Connection

Important information for Fallon Health physicians and providers

July 2025

In the July issue:

Important updates

Effective August 1, 2025, the ACO PCP referrals requirements will be reinstated

Per MassHealth All Provider Bulletin 403, the ACO PCP referrals requirements will be reinstated. This is for members of:

- Berkshire Fallon Health Collaborative
- Fallon 365 Care
- Fallon Health-Atrius Health Care Collaborative

What this means for you

PCPs will need to initiate a referral in ProAuth when referring ACO members for specialty care to in-network affiliated ACO providers. Specialists will need to confirm there is a referral on file—this can be done via ProAuth.

The referral process

- The PCP refers the member to a specialist within the member's network for medically necessary care.
- The PCP enters a referral into the ProAuth system, indicating the in-network specialist, timeframe, and number of visits approved.
- The specialist verifies member's eligibility and verifies the referral is on file and approved in ProAuth prior to seeing the member.
- The specialist treats the member according to the PCP's request and exchanges clinical information with the member's PCP.
- There is a **30-day** retro referral timeframe allowed for Berkshire Fallon Health Collaborative and Fallon 365 Care.
- There is a **90-day** retro referral timeframe allowed for Fallon Health-Atrius Health Care Collaborative.

Note: *A PCP referral is not necessary if the PCP is referring within the HealthCare Option (HCO) for Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative.*

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The prior authorization (PA) process has been in effect and remains unchanged.

- Prior authorization is required for all services that require PA; see the procedure code look-up tool for code-specific details.
- Prior authorization is required for all out-of-network services.
- Prior authorization requests are entered into ProAuth.
- Retro authorizations are **not allowed**.

Please make sure all who should have access to ProAuth are able to do so. If you or someone else on your team needs access, complete the online form.

If you have questions, please contact your Fallon Health Provider Relations representative directly, or email askfchp@fallonhealth.org. ■

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 were updated to reflect the same member cost share as non-QMB eligible members.

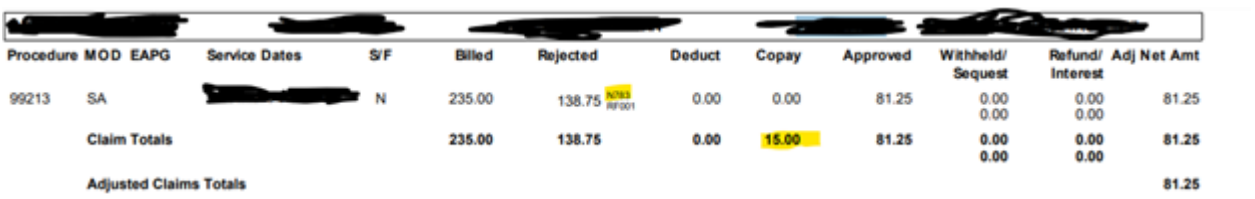
Providers may use the following tools to confirm information regarding QMB members:

- 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 message: EB*1*FAM*1*QM*PROGRAM NAME, example: EB*1*IND*1*QM*Medicare HMO
- Call Fallon Health's provider service line to verify eligibility at 1-866-275-3247, prompt 1.

Beginning in early June, enhancements to Fallon Health's Provider Remittance Advice Statements (RAS) and eligibility verification tools to identify QMB status were implemented and will appear moving forward.

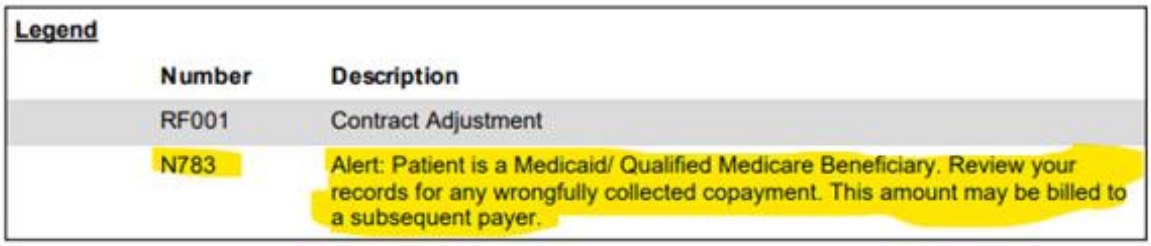
The images here are sample representations of how QMB status information will now appear on your RAS statements and 835 detail.

RAS Detail:



Procedure	MOD	EAPG	Service Dates	S/F	Billed	Rejected	Deduct	Copay	Approved	Withheld/ Sequest	Refund/ Interest	Adj	Net Amt
99213	SA	[redacted]	[redacted]	N	235.00	138.75 N783 RF001	0.00	0.00	81.25	0.00 0.00	0.00 0.00		81.25
	Claim Totals				**235.00**	**138.75**	**0.00**	**15.00**	**81.25**	**0.00 0.00**	**0.00 0.00**		**81.25**
	Adjusted Claims Totals												**81.25**

RAS Legend:



Legend

Number	Description
RF001	Contract Adjustment
N783	Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected copayment. This amount may be billed to a subsequent payer.

835 Detail:

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CLP*XXXXXXXXXX01*1*235*81.25**HM*25001X00001*11~
NM1*QC*1*NAME*PATIENT***MI*XXXXXXXXXX01~
NM1*82*1*NAME*PROVIDER****XX*XXXXX07~
DTM*233*20250101~
DTM*232*20250101~
DTM*050*20250101~
AMT*AU*235~
AMT*I*0~
SVC*HC:99213:SA*235*81.25~
DTM*472*20250106~
CAS*CO*45*138.75~
CAS*OA*209*15~
REF*6R*XXXXXX3~
AMT*B6*81.25~
LQ*HE*N783~
LX*9~
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Fallon Health ACO pharmacy updates for July 1, 2025

Title	Description
Kinase inhibitors	• Cabometyx CU for dx of HCC to include Imfinzi, Lenvima, and atezolizumab + bevacizumab as trial options • Qinlock CU to appendix for guidance when exceeding quantity limits • Lenvima CU for dx of RCC for non-clear cell histology to remove trial with Cabometyx and sunitinib to requested agent will be used in combination with Keytruda or everolimus • Vanflyta CU for maintenance therapy to remove part of induction and/or consolidation therapy and clinical rationale instead of Rydapt and sorafenib to requested agent will be used as monotherapy only

