January 2024

Connection

Important information for Fallon Health physicians and providers

In the January issue:

Important updates

Post-ACUTE Prior Auth Waiver

Based on EOHHS guidance given to all Massachusetts health insurers, Fallon Health is implementing a waiver of prior authorization requirements for admissions from acute care hospitals to sub-acute care and rehabilitation facilities. This waiver will begin on Tuesday, January 9, and conclude on Monday, April 1. Other essential information about this waiver is listed below:

- This waiver applies to all Fallon Health lines of Massachusetts business, and Massachusetts facilities only.
- This waiver applies to admissions to Skilled Nursing Facilities, Acute Rehabilitation facilities, and Long-Term Acute Care (LTAC) facilities. Fallon Health members who are admitted to a hospital in Massachusetts are eligible for this waiver. Any Fallon Health member who is admitted to a hospital **out of state** is exempt from this waiver.
- This waiver does not apply to prior authorization requests for Long Term Care or Custodial admissions.
- Please submit an authorization request, and then you will receive an administrative approval.

If you have questions, please contact your Provider Relations Representative or email askfchp@fallonhealth.org.

The UM fax number is: 1-508-368-9014.

fallonhealth

New dental vendor – DentaQuest

Effective January 1, 2024, DentaQuest is our new vendor for NaviCare® SCO and HMO SNP, Fallon Medicare Plus, and Community Care (pediatric) dental benefits. Medical oral surgery services will continue to be handled by Fallon Health.

Return to PCP referral requirements for MassHealth ACO plans

Consistent with All Provider Bulletin 384, Fallon Health will continue to pause PCP referral requirements for our MassHealth ACO plans: Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative. We intend to resume PCP referral requirements consistent with the timeline MassHealth sets forth. Please stay tuned for future communications on this important topic.

In the meantime, please ensure your access to ProAuth is still active. To sign up for access, go to *fallonhealth.org/providertools/ProAuthRegistration*.

Please contact your Provider Relations Representative with any questions.

CAQH DirectAssure and provider data updates

Fallon Health partners with CAQH DirectAssure for validation of provider directory information. Directory providers should be using the CAQH DirectAssure system and attesting to their information regularly—every 90 days.

As of January 1, 2024, Fallon Health will be able to receive your CAQH DirectAssure information automatically. We encourage providers to make their demographic updates directly in CAQH DirectAssure in lieu of sending faxes and emails. This will save time and allow your information to be updated in our system faster and in a more automated manner.

Demographic updates include:

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

Exceptions:

- "Pay to" updates that require a W-9
- New providers (require an HCAS form with appropriate supporting documentation)
- Specialty updates

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

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

Discontinuation of brand Flovent products

Fallon Health MassHealth ACO plans

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

GlaxoSmithKline (GSK) notified the United States Food and Drug Administration (FDA) on June 2, 2023, of an upcoming discontinuation of brand Flovent HFA and Flovent Diskus products. These brand products will no longer be available for ordering from the manufacturer as of December 31, 2023. It is anticipated that the supply of these products will be depleted in early 2024.

Fallon Health ACOs currently apply the brand-preferred designation to Flovent HFA and Flovent Diskus according to the MassHealth "full unified formulary" requirements. Fallon Health will continue to pay for the branded Flovent products for the ACO population until the supply is exhausted. The authorized generic fluticasone will require prior authorization. The following inhaled corticosteroid products are currently available without prior authorization:

- Asmanex HFA (mometasone inhalation aerosol)
- Asmanex Twisthaler (mometasone inhalation powder)
- Pulmicort Flexhaler (budesonide inhalation powder)
- Arnuity (fluticasone furoate inhalation powder)

Key points for Fallon Health MassHealth ACO plans

- Brand Flovent products will no longer be available for ordering from the manufacturer as of December 31, 2023.
- Flovent will remain on the Brand Over Generic List until supplies are exhausted.
- New utilizers of the authorized generics of Flovent HFA and Flovent Diskus will require prior authorization.
- Members stable on brand Flovent inhalers may use the generic fluticasone inhalers until March 4, 2024, at which point all utilizers of generic fluticasone inhalers will require prior authorization.

Fallon Health Medicare and Exchange plans

Fallon Medicare Plus™, Fallon Medicare Plus™ Central, Community Care

Fallon Health will continue to allow processing of Flovent inhalers after Jan 1, 2024 (while supplies last). The authorized generic fluticasone inhaler will be added to the formulary as of January 1, 2024.

FY23 Enough Pay to Stay Reporting deadlines

In July 2022, the Executive Office of Elder Affairs and MassHealth Office of Long-Term Services and Supports received an appropriation to temporarily provide a rate add-on, in addition to current contracted rates, to increase compensation for direct care workers providing Homemaker, Personal Care, and Home Health Aide services. This temporary rate add-on applied to units delivered through a contract with an ASAP, MassHealth (including Fee for Service or ABI/MFP Waiver), or a SCO plan. The add-on was effective from July 1, 2022 – June 30, 2023, and is referred to as the "FY23 Enough Pay to Stay" add-on.

All "FY23 Enough Pay to Stay" add-on funds must be expended no later than November 15, 2024. There will be two reporting deadlines for spending.

Reporting deadline 1: February 23, 2024

- This reporting will cover funds spent through November 15, 2023

Reporting deadline 2: February 23, 2025

- This reporting will cover funds spent through November 15, 2024

Providers who received "FY23 Enough Pay to Stay" add-on funds and do not submit this reporting by the deadlines may be subject to penalties for failure to comply with this reporting requirement as outlined in guidance or bulletins. Click here for the survey Provider Reporting for *FY23 Enough Pay to Stay*. If you have any questions regarding this survey, please email *homecareaiderates@mass.gov*.

What's new

Podimetrics program to reduce diabetic foot complications for Fallon Medicare Plus and NaviCare members

Fallon Health is partnering with Podimetrics to help reduce foot complications and lower the cost of care. Podimetrics is addressing the problem of preventable diabetic amputations and associated complications via a remote monitoring solution and care support program.

The remote monitoring solution includes a simple-to-use SmartMat that goes into the member's home and simply requires them to step on it once a day for 20 seconds—no app, no Bluetooth, no cords. Podimetrics' secure cloud analyzes the data, and their nurse support team works with members when they detect issues so the member can get them resolved early—before they become too serious.

Eligibility:

- Fallon Health-selected eligible population of high-risk diabetic members with a history of diabetic foot ulcers (DFU) in the past 24 months
- Fallon Medicare Plus and NaviCare members

Provider engagement:

Introductions will come directly from Podimetrics through materials co-branded with Fallon Health. Potential prescribing physicians include podiatrists, PCPs, and endocrinologists.

- Podimetrics Provider Outreach team will reach out directly to provider offices to introduce the program, making sure they understand that Fallon Health is covering the program for their members.
- Pre-populated and co-branded prescriptions are sent to the provider for them to fill out and return to Podimetrics.
- Podimetrics will contact the provider when infections/problems are detected for recommendations and next steps.

Member engagement:

- Fallon Health will identify which members are eligible for the Podimetrics program based on the code set provided by Podimetrics.
- Podimetrics has co-branded outreach material/postcards with Fallon Health logos that will be sent out to members to introduce the program.
- Providers with eligible patients will be sent a notification and description of the program along with a prescription form to be completed if the provider would like the member to participate.
- Once Podimetrics receives a prescription from the member's provider, the Podimetrics Care Support staff will reach out directly to members by phone to introduce the program,and let them know Fallon Health is covering the program at no charge to them, etc.
- Once a member enrolls, and the SmartMat has been delivered, the Podimetrics Care Support staff will schedule an onboarding/intro call. Podimetrics staff do not go directly into members' homes. This is a remote monitoring program.
- Member telephonic touchpoints include an onboarding call, monthly wellness calls, and adherence calls when member goes more than four days without stepping on the mat.

Provider Eligibility Tool update

We are pleased to share that our Provider Eligibility Tool now includes the primary language of a member when this information has been provided. If you need access to Fallon Health's Provider Tools, please sign up at *fallonhealth.org/en/providers/Secure/tools-regform*. If you need help with the Provider Tools, contact your Provider Relations Representative or send an email to *askfchp@fallonhealth.org*.

