	Hearing aid check; monaural
99173	Screening test of visual acuity, quantitative, bilateral
99177	Ocular instrumnt screen bil
92310	Contact lens fitting ou
T1040	Comm bh clinic svc per diem
90882	Environmental ivntj mgmt purposes psyc pt

Effective September 1, 2024, the following codes will be *not covered* for Medicare Advantage, NaviCare, Summit ElderCare (PACE), and Community Care only:

Code	Description
99172	Ocular function screen
90875	Indiv psychophys biofeed train w/psytx 30 min
98943	Chiropractic manipltv tx extraspinal 1/> region
90619	Menacwy-tt conj vacc serogroups acwy for im use

Payment policies

Revised policies – Effective September 1, 2024

The following policies have been revised; details about the changes are indicated in the policies.

- **Non-covered services –** Updated code report (generated 07/02/2024).
- **Preventive services –** Under Billing/coding guidelines, removed S0610, S0612 and S0613 under Preventive Exams; added new section for Medicare Wellness Visits; added new section for Screening Pap Tests and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.1)).
- **Review of provider claims –** Replaced the term "audit" with "review" throughout and renamed Review of Provider Claims (formerly Provider Audit).
- **Podiatry –** Under Billing/coding guidelines, clarified that HCPCS code G0127 is nonpayable for MassHealth ACO members per MassHealth Podiatrist Manual Subchapter 6 (effective 01/01/2023).
- **Drugs and biologicals –** Under Billing/coding guidelines, added new section for Drugs Designated for Exclusion from 340B Coverage.
- **Personal care attendant services –** Under Policy, added new section Requirement for Consumers, Surrogates, and PCAs to Provide Email Address, as communicated in MassHealth Personal Care Attendant Program Bulletin 16, under Reimbursement, added new section Payment for Overtime Services.
- **Durable medical equipment –** Under Reimbursement, Medicare Power Mobility Devices, added new section Wheelchair Replacements When the Manufacturer Exits Wheelchair Business; under Reimbursement, added new section Documentation Requirements for DME and Related Supplies and Accessories Provided on a Recurring Basis Secondary to Written Order/Prescription; under Reimbursement, updated information under Written Orders/Prescriptions.

New policies – Effective September 1, 2024

- **Telehealth services –** Community Care

Medical policies

Revised policies – Effective May 1, 2024 (annual review; no significant changes)

- **Zolgensma** (onasemnogene abeparvovec-xioi)
- **Ultrasound-guided transcervical ablation of uterine fibroids**
- **Autologous chondrocyte implantation**
- **Hip arthroscopy for femoroacetabular impingement**
- **Infertility services**
- **Skilled nursing facility level of care**
- **Orthognathic surgery**
- **Skin substitutes**
- **Cosmetic, reconstructive and restorative surgery**
- **Stretch devices for joint stiffness and contractures**
- **Intensity modulated radiation therapy** (IMRT)
- **Long-term acute care** (LTAC)

Revised policies – Effective July 1, 2024 (annual review; no significant changes)

- **Acute inpatient rehabilitation hospital**
- **Allogeneic stem cell transplantation**
- **Ambulatory cardiac monitoring**
- **Anterior segment optical coherence tomography**
- **Chimeric antigen receptor (CAR) T-cell therapy**
- **Arthroscopy for osteoarthritis of the knee**
- **Bone growth stimulators**
- **Neuropsychological testing for non-behavioral health diagnoses**
- **Autologous stem cell transplantation**
- **Deep brain stimulation**
- **High frequency chest wall oscillation devices**
- **Transcutaneous electric nerve stimulation** (TENS)
- **Hyperbaric oxygen therapy**

Revised policies – Effective September 1, 2024

- **Peripheral nerve blocks –** The first two (2) nerve blocks in a 12-month period will not require prior authorization. Any subsequent nerve blocks during the 12-month period will require prior authorization.

Retired policy – Effective July 1, 2024

- **HIV-1 Co-receptor tropism assays**

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

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