Title	Description
Lymphoma and leukemia agents	• Revuforj added, PA required
Wilson's Disease agents	• Cuvrior update to remove strength of trientine trial and add quantity limit of 10 units/day
Brand name and non-preferred generic drugs	• Add Depen (penicillamine tablet) to BOGL
JAK inhibitors for myelofibrosis, graft versus host disease, and polycythemia vera	• Jakafi update for dx of PV to add age for consistency • Guideline name updated from JAK Inhibitors for Myelofibrosis to JAK Inhibitors for Myelofibrosis, Graft Versus Host Disease, and Polycythemia Vera
Asthma and allergy monoclonal antibodies	• CU for Dupixent for dx of COPD clarifying accepted LCA trials • Update diagnosis for nasal polyps for Nucala and Xolair to note "chronic rhinosinusitis with nasal polyps" and update required trials to one LCA (previously two)
Presbyopia, myopia, and mydriasis agents	• Add Qlosi to MHDL requiring PA (currently non-rebate) • Rename the guideline name updated to Presbyopia, Myopia, and Mydriasis Agents [previously: pilocarpine (Vuity)]
Brand name and non-preferred generic drugs	• Add to Adzenys, Xeljanz, and Xeljanz XR to BOGL • Add Riduara (auranofin) to BOGL
Antibiotics – oral	• Pivya added, PA required
Amyloidosis therapies	• Remove Tegsedi (discontinued product) • Wainua CU, require step thru with both Amvuttra and Onpattro update diagnosis verbiage for consistency
Opioid dependence and reversal agents	• Brixadi CU to the clinical rationale options for using Brixaldi instead of Sublocade
Butalbital containing agents	• butalbital/aspirin/caffeine tablet (50-325-40 mg tablet (GSN 004309) gained rebate. Prescriber verbiage updates
nirogacestat (Ogsiveo)	• Prescriber verbiage updated. Ok to accept consult notes from a specialist
tisotumab (Tivdak)	• N/A

Title	Description
Beta Thalassemia, Myelodysplastic Syndrome and Sickle Cell Disease agents	• Xromi added, PA required
Oncology immunotherapies	• Opdivo Qvantig added, PA required and restricted to MB • Add expanded indications for Keytruda, Imfinzi, Opdivo and Tevimbra • CU for Opdivo for diagnosis of advanced renal cell carcinoma (RCC) and diagnosis of advanced or metastatic gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma • CU for Keytruda for diagnosis of RCC, Stage III NSCLC, and clarification of Hodgkin lymphoma diagnosis • CU for Zynyz for diagnosis of Metastatic Merkel Cell carcinoma • CU for Yervoy for diagnosis of unresectable or metastatic melanoma, and add criteria for diagnosis of cutaneous melanoma • Update of guideline appendices
Nonhormonal agents for menopausal symptoms	• Update approval duration of Veozah
Benzodiazepines and other antianxiety agents	• Alprazolam solution updated from no PA to PA ≥ 13 years of age • Lorazepam solution updated from no PA to PA ≥ 13 years of age • Diazepam 25 mg/5 mL solution updated from no PA to PA required • Alprazolam ODT CU to update medical necessity to one of the following formats including age < 13 years • Quazepam, flurazepam, and temazepam 22.5 mg update to remove medical records requirement for trials
Gastrointestinal agents-H2 antagonists, PPIs and misc. agents	• Zegerid powder for oral suspension updated from no PA to PA required
Pediatric Behavioral Health Medication Initiative	• Alprazolam solution updated from no PA to PA ≥ 13 years of age • Lorazepam solution updated from no PA to PA ≥ 13 years of age • Diazepam 25 mg/5 mL solution updated from no PA to PA required

Title	Description
Cerebral stimulants and ADHD medications	• Criteria update to Ritalin LA and Metadate CD to remove step through methylphenidate transdermal.
Lupus agents	• Criteria update for diagnosis of SLE to require trial with hydroxychloroquine • Criteria update for diagnosis of Lupus nephritis for both Benlysta and Lupkynis (incorporate footnote regarding use of mycophenolic acid analog or azathioprine into criteria)
Topical hyperhidrosis agents	• Sofdra gained rebate, update criteria to remove Qbrexa step through. • Quantity limit verbiage update, move "no documented quantity" directions to notes section.
Anti hemophilia agents	• Add Alhemo, requiring PA
Antibiotics – oral	• Add Emrosi ER, requiring PA (non-rebate) • Add metronidazole 125 mg tablet, requiring PA • Likmez criteria update to add age criteria
crinecerfont (Crenessity)	• Add Crenessity, requiring PA
Brand name and non-preferred generic drugs	• Remove Dermotic from BOGL
Targeted immunomodulators	• Otulfi added to PA, vial added to PA and restricted to MB • Pyzchiva added to PA, vial added to PA and restricted to MB • Selarsdi added to PA • Steqeyma added to PA, vial added to PA and restricted to MB • Ustekinumab-ttwe added to PA, vial added to PA and restricted to MB • Yesintek added to PA, 130 mg/26 mL vial added to PA and restricted to MB • Wezlana added to PA, 130 mg/26 mL vial added to PA restricted to MB, will not be added to MHDL (non-rebate)

Title	Description
	• Stelara biosimilars (Otulfi, Pyzchiva, Selarsdi, Stegeyma, ustekinumab-ttwe, Yesintek, Wezlana) to require step through Stelara or clinical rationale for use • Pyzchiva add BNO criteria • Ustekinumab-ttwe to be added to procedure table where applicable • Stability for Stelara biosimilars not accepted to bypass GL criteria
Lymphoma and leukemia agents	• Revuforj CU to differentiate QLs by drug strength; add 25 mg tablet
Iron agents and chelators	• Add Triferic to PA with non-rebate criteria, remove from MHDL due to losing rebate
Opioids and analgesics	• Olinvyk CU to add non-rebate criteria, remove from MHDL due to losing rebate
Enzyme and Metabolic Disorder therapies	• Add Kebilidi to PA with CO designation
Spinal muscular atrophy agents	• Add Evrysdi 5 mg tablet to PA with QL of 1 unit/day
Thyroid preparations	• Add Euthyrox to PA without non-rebate criteria. Stability only accepted for medical necessity
Targeted immunomodulators	• Add Omvoh 200mg/mL pen and syringe dose-pack to PA, CU asking for rationale for use over 300 mg in dx of CD • Add Omvoh 300 mg/mL pen and syringe dose-pack to PA, CU asking for rationale for use over 100 mg or 200 mg in dx of UC • Omvoh 100 mg/mL pen and syringe CU asking for rationale for use over 300 mg in dx of CD • GSN level coding by package (for dx of CD and UC) to ensure proper use
enfortumab vedotin-ejfv (Padcev)	• Criteria update to remove requested agent will be used as monotherapy
mirvetuximab soravtansine-gynx (Elahere)	• Verbiage update to include consult notes from oncologist

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

New postpartum home visit benefit

Pursuant to Chapter 186 of the Acts of 2024—An Act Promoting Access to Midwifery Care and Out-of-Hospital Birth Options—Fallon's Community Care product will cover at least 1 postpartum home care visit with a visiting nurse for caregivers with newborns within the first 8 weeks postpartum.