Product spotlight

NaviCare – Model of Care training

The main philosophy behind our NaviCare product is to assist our members in functioning at the safest level in the most appropriate setting, utilizing both Medicare and Medicaid covered benefits and services. Eligible members must be age 65 or older, have MassHealth Standard, and may or may not have Medicare. NaviCare services every county in Massachusetts, except for Nantucket and Dukes.

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

NaviCare benefits that all members receive include:

- Unlimited transportation to medical appointments.
- 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/caregiver can arrange transportation. Fallon Health Navigators are also available to assist. Members/their caregivers can also qualify for mileage reimbursement for covered trips provided by friends and family. Continuing in 2024: NaviCare will provide mileage reimbursement to friends and family who give members rides to pre-approved locations.
- 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 SilverSneakers™ gym membership.
- Worldwide ambulance, emergency room, and urgent care services
- Up to 20 acupuncture visits without prior authorization
- High-tech imaging (CT, MRI, etc.)
- EyeMed supplemental eyewear – $570 annual eyewear benefit that members may use toward two pairs of new eyeglasses, contacts, new lenses, new frames, and/or upgrades per year.
- Hearing aids
- **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 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 learn more about eligibility criteria, call 1-877-255-7108.

New NaviCare benefits for 2024

NaviCare changes to benefits for 2024 include:

- **Dental services.** 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, PCPs or other plan providers must get prior authorization (approval in advance) from the plan.
- **Dental provider network.** Members have access to the DentaQuest network of dental providers.

- **Advance exception request for upcoming plan year.** If a current member has been prescribed a medication that will be removed from the formulary or restricted in some way for next year, NaviCare will inform members about any change prior to the new year. Members will be able to ask for an 'advanced exception' before next year. NaviCare will give members an answer within 72 hours after the request is received. If the request is approved, NaviCare will authorize the coverage before the change takes effect.
- **Save Now card.** Members pay $0 for approved over the-counter items with the Save Now card, up to $162 every quarter. Members pay all costs over $162 per quarter. Members will not receive a separate Self-Care card. Instead, members will receive a new Save Now card that will now include separate "banks" of money that hold both Save Now and Self-Care quarterly allowance amount.

Compliance

Home Health Aide flow sheet process update

Summit ElderCare® is implementing a new process—as a result of CMS PACE regulations—for any external contracted entities (Home Care Agencies and Assisted Living Facilities) that provide direct personal care to PACE participants. Per the new process, the Health Aide, Home Maker, Personal Care Attendant, Registered Nurse, or other contracted entity staff member will be required to document each occurrence of providing personal care to a PACE participant on a new form that will be provided for each participant. This form will be collected from external contracted entities on a monthly basis by Summit ElderCare staff and will become part of the participant's Electronic Medical Record (EMR). The form consists of various activities of daily living (ADLs), schedules for when these ADLs are to be completed, and signatures from any Personal Care staff assisting the participant during any given day.

The purpose of this new process is to ensure that Summit ElderCare has appropriate oversight of all external contracted entities providing personal care to PACE participants, per CMS regulations, and to obtain documented evidence that the care and services that are care planned by the PACE care team have been provided.

If you represent an external contracted Home Health Agency or Assisted Living Facility, someone from Summit ElderCare will be reaching out to you to educate you and your team on the new process as well as the new form.

Important reminders

Provider manual availability

The Fallon Health provider manual is available to all contracted providers and applies to all our products which includes **Community Care, Berkshire Fallon Health Collaborative, Fallon 365 Care, Fallon Health-Atrius Care Health Collaborative, Fallon Medicare Plus HMO, Fallon Medicare Plus Central HMO, Fallon Medicare Plus Supplement, NaviCare,** and **Summit ElderCare.**

Our provider manual covers all you need to know about our health plans, member benefit information, and how to do business with Fallon Health. All current payment policies and medical policies are also available in the provider manual.

You can access the *provider manual* without a username or a password.

If you have questions or need anything in writing, please contact your Provider Relations Representative.

Medicare opioid edits and programs for 2024

There are several opioid safety edits and programs for the 2024 Medicare Part D plan year. This impacts all Fallon Health Medicare members: Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and Fallon Health Weinberg PACE. The criteria used to identify members potentially at risk or for the point-of-sale pharmacy edits are not intended as prescribing limits. They are used to identify members that may be at risk for opioid overuse. The edits are not a substitute for your professional judgment and do not mean that you cannot prescribe over these limits. Decisions by clinicians to taper opioid dosages should be carefully considered and individualized, if appropriate. Opioids should not be tapered rapidly or discontinued suddenly due to the significant risks of opioid withdrawal, unless there is a life-threatening issue confronting the individual patient. Tapering is most likely to be effective when there is patient buy-in and collaboration, tapering is gradual, and clinicians provide support. You need to attest that the identified medications and doses are intended and medically necessary for the member.

Please be aware that network pharmacies, the Fallon Health Pharmacy Department, our MTM vendor (Clinical Support Services (CSS)), and/or our opioid drug management vendor and PBM (Optum Rx) may outreach to you for your assistance in resolving these safety edits and opioid management cases.

Please assist us in meeting the expectation that prescribers respond to pharmacy outreach related to opioid safety alerts in a timely manner, including educating their on-call staff. Some of these issues can be completed directly with the retail pharmacy by attesting that the medications and doses are intended and medically necessary for the member.

If you need to submit a coverage determination or an exception request, please call 1-844-657-0494 (1-844-722-1701 for Fallon Health Weinberg PACE), or fax 1-844-403-1028.

Below is a summary of the programs:

Point of Sale (POS) opioid safety edits

CMS requires certain prospective safety edits. These edits will occur when the member is filling the prescription at the pharmacy. These edits require resolution. The pharmacist at the pharmacy may override some of the edits with appropriate codes, may need to consult with the provider, and may need to inform the provider that a prior authorization is required. Since these are safety edits, they will still apply during a member's transition period; meaning the claims will still reject with the edits and require resolution. Buprenorphine for medication-assisted treatment (MAT) is not included in the safety edits.

Hospice/palliative care, active cancer-related pain, sickle cell disease, and LTC members are excluded from the safety edits. Members have coverage determination and appeal rights under this program. The edits include:

- Soft edit for concurrent opioid and benzodiazepine use – pharmacy can override
- Soft edit for duplicative long-acting (LA) opioid therapy – pharmacy can override
- Soft edit for concurrent opioid and prenatal vitamins use – pharmacy can override

- Soft edit for concurrent opioid and MAT use – pharmacy can override
- Care coordination edit at 90 morphine milligram equivalents (MME) and two prescribers—pharmacy can override only after consultation with the prescriber, documentation of the discussion, and if the prescriber confirms intent (the opioids and/or day supply is intended and medically necessary for the member), using an override code that indicates the prescriber has been consulted.
- Hard edit for a 7-day supply limit for initial opioid fills (opioid naïve) with a 120-day look-back. If the pharmacy cannot resolve at point of sale (POS), this will require a prior authorization to be submitted. Provider needs to attest that the opioids and/or day supply is intended and medically necessary for the member. Member is considered opioid naïve if there are no opioid claims in the past 120 days.

Medication Therapy Management (Not applicable to PACE programs)
We are also including special eligibility criteria into our Medication Therapy Management Program (MTMP). In addition to traditional MTMP eligibility, members are eligible for MTMP if they have been identified as an at-risk beneficiary (ARB) under a drug management program (DMP).

Comprehensive Addiction and Recovery Act of 2016 (CARA) – Drug Management Program (DMP)
This is a comprehensive opioid management program required under the Comprehensive Addiction and Recovery Act of 2016 (CARA). This is a retrospective DUR program to identify members at risk for frequently abused drugs and conduct case management. Frequently abused drugs are defined by CMS as opioids and benzodiazepines. Buprenorphine for medication-assisted treatment (MAT) is not included in the 90 MME accumulations. The program excludes members with active cancer pain, palliative/hospice care, sickle cell disease, and in LTC. Dual/Low Income Subsidy (LIS) members are limited in ability to change plans to avoid intervention once identified as at-risk.