These visits are exempt from cost sharing, including copayments, coinsurance, and deductibles for most Community Care plans. The only exception is the Connector Low Silver HSA, which is a Qualified High-Deductible Plan. On that plan, the deductible must be met first before services are covered in full.

Home health agencies that provide postpartum home visits should bill for the first visit using revenue codes 0551, 0552, or 0559 with CPT code 99501 and diagnosis code Z39.2. Additional visits beyond the initial postpartum visit require prior authorization. Provided medical necessity is met and a plan authorization is granted, additional postpartum visits should be billed using revenue codes 0551, 0552, or 0559 and diagnosis code Z39.2. ■

Podimetrics termination notification – update

Fallon Health is terminating the partnership with Podimetrics as of August 1, 2025.
This program began in October 2023 and was implemented to help reduce foot complications, addressing the problem of preventable diabetic amputations and associated complications via a remote monitoring solution and care support program.

Eligibility was determined based on the following criteria:

- Fallon Health-selected eligible population of high-risk diabetic members with history of diabetic foot ulcers in the past 24 months
- Limited to Fallon Medicare Plus and NaviCare members
- Potential prescribing physicians: podiatrist, PCP, endocrinologists

Fallon Health has determined, through claims analytics, that the program has shown no significant clinical benefits associated with reducing diabetic foot ulcer prevention and complications associated with these episodes. We are committed to allocating resources to care management programs that will focus on improved member health outcomes.

Fallon Health will be notifying enrolled Fallon Medicare Plus and NaviCare members in July 2025 of the program end date. Notification outreach calls will be made by Fallon's Clinical Care Management staff and will include assisting members with transitioning out of the program as well as offering referral into Fallon's internal Disease Management program. ■

What's new

Coming soon! New Fallon Health provider portal

Fallon Health is excited to share that our provider portal, which has been under development since early this year, is **on track for rollout in the 3rd quarter of 2025.** This portal will allow our contracted providers to perform eligibility and benefit verifications, claim status checks, claims submission for 1500 claim forms, authorization status checks, and more! At the end of July, a select group of providers will participate in the soft launch of the portal.

One new feature of the portal is the role of a super user. Super users will act as a point person who will set up, manage, and maintain user access within their own group or practice. To ensure a smooth transition, we are asking each provider group to designate a portal super user for when the portal goes live. We are anticipating the new provider portal to go live in mid-September. Starting in August, pre-registration for the new portal will open for designated super users and other direct portal users. **All providers will have to register as new users with the provider portal.**

Please note that with our transition to the provider portal, we will not be accepting new enrollment requests for the existing provider tools after June 30, 2025.

Additional information regarding the provider portal launch will be shared throughout the summer. ■

PACT Act requirements

Effective July 1, 2025 for Community Care:

Chronic care drugs

Effective July 1, 2025, under the terms of Massachusetts' new Pharmaceutical Access, Costs and Transparency Act ("PACT Act"), Fallon's Community Care product provides access to one generic drug and one brand name drug used to treat each of the following chronic conditions, with limited cost-sharing: diabetes, asthma, hypertension, and coronary artery disease.

Per state regulations, the drugs for diabetes must be insulin. Coverage for identified generic drugs is exempt from cost-sharing, including copayments, coinsurance, and deductibles for most Community Care plans*.

Coverage for identified brand-name drugs is exempt from deductibles and coinsurance, with copayments capped at $25 per 30-day supply for most Community Care plans*. This includes one brand-name insulin drug per dosage type. Note, as there currently are no generic insulins as defined in the regulation, our list only includes brand name insulins.

** The only exception is the Connector Low Silver HSA plan, which is a Qualified High-Deductible Plan. On that plan, the deductible must be met first before these generic drugs are covered in full or brand drugs are covered at the capped copay.*

Our chronic conditions and chronic care drugs

(Brand name drugs are in regular font; generic drugs are in *Italics*):

Medication	Condition	Type of insulin	Brand/Generic
Atrovent 200 ACTUAT Ipratropium Bromide 0.017 MG/ACTUAT Metered Dose Inhaler	Asthma	N/A	Brand
Levalbuterol 2.5 MG/ML Inhalation Solution	*Asthma*	*N/A*	*Generic*
Levalbuterol 200 ACTUAT 0.045 MG/ACTUAT Metered Dose Inhaler	*Asthma*	*N/A*	*Generic*

Medication	Condition	Type of insulin	Brand/Generic
Levalbuterol 0.21 MG/ML Inhalation Solution	*Asthma*	*N/A*	*Generic*
Levalbuterol 0.417 MG/ML Inhalation Solution	*Asthma*	*N/A*	*Generic*
Levalbuterol 0.103 MG/ML Inhalation Solution	*Asthma*	*N/A*	*Generic*
Humalog Mix 3 ML Insulin Lispro 50 UNT/ML / insulin lispro protamine, human 50 UNT/ML Pen Injector	Diabetes - insulin	Premixed	Brand
Humalog Mix 3 ML Insulin Lispro 25 UNT/ML / insulin lispro protamine, human 75 UNT/ML Pen Injector	Diabetes - insulin	Premixed	Brand
Humulin 3 ML insulin isophane, human 70 UNT/ML / insulin, regular, human 30 UNT/ML Pen Injector	Diabetes - insulin	Premixed	Brand
Humulin insulin isophane, human 70 UNT/ML / insulin, regular, human 30 UNT/ML Injectable Suspension	Diabetes - insulin	Premixed	Brand
Humulin N insulin isophane, human 100 UNT/ML Injectable Suspension	Diabetes - insulin	Intermediate acting	Brand
Humulin R insulin, regular, human 100 UNT/ML Injectable Solution	Diabetes - insulin	Short acting	Brand
Lyumjev 3 ML insulin lispro-aabc 100 UNT/ML Pen Injector	Diabetes - insulin	Rapid acting	Brand
Lyumjev 3 ML insulin lispro-aabc 200 UNT/ML Pen Injector	Diabetes - insulin	Rapid acting	Brand

Medication	Condition	Type of insulin	Brand/Generic
Humulin R insulin, regular, human 500 UNT/ML Injectable Solution	Diabetes - insulin	Short acting	Brand
Humulin N 3 ML insulin isophane, human 100 UNT/ML Pen Injector	Diabetes - insulin	Intermediate acting	Brand
Humalog Mix Insulin Lispro 25 UNT/ML / insulin lispro protamine, human 75 UNT/ML Injectable Suspension	Diabetes - insulin	Premixed	Brand
Toujeo 1.5 ML Insulin Glargine 300 UNT/ML Pen Injector	Diabetes - insulin	Long acting	Brand
Tresiba 3 ML insulin degludec 100 UNT/ML Pen Injector	Diabetes - insulin	Ultra long acting	Brand
Tresiba 3 ML insulin degludec 200 UNT/ML Pen Injector	Diabetes - insulin	Ultra long acting	Brand
Humulin R 3 ML insulin, regular, human 500 UNT/ML Pen Injector	Diabetes - insulin	Short acting	Brand
Toujeo 3 ML Insulin Glargine 300 UNT/ML Pen Injector	Diabetes - insulin	Long acting	Brand
Lescol 24 HR fluvastatin 80 MG Extended Release Oral Tablet	Prevalent heart condition-coronary artery disease	N/A	Brand
Lescol fluvastatin 40 MG Oral Capsule	Prevalent heart condition-coronary artery disease	N/A	Brand
Fluvastatin 24 HR 80 MG Extended Release Oral Tablet	*Prevalent heart condition-coronary artery disease*	*N/A*	*Generic*
Fluvastatin 20 MG Oral Capsule	*Prevalent heart condition-coronary artery disease*	*N/A*	*Generic*
Fluvastatin 40 MG Oral Capsule	*Prevalent heart condition-coronary artery disease*	*N/A*	*Generic*
Lotensin Benazepril hydrochloride 40 MG Oral Tablet	Prevalent heart condition-hypertension	N/A	Brand

Medication	Condition	Type of insulin	Brand/Generic
Lotensin Benazepril hydrochloride 10 MG Oral Tablet	Prevalent heart condition-hypertension	N/A	Brand
Lotensin Benazepril hydrochloride 20 MG Oral Tablet	Prevalent heart condition-hypertension	N/A	Brand
Lotensin Benazepril hydrochloride 5 MG Oral Tablet	Prevalent heart condition-hypertension	N/A	Brand
Benazepril hydrochloride 10 MG Oral Tablet	*Prevalent heart condition-hypertension*	*N/A*	*Generic*
Benazepril hydrochloride 20 MG Oral Tablet	*Prevalent heart condition-hypertension*	*N/A*	*Generic*
Benazepril hydrochloride 40 MG Oral Tablet	*Prevalent heart condition-hypertension*	*N/A*	*Generic*
Benazepril hydrochloride 5 MG Oral Tablet	*Prevalent heart condition-hypertension*	*N/A*	*Generic*

Please refer to our website for formulary information:

https://fallonhealth.org/providers/pharmacy/online-drug-formulary

Opioid reversal agents

Fallon's Community Care product ensures coverage for opioid antagonists used to reverse opioid overdoses. These medications do not require prior authorization, or a prescription for coverage or reimbursement (i.e., state standing order).

Effective July 1, 2025, these drugs will not be subject to deductibles, copayments, or out-of-pocket limits for most Community Care plans. The only exception is the Connector Low Silver HSA plan, which is a Qualified High-Deductible Plan. On that plan, the deductible must be met first before these drugs are covered in full.

These are both available as a medical benefit when dispensed at healthcare facilities and as a pharmacy benefit when provided by pharmacists.

Opioid antagonists dispensed at healthcare facilities must be billed using revenue code 0636 with one of the following HCPCS and NDC codes, and Diagnosis codes F11.1 through F11.99. Patients cannot be balance-billed by the healthcare facility.

NDC	Product label	GPI-14 description	HCPCS code
59467067901	KLOXXADO SPR 8MG	NALOXONE HCL NASAL SPRAY 8 MG/0.1ML	J3490
59011096010	NALMEFENE INJ 1MG/ML	NALMEFENE HCL INJ 1 MG/ML (BASE EQUIV)	J3490
00409121501	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00409121521	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00641613201	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00641613225	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
36000030801	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
36000030810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
55150032701	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
55150032710	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457029200	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457029202	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457059900	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457059902	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457064500	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
67457064502	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70069007101	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70069007110	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70756065810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
70756065825	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72572045001	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72572045025	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72603059010	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
72603059025	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 0.4 MG/ML	J2312
00409121901	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
55150032801	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
55150032810	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457029900	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457029910	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457098700	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
67457098710	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
70069007201	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
70069007210	NALOXONE INJ 0.4MG/ML	NALOXONE HCL INJ 4 MG/10ML	J2312
00409178203	NALOXONE INJ 0.4MG/ML	NALOXONE HCL SOLN CARTRIDGE 0.4 MG/ML	J2312
00409178269	NALOXONE INJ 0.4MG/ML	NALOXONE HCL SOLN CARTRIDGE 0.4 MG/ML	J2312

NDC	Product label	GPI-14 description	HCPCS code
36000031001	NALOXONE INJ 4MG/10ML	NALOXONE HCL INJ 4 MG/10ML	J2312
36000031002	NALOXONE INJ 4MG/10ML	NALOXONE HCL INJ 4 MG/10ML	J2312
68001064545	NALOXONE SPR	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
00781717606	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
00781717612	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
42291049301	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
42291049302	NALOXONE SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
76329146901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76329336901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76329346901	NALOXONE HCL INJ 1MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
00641620501	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
00641620510	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
42023022401	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
43598075010	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
43598075011	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
55150034501	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
55150034510	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
67457099202	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011201	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011220	NALOXONE HCL INJ 2MG/2ML	NALOXONE HCL SOLN PREFILLED SYRINGE 2 MG/2ML	J2312
76045011401	NALOXONE HCL SOL 0.4MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 0.4 MG/ML	J2312
76045011410	NALOXONE HCL SOL 0.4MG/ML	NALOXONE HCL SOLN PREFILLED SYRINGE 0.4 MG/ML	J2312
00480347819	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490

NDC	Product label	GPI-14 description	HCPCS code
00480347868	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802057800	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802057884	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802081100	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
45802081184	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
60219210407	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69238210401	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69238210407	NALOXONE HCL SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69547035302	NARCAN SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
69547062702	NARCAN SPR 4MG	NALOXONE HCL NASAL SPRAY 4 MG/0.1ML	J3490
12496000301	OPVEE SPR 2.7/0.1	NALMEFENE HCL NASAL SPRAY 2.7 MG/0.1ML (BASE EQUIV)	J3490
12496000302	OPVEE SPR 2.7/0.1	NALMEFENE HCL NASAL SPRAY 2.7 MG/0.1ML (BASE EQUIV)	J3490
76329366902	REXTOVY SPR 4/0.25ML	NALOXONE HCL NASAL SPRAY 4 MG/0.25ML	J3490
78670014002	ZIMHI SOL	NALOXONE HCL SOLN PREFILLED SYRINGE 5 MG/0.5ML	J2313
78670014011	ZIMHI SOL	NALOXONE HCL SOLN PREFILLED SYRINGE 5 MG/0.5ML	J2313

Please refer to our website for formulary information on opioid antagonist reversal agents:
https://fallonhealth.org/providers/pharmacy/online-drug-formulary

Pain management alternatives to opiate products

Fallon's Community Care product provides access to a broad spectrum of pain management services, including, but not limited to, non-medication, nonsurgical treatment modalities and non-opioid medication treatment options that serve as alternatives to opioid prescribing. Prior authorization is not required for covered non-medication, nonsurgical treatments. Benefit limitations may apply. Additionally, utilization controls on non-opioid drugs are not stricter than those applied to opioid medications.