Criteria for identification into the program include:

- Members with opioid pharmacy claims equal to or greater than 90 MME and 3+ opioid prescribers and 3+ opioid dispensing pharmacies
- Members with opioid pharmacy claims equal to or greater than 90 MME and 5+ opioid prescribers
- Members with any MME level and 7+ opioid prescribers or 7+ opioid dispensing pharmacies
- Members identified as having a history of opioid-related overdose are also included in the DMP.
- Program includes case management and clinical outreach to providers to determine if the member is at risk for opioid overutilization, notifications to the member, potential lock-in restrictions to specific provider(s), pharmacy(ies), and/or at the drug level. Members have appeal rights under this program.

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

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

Opioid Safety Alert	Prescriber Tips
Seven-day supply limit for opioid naïve patients This hard edit alert triggers when an enrollee who has not filled an opioid prescription recently (such as within the past 60 days) attempts to fill an opioid prescription for more than a 7-day supply. This edit should not impact enrollees who already take opioids but may occur for enrollees who enroll in a new plan that does not know their current prescription information.	Enrollee may receive up to a 7-day supply without taking any action. Enrollee or prescriber can request a coverage determination for full days' supply as written. Prescriber only needs to attest that the days' supply is the intended and medically necessary amount. Subsequent prescriptions filled within the plan's look-back window are not subject to the 7-day supply limit, as the enrollee will no longer be considered opioid naïve.
Optional Safety Alert at 200 morphine milligram equivalent (MME) or more Some plans may implement a hard edit safety alert when an enrollee's cumulative opioid daily dosage reaches 200 MME or more. Some plans have this alert only when the enrollee uses multiple opioid prescribers and/or opioid dispensing pharmacies. This alert stops the pharmacy from processing the prescription until an override is entered or authorized by the plan.	Resolving this alert generally requires the plan to process a coverage determination which may be requested by the enrollee or prescriber. In the absence of other approved utilization management requirements, once the prescriber attests that the identified cumulative MME level is the intended and medically necessary amount, the plan should approve the higher MME, allowing the claim to adjudicate.
Opioid care coordination alert at 90 MME This alert triggers when an enrollee's cumulative MME per day across all of their opioid prescription(s) reaches or exceeds 90 MME. Some plans use this alert only when the enrollee uses multiple opioid prescribers and/or opioid dispensing pharmacies. This consultation usually occurs once per plan year.	The pharmacist may call to confirm the dose and medical need for the opioid prescription that prompts the alert, even if it's below 90 MME. The prescriber may be informed of other opioid prescribers or increasing level (MME) of opioids. Prescriber only needs to attest that the identified cumulative MME level days' supply is the intended and medically necessary amount.
Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy These soft edit alerts trigger when opioids and benzodiazepines or multiple long-acting opioids are taken concurrently.	The pharmacist will conduct additional safety reviews to determine if the enrollee's medication use is safe and clinically appropriate. The pharmacist may contact the prescriber to confirm medical necessity.

Opioid safety alerts

Opioid safety alerts are not prescribing limits. Part D plans are expected to implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. CMS encourages prescribers to respond to plan and pharmacist outreach in a timely manner and to give appropriate information to on-call prescribers as needed to resolve opioid safety edits and avoid disruption of therapy.

CMS expects all Part D plan sponsors to have a mechanism in place which allows all opioid safety alerts, including hard edits, to be overridden at point of sale at the pharmacy based on information from the prescriber or otherwise known to the pharmacy that an enrollee is exempt.

Prescribers have the right to request a coverage determination for a drug(s) on behalf of an enrollee, including the right to request an expedited or standard coverage determination in advance of prescribing.

Drug Management Programs (DMPs)

All Part D plans must have a DMP that limits access to opioids and/or benzodiazepines for enrollees who are considered by the plan to be at risk for prescription drug abuse or misuse. The goal of a DMP is better care coordination for safer use. Enrollees are identified by opioid use involving multiple doctors and pharmacies or a recent history of opioid-related overdoses and undergo case management conducted by the plan and involving their prescribers.

DMP limitations can include requiring the enrollee to obtain these medications from a specified prescriber and/or pharmacy, or implementing an individualized point of sale edit that limits the amount that will be covered.

After case management, and at least 30 days before implementing a coverage limitation, the plan will notify the enrollee in writing. Plans are required to make reasonable efforts to notify prescribers. After 30 days, the plan must send the enrollee a second written notice confirming the details of the limitation. This notice also explains that the enrollee, their representative, or their prescriber have the right to appeal.

To learn more, visit *cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.*

Doing business with us

Referral and authorization reminders

Community Care follows the NPI referral process, whereby the PCP communicates their NPI to the in-network specialist and the specialist submits a claim to Fallon Health.

For CMS 1500 paper submitters

- Box 17 – enter referring provider/PCP's name
- Box 17b – enter referring provider/PCP's NPI number

For Fallon Health electronic claims submitters

- Loop 2310A Segment NM1 –enter the referring provider/PCP's name
- Loop 2310A Segment REF with the G2 qualifier – enter referring provider/PCP's NPI number
- The specialist has 120 day after the Remittance Advice Summary date to submit a corrected claim if needed

Fallon Medicare Plus, Fallon Medicare Plus Central and **NaviCare** follow a referral process whereby a generated referral number must be present in our ProAuth system for in-network specialists who are outside of the PCP's Health Care Option (HCO).

- PCP referrals must be submitted by the member's PCP.
- A retroactive referral may be submitted by the PCP up to 90 days after the date of service.

Medicaid ACO – Berkshire Fallon Health Collaborative, Fallon 365 Care and **Fallon Health-Atrius Health Care Collaborative**

The PCP referral requirements remain paused at this time.

Prior Authorizations

Regardless of plan type, prior authorizations are required for all out-of-network care and for services/procedures as identified through the procedure codes look-up tool on our website, *fallonhealth.org/providertools/ProcedureCodeLookup*

- Prior authorizations should be requested through the ProAuth system by the appropriate provider with any supporting documentation that is applicable.
- Currently, an authorization request may be submitted up to 120 days after the date of service

ProAuth

ProAuth is our referral and authorization system

Benefits include:

- Plan review turnaround time is faster than faxed requests
- Supporting documentation can be attached in the request submission
- Statuses are updated in real time – as soon as a decision is made
- Providers have 24/7 access

If you are not currently set up with ProAuth, we encourage you to enroll by:

- Filling out the online registration *form*
- Or by filling out a *paper application* and sending it to *askfchp@fallonhealth.org*

Quality focus

Clinical Practice Guideline updates

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

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:

- 2020 Asthma Management Guidelines At-A-Glance
- 2020 Asthma Management Guidelines
- 2023 Gold Initiative for Chronic Obstructive Lung Disease-Gold Pocket Guide
- 2022 ACC/AHAHFSA Guideline for the Management of Heart Failure

Coding Corner

Infliximab preferred products (Remicade® Biosimilars)

Infliximab products all require prior authorization for all lines of business. Authorizations are obtained through the pharmacy medical benefits vendor (MagellanRx).

Fallon Health MassHealth ACO plans

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

- Members of Fallon Health's MassHealth ACO plans who get infliximab through the Medical Benefit will be required to use Avsola® (infliximab-axxq, HCPCS CodeQ5121) or Inflectra® (infliximab-dyyb, HCPCS Code Q5103).
- Members on alternative infliximab products will be required to use a preferred infliximab product after March 1, 2024.
- Non-preferred infliximab prior authorizations with be terminated March 1, 2024, and will require new prior authorization.

Fallon Medicare Plus, Fallon Medicare Plus Central and Community Care plans

Fallon Health will continue to prefer Inflectra® (infliximab-dyyb Q5103) without changes to the current requirements.

New ICD-10 code for PrEP services

Fallon Health's Community Care plan covers preventive care services with no member cost-sharing, in compliance with the Affordable Care Act's mandate for preventive care. This includes preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

Providers of PrEP services should be aware that a new ICD-10 code has been introduced for PrEP treatment, Z29.81, Encounter for HIV pre-exposure prophylaxis. This code was effective on October 1, 2023, and is to be used when a patient is seen for administration of PrEP medication.

For more information about Fallon Health's coding standards for PrEP, and for all other preventive services, see the Preventive Services Payment Policy posted on Fallon Health's *website*.