For more information, please refer to our website:
https://fallonhealth.org/providers/pharmacy/opioid-management

Substance use recovery coaches

Fallon's Community Care product provides coverage of recovery coach services, provided the coach is licensed or authorized under Chapter 111J. Coverage applies regardless of the service setting, as long as it is within the lawful scope of practice.

Additionally, recovery coach services are exempt from deductibles, copayments, and coinsurance for most Community Care plans. The only exception is the Connector Low Silver HSA plan, which is a Qualified High-Deductible Plan. On that plan, the deductible must be met first before services are covered in full. Effective January 1, 2026 prior authorization is not required for these services. ■

Community Care diabetic testing supplies

Effective July 1, 2025—for Community Care (available through the MA Health Connector)—Fallon Health will be changing our preferred blood glucose meter and strips from OneTouch by LifeScan to Accu-Chek by Roche.

Meters and strips will still be available at the pharmacy at the applicable copay. Please rewrite your patients' prescriptions for an Accu-Chek meter and strips. ■

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 for Nantucket and Dukes, and there are no costs to the member for covered benefits.

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

Benefits that all NaviCare members receive include:

- An entire Care Team to help them reach their personal health goals. This allows each Care Team member to focus on what they do best. It also gives providers additional resources, such as coordinated care plans to reference and other Care Team members to communicate with to have the best information possible for each NaviCare member. Care Team members visit and assess members in their homes with the member's consent and work closely with community providers and resources providing value to both our members and providers.

- Unlimited transportation to medical appointments. 130 one-way trips per calendar year to run errands, visit friends, attend religious services, and more. Trips must be within a 30-mile radius of the member's pick-up locations. Transportation must be arranged 2 business days in advance by calling our transportation vendor, Coordinated Transportation Solutions (CTS), at 1-833-824-9440. The member or caregiver can arrange transportation. Fallon Health Navigators are also available to assist. Members' friends and family can receive reimbursement for mileage of pre-approved rides.
- $400 per year to pay for fitness classes, a new fitness tracker, new cardiovascular fitness equipment, or a fitness/gym membership.
- Up to $1,100 per year on the Save Now card ($275 every quarter), to purchase items—like cold/allergy medicine, pain relievers, probiotics and more—to keep our members healthy. Purchases can be made over the phone, at stores like CVS Pharmacy, Dollar General, and Walmart, or online with free home delivery.
    - Members with chronic condition(s) that meet certain criteria may be eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI). Qualifying members will have access to $100 of the OTC funds per calendar quarter through their Save Now card for healthy food and produce items at network retailers. Our Care Team staff may work with PCPs to determine eligibility for this benefit*.

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

- Outpatient behavioral health services (Covered through our contracted providers. No authorization required.)
- Covered prescription drugs and certain approved over-the-counter (OTC) drugs and items. Members may receive a 100-day supply of medications via mail order.
- Vision care and eyeglasses ($403 annual eyewear allowance, up to 2 pairs of glasses per year)
- Hearing aids (and batteries)
- Dental care, including dentures. For comprehensive dental, including endodontics, extractions, oral surgery services in a provider's office (except for the removal or exposure of impacted teeth), periodontics, prosthodontics, restorative services, and other oral/maxillofacial surgery services to be covered, the dental provider must get prior authorization from DentaQuest. Members have access to the DentaQuest network of dental providers.
- Durable medical equipment (DME), such as wheelchairs, crutches, walkers, and related supplies. Members are allowed one Seat Lift chair per lifetime after prior authorization, up to $900.
- Diabetic services and supplies. In addition to Freestyle Libre monitors, additional glucometers may be covered (Previously, only Freestyle Libre monitors were covered). Also, Medtronic non-therapeutic or adjunctive continuous glucose monitors may be obtained at network DME providers.

Care Team members and their roles include:

Navigator

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

Nurse Case Manager or Advanced Practitioner

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

Primary Care Provider (PCP)

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

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

- Evaluates the 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

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

NaviCare Model of Care success

Embracing member perspectives

On April 4, 2025, NaviCare held the SCO Advisory meeting at the Mary Spitzer Senior Center in North Adams. These sessions gather important member input and feedback regarding experiences, benefit structure, provider networks, plan design, and other relevant topics. They help us better understand what is liked and disliked by members so that Fallon Health can improve the overall program and services NaviCare provides to members.

Due to these meetings being held virtually during the pandemic and in the years that followed—and the challenges associated with virtual settings—members of this population historically have declined to participate in these sessions. Holding the event in person at a location the members were already comfortable with removed that barrier and allowed for a robust and candid dialogue during which their voices were truly heard.

The meeting included 4 NaviCare members, 1 caregiver(daughter) of a NaviCare member, the member's Navigator, and other representatives from Fallon Health, including the NaviCare Executive Director, Director of Market Research & Planning, and the Manager of Clinical Integration Navigators.

Outcomes and successes from the meeting include:

- The initiation of a monthly on-site presence at one of the local housing sites by the NaviCare Navigator per member request to assist members with questions and care coordination in person.
- Access to a dental specialist for a member who shared that she was having difficulty finding a provider to treat her unique need. A provider was located, and an appointment was scheduled with the appropriate specialist following this session.
- Members' expressed preferences were taken into consideration for future benefits and programs. For instance, during this session, members expressed that they liked the Self Care benefit that was offered in previous years which allowed them to purchase items such as soap and shampoo. This request was communicated to the Fallon Health product team for consideration in the configuration of upcoming benefit structures.
- The members and caregiver unanimously expressed their gratitude for the NaviCare program and reported that they appreciate the personal touch of having one point of contact at the plan (Navigator) who gently navigates them through the healthcare system.

We plan to build on the success of this session by holding additional events this year in at least two other areas across the state. ■

Important reminders

Corrected claim submissions for Zelis edits

Corrected Claim submissions for Zelis edits should be submitted directly to Fallon Health. For the quickest results, it is recommended that all corrected claims be sent electronically to Fallon Health using industry standard 837 submissions.

Electronic corrections do require the following information—indicating they are corrected/replacement claims:

- Frequency code "7" for CMS 1500 claim forms
- Bill type "7" for UB claim forms

Corrected claims that are mailed or faxed require a Request for Claim Review Form and should be sent to Fallon Health:

- **By Mail:** Fallon Health Claims Adjustments P.O. Box 211308 Eagan, MN 55121-2908
- **By Fax:** 1-508-368-9890

Please note: Provider appeals for Zelis edits should still be directed to Zelis with a Request for Claim Review Form and sent to Zelis:

- **By Mail:** Zelis Claims Integrity, Inc. 340 MT Kemble Ave Morristown, NJ 07960 Attn: Appeals Department
- **By Fax:** 1-855-787-2677

Inquiries on Zelis edits should also be directed to Zelis by calling 1-866-489-9444. ■

Did you know that Fallon Health measures appointment wait times?

Fallon Health is committed to assisting our members with timely access to primary and specialty care services. We assess our performance by surveying our members about their post-appointment perceptions of the wait time between seeking and accessing regular care, urgent care, and after-hours care. We then compare those results against our contractual appointment wait time performance standards.

Our appointment wait-time performance standards vary by type of specialty, level of urgency, and product.

As part of this ongoing process, we have found performance gaps for some of these measures.

We welcome the opportunity to meet with you—our valued provider group partners—to further explore this topic and to:

- Share our findings
- Validate our findings against your performance data
- Explore barriers and obstacles
- Identify best practices for ensuring timely access to care
- Align our efforts to better serve our shared members

If you are interested in further discussion around this important topic, please contact Susan Keser, Fallon Health Vice President, Network Development and Management, to start the conversation. ■

CAQH: Action needed

Fallon Health partners with the 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. This will allow us to access the provider and accept information and updates.

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 do business 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*. ■

State-supplied vaccines

Fallon Health requires providers to obtain state-supplied vaccines. State-supplied vaccines are vaccines that are available at no cost from the state.

The Massachusetts Department of Public Health (MDPH) Immunization Division universally provides routinely recommended pediatric vaccines to all children through 18 years of age (up to the 19th birthday). Healthcare providers are to receive vaccines from the MDPH Immunization Division and may need to enroll each year. Only when there is a documented shortage of a state-supplied vaccine will the plan determine how providers are to be reimbursed for a purchased vaccine. A notification will be issued from MDPH in those rare situations.

Providers are to bill for only the administration of state-supplied vaccines:

- Submit the appropriate immunization administration CPT code (90460-90461, 90471-90474) in addition to the vaccine CPT code.
- Attach the SL modifier to the vaccine/toxoid CPT code with a charge of $0.00 to indicate that the vaccine/toxoid was state supplied.
- The plan will not reimburse providers who bill for state-supplied vaccines, i.e., vaccines that are available free from the state.

Massachusetts supplies the vaccine for human papillomavirus (HPV) as defined in the CPT codes listed below. Claims submitted for these HPV vaccinations will be denied for any age group where the vaccine is available from the state-supplied program.

To properly bill for the administration of a state-supplied vaccine:

- Submit the appropriate immunization administration CPT code in addition to the vaccine CPT code.
- Attach the SL modifier to the vaccine/toxoid CPT code with a charge of $0.00 to indicate that the vaccine/toxoid was state-supplied. ■

The Fallon Health provider manual

The Fallon Health provider manual is a valuable resource. It includes information about:

- Navigating claims
- Managing patient care
- Provider responsibilities
- Payment policies
- And much more

Providers and office personnel can access the Fallon Health provider manual on our website. No login is required. If you have any questions, please reach out to your Provider Relations representative. ■

Managing expedited MassHealth ACO appeals for GLP-1 medications: A call for provider collaboration

Fallon Health is currently receiving a high volume of expedited Accountable Care Organization (ACO) member appeals related to GLP-1 medications.

To maintain compliance, Fallon Health must adhere to strict turnaround times for appeals. When an expedited appeal is requested, it is moved to the front of the queue. While we understand members' eagerness to begin their medication regimens, we strive to process all member appeals as swiftly as possible.

Action required:

We urgently request that providers and PA teams refrain from expediting member appeals unless there is a valid clinical reason. This will help ensure that truly urgent cases receive the attention they need without unnecessary delays.

Tips for providers:

- **Preferred GLP-1 medication:** Remember that Zepbound is the preferred GLP-1 for weight loss under MassHealth, with a required phentermine step. If a member has a contraindication to phentermine or has experienced a trial and failure, please include this information in the initial PA request.
- **Timely PA renewals:** Start PA renewals promptly to avoid last-minute requests, inappropriate denials, and the need for expedited appeals.

Your cooperation in this matter is greatly appreciated. Together, we can ensure that all appeals are handled efficiently and that members receive the consideration they need in a timely manner. ■

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

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

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

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

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

Recommended strategies and interventions: Improving Bladder Control

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

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

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

Recommended strategies and interventions: Reducing the Risk of Falling

Regularly screen patients 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 Quality Rating Program, please contact your Provider Relations Representative. ■

Effective July 1, Fallon Health will be using Integrated Home Care Services (IHCS) for the coordination and provision of durable medical equipment and home health services

As communicated in May (via letter and/or email), Fallon Health will be using Integrated Home Care Services (IHCS) for the coordination and provision of durable medical equipment (DME) and home health services.

This means that effective July 1, 2025, all DME items currently requiring an authorization along with an expanded list of DME items and home health service requests for patients will need to be submitted directly to IHCS. The expanded the list of DME items includes all categories, excluding orthotics and prosthetics, diabetic supplies, PERS, and CPAP/BIPAP.

- The expanded list of DME items applies to members of Fallon 365 Care, Berkshire Fallon Health Collaborative, Fallon Health-Atrius Health Care Collaborative, and Community Care.
- For members of Fallon Medicare Plus™ (Medicare Advantage), Fallon Medicare Plus™ Premier and Premier Central HMO and NaviCare®, IHCS will apply to items and services you are currently prior authorizing. We encourage you to start using IHCS for the expanded list, but you are not required currently to do so. Future communication will be released for the effective date on the expanded list of DME services.

IHCS will coordinate your patients' covered DME and home health services with an in-network Fallon Health provider, effectively reducing your administrative burden.

If you're currently contracted with Fallon Health to provide your patients with DME items—like crutches, splints, nebulizers, or canes—you can continue to do so.

- If your practice works with a DME supplier to give out items in office and the DME will bill for the service, you will need to notify IHCS and let them know who your DME supplier is and indicate that you already dispensed the item to the patient.
- If you are a practice that has purchased the DME items, submit the notification to IHCS with the billing provider's name as the supplier.

These notifications are needed to ensure ease of claims payment in both scenarios.

IHCS contact information:

- Please fax all prescriptions, medical orders, and/or discharge orders to IHCS at 1-844-215-4265.
- If you have any questions or need assistance with an order, you can call IHCS at 1-844-215-4264.

At Fallon Health, our goal is to ensure that our members/your patients receive all the covered benefits they need. We believe this new partnership with IHCS will improve benefit coordination and result in improved member care.