Documentation language

Provider clinical judgment determines whether a condition is uncertain or certain in outpatient settings. When you are certain of the clinical diagnosis, consider using the definitive language coders look to when reporting conditions. Language that is seen in "certain"diagnosis documentation may include: "results show", "evidence of", "elements of", "significant and/or compensated".

Language that may be seen in an uncertain diagnosis documentation include: "consistent with", "suspicious for", "possible", "likely", "presumed", "pending", "symptoms of", "concern for", and "possible". This is often the language of inpatient and radiology encounters.

Documentation language is primary in the ability to be able to report the definitive diagnosis and not only the signs and symptoms.

CMS NCCI edits

After March 1, 2024, Fallon Health will implement the CMS National Correct Coding Initiative (NCCI) edits for Fallon Medicare Plus, NaviCare, Summit ElderCare, and Community Care claims. CMS develops its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Codes updated to align with latest MassHealth changes

Effective July 1, 2023, consistent with MassHealth guidelines, G0480-G0483 definitive tests are not payable when billed with 80305-80307 presumptive tests.

Effective January 1, 2024, the following code will change from not separately reimbursable to *deny vendor liable* for MassHealth ACO:

Code	Description
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure.)

Effective January 1, 2024, the following codes will be *deny vendor liable* for MassHealth ACO:

Code	Description
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0003	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs

Code	Description
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0008	Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
H0009	Alcohol and/or drug services; acute detoxification (hospital inpatient)
H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0021	Alcohol and/or drug training service (for staff and personnel not employed by providers)
H0022	Alcohol and/or drug intervention service (planned facilitation)
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0026	Alcohol and/or drug prevention process service, community-based (delivery of services to develop skills of impactors)
H0027	Alcohol and/or drug prevention environmental service (broad range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)
H0029	Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use, e.g., alcohol-free social events)
H0030	Behavioral health hotline service
H0031	Mental health assessment, by non-physician
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0041	Foster care, child, non-therapeutic, per diem
H0042	Foster care, child, non-therapeutic, per month
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H0047	Alcohol and/or other drug abuse services, not otherwise specified
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H1000	Prenatal care, at-risk assessment
H1001	Prenatal care, at-risk enhanced service; antepartum management

Code	Description
H1002	Prenatal care, at risk enhanced service; care coordination
H1003	Prenatal care, at-risk enhanced service; education
H1004	Prenatal care, at-risk enhanced service; follow-up home visit
H1005	Prenatal care, at-risk enhanced service package (includes h1001-h1004)
H1010	Non-medical family planning education, per session
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day
H2010	Comprehensive medication services, per 15 minutes
H2013	Psychiatric health facility service, per diem
H2014	Skills training and development, per 15 minutes
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2029	Sexual offender treatment service, per diem
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multisystemic therapy for juveniles, per 15 minutes
H2034	Alcohol and/or drug abuse halfway house services, per diem
H2035	Alcohol and/or other drug treatment program, per hour
H2037	Developmental delay prevention activities, dependent child of client, per 15 minutes

Effective October 1, 2023, the following code is *deny vendor liable* for MassHealth ACO:

Code	Description
92606	Therapeutic services for the use of non-speech-generating augmentation and alternative communication device. Code 92606 is used when the patient has the non-speech generating augmentation and alternative communication device (AAC) and you are working on: modifying or programming the device for the patient.

Effective October 1, 2023, the following codes are *deny vendor liable* for MassHealth ACO:

Code	Description
G0008	ADMINISTRATION INFLUENZA VIRUS VACC
G0010	ADMINISTRATION HEPATITIS B VACCINE
G0068	Adm of infusion drug in home
G0069	Adm of immune drug in home
G0070	Adm of chemo drug in home
G0071	PMT CMNCT TECH-B SRVC;RHC/FQHC ONLY
G0088	Adm IV drug 1st home visit.
G0089	Adm IV chemo 1st home visit.
G0090	Adm IV chemo 1st home visit.
G0101	CERV/VAG CANCR SCR;PELV&CLN BRST EX
G0102	PROS CANCER SCR; DIGTL RECTAL EXAM
G0103	PROSTATE CANCER SCREENING; PSA TEST
G0104	COLOREC CANCER SCREENING; FLEXSIG
G0106	COLOREC CANCR SCR; SIGMOIDSCOPY
G0117	GLAUC SCR HI RISK BY OPT/OPHTHLGIST
G0118	GLAUC SCR HI RISK UND DIR SUP DR
G0120	COLOREC CANCR SCR;COLNSCPY BA ENEMA
G0122	COLOREC CANCER SCREENING; BA ENEMA
G0123	SCR CERV/VAG THIN LAY W/PHYS SUP
G0124	SCR CERV/VAG THIN LAY PHYS INTERP
G0127	TRIM DYSTROPHIC NAILS ANY NUMBER
G0128	DIR SKLED SERV RN OP REHAB EA 10MIN
G0130	SEXA BN DNSITY STDY 1/GTR; APPNDICULR
G0141	SCR CERV/VAG MNL RSCR PHYS INTERP
G0143	SCR CERV/VAG MNL SCR/RSCR UND PHYS
G0144	SCR CERV/VAG SCR AUTO UND PHYS
G0145	SCR CERV/VAG AUTO&MNL RSCR PHYS
G0147	SCR SMEARS CERV/VAG AUTO UND PHYS
G0148	SCR SMEARS CERV/VAG MNL RESCR
G0157	HHC PT ASSISTANT EA 15
G0158	HHC OT ASSISTANT EA 15
G0159	HHC PT MAINT EA 15 MIN
G0160	HHC OCCUP THERAPY EA 15
G0161	HHC SLP EA 15 MIN
G0162	HHC RN E&M PLAN SVS, 15 MIN
G0168	WOUND CLOS UTIL TISSUE ADHES ONLY

Code	Description
G0175	SCHED INTRDISCIPLN TEAM CONF PT PRS
G0176	ACTV TX PTS DISABL MENTL HLTH-SESS
G0177	TRN&ED PTS DISABL MENTL HLTH-SESS
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC
G0181	PHYS SUPV PT RECV MCR-COVR HOM HLTH
G0182	PHYS SUPV PT UND MCR-APPRVD HOSPICE
G0186	DESTRUC LES CHOROID; PHOTOCOAG FEDR
G0219	PET BDY; MELANOMA NON-COVR INDICAT
G0235	PET IMAGING ANY SITE NOS
G0237	MUSCLES FACE FACE 1 ON 1 EA 15 MIN
G0238	TX PROC IMPRV RESP NOT G0237 15 MIN
G0239	TX PROC IMPRV RESP FUNCT 2/GTR IND
G0245	INIT PHYS E&M DIABETIC PT W/LOPS
G0246	F/U EVAL DIABETIC PT W/LOPS
G0247	ROUTINE FT CARE PHYS DIAB PT W/LOPS
G0248	DEMONSTRATE USE HOME INR MONITOR
G0249	PRVS TEST MATL&EQP HM INR MON;4 TST
G0250	PHYS REV INTEPR HOME INR MON;4 TST
G0252	PET IMAG DX BREST CA&/SURG PLAN
G0255	CPT/SNCT PER LIMB ANY NERVE
G0257	UNSCHD/EMRG DIALYS HOS OP NOT CERT
G0259	INJECTION PROC SI JNT; ARTHROGRAPY
G0260	INJ SI JNT; ANES &/TX AGT &ARTHROG
G0276	PILD/PLACEBO CONTROL CLIN TR
G0278	ILIAC &/ FEM ART ANGIO NON-SEL S&I
G0282	E-STIM 1/GTR AREAS WND CARE NOT G0281
G0283	E-STIM 1/GTR NOT WND CARE PART TX PLAN
G0288	RECON CT ANGIO AORTA PLAN VASC SURG
G0289	SCPE KNEE REMV FB TM SURG DIFF COMP
G0293	NONCOVR SURG SEDAT ANES-MCR QUAL
G0294	NONCOVR PROC NO ANES/LOC-MCR QUAL
G0295	ELECMAGNET TX 1/GTR AREA NOT G0329/OTH
G0296	VISIT TO DETERM LDCT ELIG
G0302	PRE-OP PULM SURG SRVC PREP LVRS CMP
G0303	PRE-OP PULM SURG PREP LVRS 10-15 DA
G0304	PRE-OP PULM SURG PREP LVRS 1-9 DA
G0305	POST-D/C PULM SURG SRVC AFTER LVRS

Code	Description
G0323	Care manage beh svs 20 mins
G0328	COLOREC CA SCR; FOB TST IMMUNO 1-3
G0329	EM TX ULCERS NOT HEALING 30 DA CARE
G0333	PHRM DISPN FEE INHL RX;1ST 30-DAY
G0337	HOSPICE EVAL&CNSL SRVC PREELECTION
G0339	IMAGE GUID ROBOT ACCL SRS TX 1 SESS
G0340	IMAGE GUID ROB SRS FRAC TX 2-5 SESS
G0341	PERQ ISLET CELL TPLNT PV CATH&INFUS
G0342	LAP ISLET CELL TPLNT PV CATH&INFUS
G0343	LAPROT ISLET CELL TPLNT PV CATH&INF
G0372	PHYS EST & DOC NEED PWR MOBIL DEVC
G0380	LEVEL 1 HOSP ED VISIT TYPE B ED;
G0381	LEVEL 2 HOSP ED VISIT TYPE B ED;
G0382	LEVEL 3 HOSP ED VISIT TYPE B ED;
G0383	LEVEL 4 HOSP ED VISIT TYPE B ED;
G0384	LEVEL 5 HOSP ED VISIT TYPE B ED;
G0396	ALC &/ SUBSTNC ABUSE ASSESS 15-30 M
G0397	ALC &/ SUBSTNC ABUSE ASSESS GTR 30 MIN
G0398	HOME SLEEP TEST/TYPE 2 PORTABLE
G0400	HOME SLEEP TEST/TYPE 4 PORTABLE
G0406	FU IP CNSLT LTD 15 MIN VIA TELEHLTH
G0407	FU IP CNSLT INTRMD 25 MIN TELEHLTH
G0408	FU IP CNSLT CMPLX 35 MIN/GTR TELEHLTH
G0409	SW & PSYCH SRVC EA 15 MIN F/F IND
G0410	GRP PSYCH NOT FAM PAR HOS 45-50 MIN
G0411	INTRACTV GRP PSYCH PAR HOS 45-50 MN
G0412	OPN TX ILIAC SPINE/ILIAC WING FX
G0413	PERQ SKEL FIX POST PELV BONE FX
G0414	OPN TX ANT PELV BONE FX &/ DISLOC
G0415	OPN TX POST PELV BONE FX &/ DISLOC
G0416	SURG PATH PROS SAT BX 1-20 SPEC
G0425	INIT IP TELEHEALTH CONSULT 30 MIN W/PT TELEHLTH
G0426	INIT IP TELEHEALTH CONSULT 50 MIN W/PT TELEHLTH
G0427	INIT IP TELEHEALTH CONSULT 70 MIN/> PT TELEHELTH
G0428	COLAGEN MENISCS IMP PROC FILL MENISCS DEFCT
G0429	DERML FILL INJ TX FACIL LDS
G0432	INF AB EIA TECH HIV-1 &/OR HIV-2

Code	Description
G0433	INF AB ELISA TECH HIV-1 &/OR HIV-2
G0435	INF AB RAPID TEST HIV-1 &/OR HIV-2
G0444	DEPRESSION SCREEN ANNUAL
G0446	ANN F2F INT BEHV TX CV DZ IND 15 MN
G0448	INS/RPL PRM CV-DFIB TV LEADS INSRT PACE ELCTRODE
G0452	MOLECULAR PATHOLOGY INTERPR
G0453	CONT INTRAOP NEURO MONITOR
G0458	LDR PROSTATE BRACHY COMP RAT
G0459	INP TELEHEALTH PHARMACOLOGIC MGMT
G0465	Autolog prp diab wound ulcer
G0466	FQHC VISIT NEW PATIENT
G0467	FQHC VISIT ESTABLISHED PATIENT
G0468	FQHC VISIT IPPE/AWV
G0473	GROUP BEHAVE COUNS 2-10
G0475	HIV COMBINATION ASSAY
G0476	HPV COMBO ASSAY CA SCREEN
G0490	FTF HHN VST RHC/FQHC AREA SHTG HHA
G0491	DIALYSIS ACU KIDNEY NO ESRD
G0492	MD/OTH EVAL ACUT KID NO ESRD
G0494	LPN CARE EA 15MIN HH/HOSPICE
G0495	RN CARE TRAIN/EDU IN HH
G0496	LPN CARE TRAIN/EDU IN HH
G0498	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS
G0499	HEP B SCR IN NON-PREG HIGH RISK IND
G0500	MOD SEDAT ENDO SERVICE >5YRS
G0506	COMP ASSES CARE PLAN CCM SVC
G0508	CRIT CARE TELEHEA CONSULT 60
G0509	CRIT CARE TELEHEA CONSULT 50
G0513	Prolong prev svcs, first 30m
G0514	Prolong prev svcs, addl 30m
G0516	Insert drug del implant, >4
G0517	Remove drug implant
G0518	Remove w insert drug implant
G0659	DRUG TEST DEF SIMPLE ALL CL
G1001	CDSM EVICORE
G1002	CDSM MEDCURRENT
G1003	CDSM MEDICALIS

Code	Description
G1004	CDSM NDSC
G1007	CDSM AIM
G1008	CDSM CRANBERRY PK
G1010	CDSM STANSON
G1011	CDSM QUALIFIED NOS
G1028	Take home supply 8mg per 0.1
G2000	BLINDED ADMN OF CONVULSIVE TX PROC
G2011	ALC&/SA STRCT ASMT & BRF INT 5-14 M
G2020	Hi inten serv for sip model
G2069	MED ASSIST TX INJECT
G2070	MED ASSIST TX IMPLANT
G2071	MED TX REMOVE IMPLANT
G2072	MED TX INSERT/REMOVE IMP
G2075	MED TX MEDS NOS
G2077	PERIODIC ASSESSMENT
G2080	ADD 30 MINS COUNSEL
G2081	PT 66+ SNP OR LTC POS > 90D
G2082	VISIT ESKETAMINE 56M OR LESS
G2083	VISIT ESKETAMINE, > 56M
G2086	OFF BASE OPIOID TX 70MIN
G2087	OFF BASE OPIOID TX, 60 M
G2088	OFF BASE OPIOID TX, ADD30
G2105	PT 66+ LT INTS > 90
G2106	PT 66+ LT INTS > 90
G2108	PT 66+ LT INTS > 90
G2168	SVS BY PT IN HOME HEALTH
G2169	SVS BY OT IN HOME HEALTH
G2172	Tx for opioid use demo proj
G6016	DELIVERY COMP IMRT
G6017	INTRAFRACTION TRACK MOTION
G8733	ELD MALTX SCR DOC POS & F/U PLN DOC
G8734	ELDER MALTREATMENT SCREENING DOC NEG NO F/U REQ
G8735	ELDER MALTX POS F/U NOT DOC NOT GVN
G9003	COORD CARE FEE RISK ADJUSTD HI INIT
G9004	COORD CARE FEE RISK ADJUSTD LW INIT
G9005	COORD CARE FEE RISK ADJUSTED MAINT
G9006	COORD CARE FEE HOME MONITORING