If you have questions, please contact your Fallon Health Provider Relations representative directly, or email askfchp@fallonhealth.org. ■

Doing business with us

Provider satisfaction survey – your opinion matters!

At Fallon Health, we value our providers and your feedback. To ensure we continually improve our services, we conduct monthly provider satisfaction surveys via Survey Monkey through email.

If you receive one of these emails, we ask that you take a few minutes to share your thoughts with us. Your feedback is instrumental in helping us understand what works and what does not work, so we can better meet your needs.

Thank you in advance for your time and insights. ■

EDI enhancement

Fallon Health is enhancing its operational efficiency and offering additional flexibility for EDI transactions by onboarding additional clearinghouses. This initiative will expand availability, ensuring a more reliable and streamlined experience for our partners while giving providers choices that best fit their needs. This diversification allows for better scalability, optimized processing speeds, and improved accuracy in claims management and electronic transactions. Leveraging multiple clearinghouses will strengthen data integrity and foster stronger relationships with trading partners, ultimately leading to a more seamless and reliable experience for both Fallon Health and our provider community.

The following is a list of available clearinghouses Fallon Health is contracted with:

- **Change Healthcare**
  Website: changehealthcare.com
  Fallon Health: Payor ID: 22254; FHW: Payor ID: 22254

- **NEHEN**
  Call: 1-781-907-7210 | Website: nehen.org
  Email: nehen@maehc.org

- **Athena Health** (Billing Service)
  Call: 1-617-402-1000 | Website: athenahealth.com

- **Office Ally**
  Call: 1-360-975-7000 | Website: cms.officeally.com

- **Finthrive**
  Call: 1-800-390-7459 | Website: finthrive.com

- **Waystar**
  Call: 1-844-392-9782 | Website: waystar.com
  EDI: zirmedeoperationsteam@waystar.com
  Trading Partner Operations: payers@waystar.com
  Fallon Health Payer ID: SX072 ■

Quality focus

Clinical practice guidelines update

Our Clinical Practice Guidelines are available online. For a paper copy, please contact Robin Byrne at 1-508-368-9103.

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

- 2025 MHQP Pediatric Preventive Care Guidelines
- 2025 MHQP Adult Preventive Care Guidelines
- GOLD Initiative for Chronic Obstructive Lung Disease Pocket Guide to COPD Diagnosis Management and Prevention 2025 Pocket Guide
- CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 ■

Enhancing quality of care through Medication Regimen Management

CMS Star Rating

The Centers for Medicare & Medicaid Services (CMS) have implemented polypharmacy measures within the Medicare Part D Star Rating system to enhance patient safety and reduce the risk of harm.

Measures include:

- Concurrent Use of Opioids and Benzodiazepines (COB)
- Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)
- Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

Polypharmacy

Polypharmacy can be defined in a few different ways: specific number of medications or use of multiple medications when the risks outweigh the benefits, or the continued use of medications that are no longer appropriate or necessary. Polypharmacy significantly increases the risk of adverse effects such as falls and fractures. For instance, patients with a high anticholinergic burden from multiple agents are at greater risk of cognitive decline and falls. Similarly, the use of multiple CNS depressant medications, including benzodiazepines, gabapentinoids, and opioids, can further elevate the risk of falls.

The clinical picture becomes more complex when polypharmacy leads to a prescribing cascade. A prescribing cascade occurs when the adverse effects of one drug are misinterpreted as a new medical condition, resulting in additional therapies. Older adults are particularly vulnerable to polypharmacy and prescribing cascades due to multiple comorbid conditions and age-related changes. Examples include patients with high anticholinergic burden being prescribed medications for declining memory and cognition, or patients on stimulant drugs being prescribed sedative-hypnotics.

Deprescribing

To mitigate the risks associated with polypharmacy and prescribing cascades, deprescribing should be considered during medication reviews. Recommendations from American Family Physician include:

- Assessing the patient's goals of therapy
- Understanding the patient's perspective and priorities related to medical conditions and medications
- Aligning these beliefs with long-term goals

Other considerations for medication evaluation or deprescribing include:

- Prioritizing medications for discontinuation
- Establishing follow-up plans
- Utilizing each visit as an opportunity to follow up on the deprescribing plan
- Evaluating new therapies for necessity, risk-benefit, and alternative non-pharmacological treatments
- Implementing a trial period for new medications
- Assessing the risk-benefit ratio when renewing prescriptions

These strategies can be applied to review drug regimens and reduce the risks of polypharmacy and adverse drug effects. ■

Coding corner

Coding updates

Effective January 1, 2025, the following codes were deemed *payable with prior authorization* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative):

Code	Description
15016	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq. cm. or part thereof (List separately in addition to code for primary procedure.)
49186	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm. or less
49187	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm.
49188	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 10.1 to 20 cm.
49189	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm.
49190	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm.
51271	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed
64474	Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed
93896	Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure.)

Effective January 1, 2025, the following codes were deemed *payable without prior authorization* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative):

Code	Description
25448	Arthroplasty, intercarpal or carpometacarpal joints; suspension, including transfer or transplant of tendon, with interposition, when performed
92137	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Code	Description
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

Code	Description
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90689	Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use

Effective September 1, 2025, the following code will *require prior authorization* for all lines of business:

Code	Description
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq. mm. surface area of bone deep to the outer cranial cortex

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

Code	Description
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)
S2079	Laparoscopic esophagomyotomy (Heller type)
S2115	Osteotomy, periacetabular, with internal fixation
S2225	Myringotomy, laser-assisted
S2325	Hip core decompression

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

Code	Description
S5180	Home health respiratory therapy, initial evaluation
S5181	Home health respiratory therapy, NOS, per diem
S9097	Home visit for wound care

Code	Description
S9212	Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (Do not use this code with any home infusion per diem code.)

Effective September 1, 2025, the following codes will be *deny vendor liable* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative):

Code	Description
A2019	Kerecis omega3 marigen shield, per square centimeter
A2020	Ac5 advanced wound system (ac5)
A2021	Neomatrix, per square centimeter
A4341	Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each
A4342	Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each
A4560	Neuromuscular electrical stimulator (nmes), disposable, replacement only
A6590	External urinary catheters; disposable, with wicking material, for use with suction pump, per month
A6591	External urinary catheter; non-disposable, for use with suction pump, per month
A7049	Expiratory positive airway pressure intranasal resistance valve
E0677	Non-pneumatic sequential compression garment, trunk
E0711	Upper extremity medical tubing/lines enclosure or covering device, restricts elbow range of motion
L8678	Electrical stimulator supplies (external) for use with implantable neurostimulator, per month
S9563	Home injectable therapy, immunotherapy, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
A2024	Resolve matrix, per square centimeter
A2025	Miro3d, per cubic centimeter
A9156	Oral mucoadhesive, any type (liquid, gel, paste, etc.), per 1 ml