Code	Description
G9007	COORD CARE FEE SCHEDULE TEAM CONF
G9008	COORD CARE FEE PHYS OVRSIGHT SRVC
G9009	COORD CARE FEE RISK ADJ MAINT LVL 3
G9010	COORD CARE FEE RISK ADJ MAINT LVL 4
G9011	COORD CARE FEE RISK ADJ MAINT LVL 5
G9012	OTH SPEC CASE MGMT SERVICE NEC
G9013	ESRD DEMO BASIC BUNDLE LEVEL I
G9014	ESRD DEMO EXPND BUNDLE W/VENUS ACSS
G9016	SMOK CESSATN CNSL IND ABSNC/ADD E&M
G9157	TRANSESOPHAGEAL DOPPLER USED FOR CARDIAC MONITORING
G9187	BPCI HOME VST PT ASMT QUAL HC PROF
G9361	Doc rsn elect c-sec/induct
G9422	Rpt doc class histo type
G9621	SCR UNHEAL ETOH W/COUNSEL
G9622	NO UNHEAL ETOH USER
G9624	PT NOT SCRN OR NO COUNSELING
G9625	PT BL SRG 30 DAY PST SRG
G9626	MED RSN NO RPT BALDDER INJ
G9627	PT NO BL SRG 30 DAY PST SRG
G9628	PT BWLI SRG 30 DAY PST SRG
G9629	MED RSN NO RPT BOWEL INJ
G9685	PHYS OTH PROF E&M BENEF CHG COND NF
G9868	NEXT GEN ACO MODEL<10min
G9869	NEXT GEN ACO MODEL 10-20min
G9870	NEXT GEN ACO MODEL>20min
G9873	1ST MDPP COR SESS ATD MDPP B UND EM
G9874	4 T MDPP COR SESS ATD MDPP B UND EM
G9875	9 T MDPP COR SESS ATD MDPP B UND EM
G9876	2 MDPP COR MS ATD BNF MO 7-9 UND EM
G9877	2 MDPP C MS ATD BNF MO 10-12 UND EM
G9878	2 MDPP COR MS ATD BNF MO 7-9 UND EM
G9879	2 MDPP C MS ATD BNF MO 10-12 UND EM
G9880	MDPP BNF ACHV AL 5% WL MO 1-12 U EM
G9881	MDPP BNF ACHV AL 9% WL MO 1-24 U EM
G9882	2 MDPP O MS ATD BNF MO 13-15 U EM
G9883	2 MDPP OM S ATD BNF MO 16-18 U EM
G9884	2 MDPP OM S ATD BNF MO 19-21 U EM

Code	Description
G9885	2 MDPP OM S ATD BNF MO 22-24 U EM
G9890	BRDG PMT:1ST MDPP SPL BNF M 1-24 EM
G9891	MDPP S RPT LN-I CLM PAYABL MDPP EM

Effective October 1, 2023, the following code is payable with *no plan prior authorization* for MassHealth ACO:

Code	Description
G2212	PROLONG OUTPT/OFFICE VIS

Effective July 1, 2023, the following codes are payable with *no plan prior authorization* for MassHealth ACO:

Code	Description
S0013	Esketamine, nasal spray, 1 mg
T2023	Targeted case management, per month. (Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) program services for members younger than 21 years of age
77523	Proton treatment delivery; intermediate
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM
99242	OFFICE/OP CONSLTJ NEW/EST PT SF MDM 20 MINUTES
99243	OFFICE/OP CONSLTJ NEW/EST PT LOW MDM 30 MINUTES
99244	OFFICE/OP CONSLTJ NEW/EST PT MOD MDM 40 MINUTES
99245	OFFICE/OP CONSLTJ NEW/EST PT HIGH MDM 55 MINUTES
99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M
99495	TRANSJ CARE MGMT MOD MDM F2F 14 CAL D DISCHARGE
99496	TRANSJ CARE MGMT HIGH MDM F2F 7 CAL D DISCHARGE

Effective July 1, 2023, the following codes are *deny vendor liable* for MassHealth ACO:

Code	Description
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter
Q4225	Amniobind, per square centimeter
Q4256	Mlg-complete, per square centimeter
Q4257	Relese, per square centimeter

Code	Description
Q4258	Enverse, per square centimeter
Q4259	Celera dual layer or celera dual membrane, per square centimeter
Q4260	Signature apatch, per square centimeter
Q4261	Tag, per square centimeter
Q4262	Dual layer impax membrane, per square centimeter
Q4263	Surgraft tl, per square centimeter
Q4264	Cocoon membrane, per square centimeter

Effective July 1, 2023, the following code is payable with *no plan prior approval* for MassHealth ACO:

Code	Description
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Effective September 1, 2022, the following code is *deny vendor liable* for MassHealth ACO:

Code	Description
55880	ABLATION OF MALIGNANT PROSTATE TISSUE, TRANSRECTAL, WITH HIGH INTENSITY-FOCUSED ULTRASOUND (HIFU), INCLUDING ULTRASOUND GUIDANCE

Coding updates

Effective March 1, 2024, the following code will be *deny vendor liable* for MassHealth ACO:

Code	Description
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING

Effective March 1, 2024, the following codes will be *deny vendor liable* for Medicare, NaviCare, and Summit ElderCare PACE:

Code	Description
G2081	PT 66+ SNP OR LTC POS > 90D
G2105	PT 66+ LT INTS > 90
G2106	PT 66+ LT INTS > 90
G2108	PT 66+ LT INTS > 90
G8733	ELD MALTX SCR DOC POS & F/U PLN DOC
G8734	ELDER MALTREATMENT SCREENING DOC NEG NO F/U REQ
G8735	ELDER MALTX POS F/U NOT DOC NOT GVN
G9361	Doc rsn elect c-sec/induct
G9422	Rpt doc class histo type
G9621	SCR UNHEAL ETOH W/COUNSEL

Code	Description
G9622	NO UNHEAL ETOH USER
G9624	PT NOT SCRN OR NO COUNSELING
G9625	PT BL SRG 30 DAY PST SRG
G9626	MED RSN NO RPT BALDDER INJ
G9627	PT NO BL SRG 30 DAY PST SRG
G9628	PT BWLI SRG 30 DAY PST SRG
G9629	MED RSN NO RPT BOWEL INJ

Effective January 1, 2024, the following codes will *require plan prior authorization* for MassHealth ACO:

Code	Description
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS

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

Code	Description
J1304	Injection, tofersen, 1 mg

Effective January 1, 2024, the following codes will be *deny vendor liable* for MassHealth ACO:

Code	Description
99459	Pelvic examination (List separately in addition to code for primary procedure)
86041	Acetylcholine receptor (AChR); binding antibody
86042	Acetylcholine receptor (AChR); blocking antibody
86043	Acetylcholine receptor (AChR); modulating antibody
86366	Muscle-specific kinase (MuSK) antibody
93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)
93585	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemiazygos venous system (List separately in addition to code for primary procedure)
93586	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)
93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)
93588	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)

Code	Description
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)
A4457	Enema tube, with or without adapter, any type, replacement only, each
C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (sdoh) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit: person-centered assessment, performed to better understand the individualized context of the intersection between the sdoh need(s) and the problem(s) addressed in the initiating visit. ++ conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed). ++ facilitating patient-driven goal-setting and establishing an action plan. ++ providing tailored support to the patient as needed to accomplish the practitioner's treatment plan. practitioner, home-, and community-based care coordination. ++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable). ++ communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the sdoh need(s). health education- helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the sdoh need(s), and educating the patient on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the sdoh need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment. health care access / health system navigation. ++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them. facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals. leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
G0022	Community health integration services, each additional 30 minutes per calendar month (list separately in addition to g0019)

Code	Description
G0023	Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the practitioner's treatment plan.identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.practitioner, home, and community-based care coordination. ++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable). ++ communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, likely to promote personalized and effective treatment of their condition.health care access / health system navigation. ++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care,and helping secure appointments with them. ++ providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals.leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
G0146	Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to g0140)
97550	Caregiver training in strategies and techniques to facilitate the patientâ€™s functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers
G9886	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes
G9887	Behavioral counseling for diabetes prevention, distance learning, 60 minutes
G9888	Maintenance 5% wl from baseline weight in months 7-12

Effective January 1, 2024, the following codes will be covered and *require plan prior authorization* for all lines of business. The following codes will be *deny vendor liable* for MassHealth ACO:

Code	Description
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional
82166	Anti-mullerian hormone (AMH)
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
93153	Interrogation without programming of implanted phrenic nerve stimulator system
0420U	Oncology (urothelial), mRNA expression profiling by real-time quantitative PCR of MDK, HOXA13, CDC2, IGFBP5, and CXCR2 in combination with droplet digital PCR (ddPCR) analysis of 6 single-nucleotide polymorphisms (SNPs) genes TERT and FGFR3, urine, algorithm reported as a risk score for urothelial carcinoma
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk
0422U	Oncology (pan-solid tumor), analysis of DNA biomarker response to anti-cancer therapy using cell-free circulating DNA, biomarker comparison to a previous baseline pre-treatment cell-free circulating DNA analysis using next-generation sequencing, algorithm reported as a quantitative change from baseline, including specific alterations, if appropriate
0423U	Psychiatry (eg, depression, anxiety), genomic analysis panel, including variant analysis of 26 genes, buccal swab, report including metabolizer status and risk of drug toxicity by condition
0424U	Oncology (prostate), exosomebased analysis of 53 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RTqPCR), urine, reported as no molecular evidence, low-, moderate- or elevated-risk of prostate cancer
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis
0427U	Monocyte distribution width, whole blood (List separately in addition to code for primary procedure)
0428U	Oncology (breast), targeted hybrid-capture genomic sequence analysis panel, circulating tumor DNA (ctDNA) analysis of 56 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutation burden
0429U	Human papillomavirus (HPV), oropharyngeal swab, 14 high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68)
0430U	Gastroenterology, malabsorption evaluation of alpha-1-antitrypsin, calprotectin, pancreatic elastase and reducing substances, feces, quantitative

Code	Description
0431U	Glycine receptor alpha1 IgG, serum or cerebrospinal fluid (CSF), live cell-binding assay (LCBA), qualitative
0432U	Kelch-like protein 11 (KLHL11) antibody, serum or cerebrospinal fluid (CSF), cell-binding assay, qualitative
0433U	Oncology (prostate), 5 DNA regulatory markers by quantitative PCR, whole blood, algorithm, including prostate-specific antigen, reported as likelihood of cancer
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes
0435U	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on cytotoxicity percentage observed, minimum of 14 drugs or drug combinations
0436U	Oncology (lung), plasma analysis of 388 proteins, using aptamerbased proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy
0437U	Psychiatry (anxiety disorders), mRNA, gene expression profiling by RNA sequencing of 15 biomarkers, whole blood, algorithm reported as predictive risk score
0438U	Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes, including deletion/duplication analysis of CYP2D6, including reported phenotypes and impacted gene drug interactions
A6520	Gradient compression garment, glove, padded, for nighttime use, each
A6521	Gradient compression garment, glove, padded, for nighttime use, custom, each
A6522	Gradient compression garment, arm, padded, for nighttime use, each
A6523	Gradient compression garment, arm, padded, for nighttime use, custom, each
A6524	Gradient compression garment, lower leg and foot, padded, for nighttime use, each
A6525	Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each
A6526	Gradient compression garment, full leg and foot, padded, for nighttime use, each
A6527	Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each
A6528	Gradient compression garment, bra, for nighttime use, each
A6529	Gradient compression garment, bra, for nighttime use, custom, each
A6552	Gradient compression stocking, below knee, 30-40 mmhg, each
A6553	Gradient compression stocking, below knee, 30-40 mmhg, custom, each
A6554	Gradient compression stocking, below knee, 40 mmhg or greater, each
A6555	Gradient compression stocking, below knee, 40 mmhg or greater, custom, each
A6556	Gradient compression stocking, thigh length, 18-30 mmhg, custom, each
A6557	Gradient compression stocking, thigh length, 30-40 mmhg, custom, each
A6558	Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each
A6559	Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each
A6560	Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each
A6561	Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each
A6562	Gradient compression stocking, waist length, 18-30 mmhg, custom, each
A6563	Gradient compression stocking, waist length, 30-40 mmhg, custom, each
A6564	Gradient compression stocking, waist length, 40 mmhg or greater, custom, each

Code	Description
A6565	Gradient compression gauntlet, custom, each
A6566	Gradient compression garment, neck/head, each
A6567	Gradient compression garment, neck/head, custom, each
A6568	Gradient compression garment, torso and shoulder, each
A6569	Gradient compression garment, torso/shoulder, custom, each
A6570	Gradient compression garment, genital region, each
A6571	Gradient compression garment, genital region, custom, each
A6572	Gradient compression garment, toe caps, each
A6573	Gradient compression garment, toe caps, custom, each
A6574	Gradient compression arm sleeve and glove combination, custom, each
A6575	Gradientcompression arm sleeve and glove combination, each
A6576	Gradientcompression arm sleeve, custom, medium weight, each
A6577	Gradientcompression arm sleeve, custom, heavy weight, each
A6578	Gradientcompression arm sleeve, each
A6579	Gradient compression glove, custom, medium weight, each
A6580	Gradientcompression glove, custom, heavy weight, each
A6581	Gradient compression glove, each
A6582	Gradient compression gauntlet, each
A6583	Gradient compression wrap with adjustable straps, below knee, 30-50 mmhg, each
A6584	Gradient compression wrap with adjustable straps, not otherwise specified
A6585	Gradient pressure wrap with adjustable straps, above knee, each
A6586	Gradient pressure wrap with adjustable straps, full leg, each
A6587	Gradient pressure wrap with adjustable straps, foot, each
A6588	Gradient pressure wrap with adjustable straps, arm, each
A6589	Gradient pressure wrap with adjustable straps, bra, each
A6593	Accessory for gradient compression garment or wrap with adjustable straps, non-otherwise specified
A6594	Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each
A6595	Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each
A6596	Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each
A6597	Gradient compression bandage roll, elastic long stretch, linear yard, any width, each
A6598	Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each
A6599	Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each
A6600	Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each
A6601	Gradient compression bandaging supply, high density foam pad, any size or shape, each
A6602	Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each

Code	Description
A6603	Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each
A6604	Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each
A6605	Gradient compression bandaging supply, padded foam, per linear yard, any width, each
A6606	Gradient compression bandaging supply, padded textile, per linear yard, any width, each
A6607	Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each
A6608	Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each
A6609	Gradient compression bandaging supply, not otherwise specified
A6610	Gradient compression stocking, below knee, 18-30 mmhg, custom, each
A9608	Flotufolastat f 18, diagnostic, 1 millicurie
A9609	Fludeoxyglucose f18 up to 15 millicuries
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)
C1601	Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components
C7556	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance, when performed
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed and intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
C7560	Endoscopic retrograde cholangiopancreatography (ercp) with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s) and endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)
C7561	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less with manual preparation and insertion of drug-delivery device(s), deep (e.g., subfascial)
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report

Code	Description
C9794	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
C9795	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
L3161	Foot, adductus positioning device, adjustable
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type
Q4279	Vendaje ac, per square centimeter
Q4287	Dermabind dl, per square centimeter
Q4288	Dermabind ch, per square centimeter
Q4289	Revoshield + amniotic barrier, per square centimeter
Q4290	Membrane wrap-hydro, per square centimeter
Q4291	Lamellas xt, per square centimeter
Q4292	Lamellas, per square centimeter
Q4293	Acesso dl, per square centimeter
Q4294	Amnio quad-core, per square centimeter
Q4295	Amnio tri-core amniotic, per square centimeter
Q4296	Rebound matrix, per square centimeter
Q4297	Emerge matrix, per square centimeter
Q4298	Amnicore pro, per square centimeter
Q4299	Amnicore pro+, per square centimeter
Q4300	Acesso tl, per square centimeter
Q4301	Activate matrix, per square centimeter
Q4302	Complete aca, per square centimeter
Q4303	Complete aa, per square centimeter
Q4304	Grafix plus, per square centimeter

Effective January 1, 2024, the following codes *will be covered* and *require plan prior authorization* for all lines of business. The following codes will be *deny vendor liable* for MassHealth ACO and Community Care:

Code	Description
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency
81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability
81458	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability

Code	Description
81459	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements
81462	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements
81463	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis, copy number variants, and microsatellite instability
81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements

Effective July 1, 2023, the following codes are *deny vendor liable* for all lines of business:

Code	Description
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed

Code	Description
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array
64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)
76984	Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic
76987	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only
81517	Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years
87523	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis D (delta), quantification, including reverse transcription, when performed
90589	Chikungunya virus vaccine, live attenuated, for intramuscular use
90623	Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction
0784T	Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed
0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator

Code	Description
0788T	Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters
0789T	Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
0811T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment
0812T	Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); device supply with automated report generation, up to 10 days
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral
0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial
0820T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour
0821T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; second physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)
0822T	Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; clinical staff under the direction of a physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)