Effective September 1, 2025, the following codes will be *payable with prior authorization* for MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Health Care Collaborative):

Code	Description
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve

Code	Description
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve

Effective September 1, 2025, the following code will *require prior authorization* for all lines of business:

Code	Description
28280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed

Effective September 1, 2025, the following code will be *deny vendor liable* for all lines of business, excluding MassHealth ACO, Summit ElderCare® PACE, and NaviCare:

Code	Description
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency

Effective September 1, 2025, the following code will *require prior authorization* for MassHealth ACO, Summit ElderCare PACE, and NaviCare:

Code	Description
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (e.g., bone allograft(s), synthetic device(s)), without placement of transfixing device ■

Effective September 1, 2025, the following codes will *be payable with prior authorization* for MassHealth ACO:

Code	Description
A4657	Syringe, with or without needle, each
L5783	Addition to lower extremity, user adjustable, mechanical, residual limb volume management system

Effective September 1, 2025, the following code will *be payable with prior authorization* for MassHealth ACO, Summit ElderCare PACE, and NaviCare:

Code	Description
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated

Effective September 1, 2025, the following code will *deny vendor liable* for Medicare HMO, NaviCare, and Summit ElderCare PACE:

Code	Description
S0013	Esketamine, nasal spray, 1 mg

Effective September 1, 2025, the following codes will *be payable with prior authorization* for MassHealth ACO:

Code	Description
81515	NFCT DS BV&VAGINITIS DNA ALG
82233	BETA-AMYLOID 1-40 (ABETA 40)
82234	BETA-AMYLOID 1-42 (ABETA 42)
83884	ASSAY NEURFLMNT LIGHT CHAIN
84393	TAU PHOSPHORYLATED EA
84394	TOTAL TAU
86581	STRPTCS PNEUM ANTB SEROT IA
87513	H PYLRI CLRTHMCN RST AMP PRB
87564	MTB RIFAMPIN RST AMP PRB TQ
87594	PNEUMCYSTS JIROVECII AMP PRB
87626	HPV SEP HI-RSK TYP&POOL RSLT

Effective September 1, 2025, the following code will *be payable with prior authorization* for MassHealth ACO, Summit ElderCare PACE, and NaviCare:

Code	Description
81514	NFCT DS BV&VAGINITIS DNA ALG ■

Payment policies

Revised policies – Effective September 1, 2025

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

- **Non-Covered Services** – Updated code report (generated 07/02/2025).
- **Oxygen and Oxygen Equipment** – Clarified use of Advance Beneficiary Notice of Noncoverage (ABN) Modifiers; clarified use of KX modifier with DMEPOS items; updated information regarding 6-month maintenance and servicing fee (MS modifier); under Referral/notification/prior authorization requirements, added new information about how to obtain prior authorizations for oxygen and oxygen equipment effective July 1, 2025; under Billing/coding guidelines, added new section Who Can Order Oxygen and Oxygen Equipment?
- **Durable Medical Equipment** – Under Referral/notification/prior authorization requirements, added new information about how to obtain prior authorizations for durable medical equipment effective July 1, 2025, under Billing/coding guidelines, clarified that the 6-month maintenance and servicing fee billed with the MS modifier is not payable for capped rental items.

- **Home Health Care** – Removed updates related to coronavirus disease 2019 (COVID-19) throughout as this information is outdated; under Billing/coding guidelines, added new section Modifier EY for MassHealth ACO and NaviCare Members; also under Billing/coding guidelines, added new section for Universal Postpartum Home Visiting Services for Community Care Members; under Referral/notification/prior authorization requirements, added new information about how to obtain prior authorizations for home health services effective July 1, 2025.
- **Drugs and Biologicals** – Under Billing/coding guidelines, added new section for Opioid Reversal Agents; under Billing/coding guidelines, added new section Spravato® (Esketamine Nasal Spray) Billing and Coding Update; under Billing/coding guidelines, added new section for Long-Acting Injectable (LAI) Antipsychotics for MassHealth ACO Members.
- **Newborn Services Payment Policy** – Under Reimbursement, added new section for Donor Human Milk and Donor Human Milk-Derived Products for Community Care Members.
- **Modifier Payment Policy** – Under Reimbursement, clairified use of Advance Beneficiary Notice of Noncoverage (ABN) Modifiers.

New policy – Effective September 1, 2025

- **Community Health Centers** ■

Medical policies

Revised policies – Effective May 1, 2025

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

- **Autologous Chondrocyte Implantation**
- **Balloon Sinus Ostial Dilation**
- **Bone-Anchored Hearing Aids**
- **Corneal and Scleral Contact Lenses**
- **Fecal Calprotectin Testing**
- **Fecal Microbiota Transplant**
- **Hip Arthroscopy for Femoroacetabular Impingement**
- **Lung Transplantation**
- **Durable Medical Equipment**
- **Enteral Nutrition, Parenteral Nutrition, Low Protein Food Products, and Special Medical Formulas**
- **Excimer Laser Skin Therapy**
- **Hearing Aids for Plan Members 21 Years of Age and Younger**
- **Home Health Services**
- **Urine Drug Testing**

Revised policies – Effective June 1, 2025

- Sacroiliac Joint Fusion
- Luxturna (voretigene neparvovec-rzyl)
- Skilled Nursing Facility
- Radiofrequency Ablation of Uterine Fibroids (formerly Ultrasound-Guided Transcervical Radiofrequency Ablation of Uterine Fibroids)
- Zolgensma (onasemnogene abeparvovec-xioi)
- Varicose Veins of the Lower Extremities
- Hospital Beds with Added Safety Enclosure

Revised policies – Effective July 1, 2025

- Durable Medical Equipment
- Home Health Services
- Acute Inpatient Rehabilitation Hospital
- Allogeneic Stem Cell Transplantation
- Ambulatory Cardiac Monitoring
- Anterior Segment Optical Coherence Tomography
- Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee (formerly Arthroscopy for Osteoarthritis of the Knee)
- Bone Growth Stimulators

Retired policies – Effective July 1, 2025

- Stretch Devices for Joint Stiffness and Contractures
- High Frequency Chest Wall Oscillation Devices
- Speech Generating Devices ■

Our products*

Medicare Advantage

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

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

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

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

- Exclusively for Medicare members who live in Worcester County

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

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

Medicare Supplement

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

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

Individual and small group

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

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

MassHealth ACO

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

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

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

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

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

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

Our products* *(continued)*

PACE program

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

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

Senior Care Options program and Special Needs Plan

NaviCare SCO – Fallon Health's Senior Care Options (SCO) program for people aged 65 and older, who live in our service area—which includes all of the cities and towns in Massachusetts, except those in Nantucket and Dukes counties—and who have MassHealth Standard.

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

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

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

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

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