Code	Description
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber
0827T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)
0828T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)
0829T	Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique) (List separately in addition to code for primary procedure)
0830T	Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal (List separately in addition to code for primary procedure)
0831T	Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for primary procedure)
0832T	Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (List separately in addition to code for primary procedure)
0833T	Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening and interpretation (List separately in addition to code for primary procedure)
0834T	Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)
0835T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site (List separately in addition to code for primary procedure)
0836T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)
0837T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)
0838T	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)

Code	Description
0839T	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)
0840T	Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material (List separately in addition to code for primary procedure)
0841T	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (List separately in addition to code for primary procedure)
0842T	Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)
0843T	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), initial site (List separately in addition to code for primary procedure)
0844T	Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), each additional site (List separately in addition to code for primary procedure)
0845T	Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)
0846T	Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)
0847T	Digitization of glass microscope slides for examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis) (List separately in addition to code for primary procedure)
0848T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)
0849T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)
0850T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)
0851T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)
0852T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)
0853T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)
0854T	Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (List separately in addition to code for primary procedure)
0855T	Digitization of glass microscope slides for bone marrow, smear interpretation (List separately in addition to code for primary procedure)
0856T	Digitization of glass microscope slides for electron microscopy, diagnostic (List separately in addition to code for primary procedure)

Code	Description
0857T	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report
0859T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure)
0860T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)
A4468	Exsufflation belt, includes all supplies and accessories
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm
A4541	Monthly supplies for use of device coded at e0733
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist
A7023	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application
E0493	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type
E0678	Non-pneumatic sequential compression garment, full leg
E0679	Non-pneumatic sequential compression garment, half leg

Code	Description
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure
E0681	Non-pneumatic compression controller without calibrated gradient pressure
E0682	Non-pneumatic sequential compression garment, full arm
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist
E0735	Non-invasive vagus nerve stimulator
E1301	Whirlpool tub, walk-in, portable
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system
E3000	Speech volume modulation system, any type, including all components and accessories
G0011	Individual counseling for pre-exposure prophylaxis (prep) by physician or qualified health care professional (qhp)to prevent human immunodeficiency virus (hiv), includes hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence, 15-30 minutes
G0012	Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle
G0013	Individual counseling for pre-exposure prophylaxis (prep) by clinical staff to prevent human immunodeficiency virus (hiv), includes: hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence
G0024	Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to g0023)
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes
G0137	Intensive outpatient services; weekly bundle, minimum of 9 services over a 7 contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; and such other items and services (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services in accordance with a physician certification and plan of treatment (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

Code	Description
G0140	Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet sdoh needs (that are not billed separately). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan. identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care communication. ++ assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address sdoh need(s). health education. helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
M1211	Most recent hemoglobin a1c level > 9.0%
M1212	Hemoglobin a1c level is missing, or was not performed during the measurement period (12 months)
M1213	No history of spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) and present spirometry is >= 70%
M1214	Spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and reviewed
M1215	Documentation of medical reason(s) for not documenting and reviewing spirometry results (e.g., patients with dementia or tracheostomy)
M1216	No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed with results documented during the encounter
M1217	Documentation of system reason(s) for not documenting and reviewing spirometry results (e.g., spirometry equipment not available at the time of the encounter)
M1218	Patient has copd symptoms (e.g., dyspnea, cough/sputum, wheezing)
M1219	Anaphylaxis due to the vaccine on or before the date of the encounter
M1220	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; with evidence of retinopathy
M1221	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; without evidence of retinopathy
M1222	Glaucoma plan of care not documented, reason not otherwise specified

Code	Description
M1223	Glaucoma plan of care documented
M1224	Intraocular pressure (iop) reduced by a value less than 20% from the pre-intervention level
M1225	Intraocular pressure (iop) reduced by a value of greater than or equal to 20% from the pre-intervention level
M1226	Iop measurement not documented, reason not otherwise specified
M1227	Evidence-based therapy was prescribed
M1228	Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, has hcv treatment initiated within 3 months of the reactive hcv antibody test
M1229	Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, is referred within 1 month of the reactive hcv antibody test to a clinician who treats hcv infection
M1230	Patient has a reactive hcv antibody test and does not have a follow up hcv viral test, or patient has a reactive hcv antibody test and has a follow up hcv viral test that detects hcv viremia and is not referred to a clinician who treats hcv infection within 1 month and does not have hcv treatment initiated within 3 months of the reactive hcv antibody test, reason not given
M1231	Patient receives hcv antibody test with nonreactive result
M1232	Patient receives hcv antibody test with reactive result
M1233	Patient does not receive hcv antibody test or patient does receive hcv antibody test but results not documented, reason not given
M1234	Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia
M1235	Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period
M1236	Baseline mrs > 2
M1237	Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons)
M1238	Documentation that administration of second recombinant zoster vaccine could not occur during the performance period due to the recommended 2-6 month interval between doses (i.e, first dose received after october 31)
M1239	Patient did not respond to the question of patient felt heard and understood by this provider and team
M1240	Patient did not respond to the question of patient felt this provider and team put my best interests first when making recommendations about my care
M1241	Patient did not respond to the question of patient felt this provider and team saw me as a person, not just someone with a medical problem
M1242	Patient did not respond to the question of patient felt this provider and team understood what is important to me in my life
M1243	Patient provided a response other than “completely true” for the question of patient felt heard and understood by this provider and team
M1244	Patient provided a response other than “completely true” for the question of patient felt this provider and team put my best interests first when making recommendations about my care
M1245	Patient provided a response other than “completely true” for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem
M1246	Patient provided a response other than “completely true” for the question of patient felt this provider and team understood what is important to me in my life

Code	Description
M1247	Patient responded "completely true" for the question of patient felt this provider and team put my best interests first when making recommendations about my care
M1248	Patient responded "completely true" for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem
M1249	Patient responded "completely true" for the question of patient felt this provider and team understood what is important to me in my life
M1250	Patient responded as "completely true" for the question of patient felt heard and understood by this provider and team
M1251	Patients for whom a proxy completed the entire hu survey on their behalf for any reason (no patient involvement)
M1252	Patients who did not complete at least one of the four patient experience hu survey items and return the hu survey within 60 days of the ambulatory palliative care visit
M1253	Patients who respond on the patient experience hu survey that they did not receive care by the listed ambulatory palliative care provider in the last 60 days (disavowal)
M1254	Patients who were deceased when the hu survey reached them
M1255	Patients who have another reason for visiting the clinic [not prenatal or postpartum care] and have a positive pregnancy test but have not established the clinic as an ob provider (e.g., plan to terminate the pregnancy or seek prenatal services elsewhere)
M1256	Prior history of known cvd
M1257	Cvd risk assessment not performed or incomplete (e.g., cvd risk assessment was not documented), reason not otherwise specified
M1258	Cvd risk assessment performed, have a documented calculated risk score
M1259	Patients listed on the kidney-pancreas transplant waitlist or who received a living donor transplant within the first year following initiation of dialysis
M1260	Patients who were not listed on the kidney-pancreas transplant waitlist or patients who did not receive a living donor transplant within the first year following initiation of dialysis
M1261	Patients that were on the kidney or kidney-pancreas waitlist prior to initiation of dialysis
M1262	Patients who had a transplant prior to initiation of dialysis
M1263	Patients in hospice on their initiation of dialysis date or during the month of evaluation
M1264	Patients age 75 or older on their initiation of dialysis date
M1265	Cms medical evidence form 2728 for dialysis patients: initial form completed
M1266	Patients admitted to a skilled nursing facility (snf)
M1267	Patients not on any kidney or kidney-pancreas transplant waitlist or is not in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1268	Patients on active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1269	Receiving esrd mcp dialysis services by the provider on the last day of the reporting month
M1270	Patients not on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1271	Patients with dementia at any time prior to or during the month
M1272	Patients on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period

Code	Description
M1273	Patients who were admitted to a skilled nursing facility (snf) within one year of dialysis initiation according to the cms-2728 form
M1274	Patients who were admitted to a skilled nursing facility (snf) during the month of evaluation were excluded from that month
M1275	Patients determined to be in hospice were excluded from month of evaluation and the remainder of reporting period
M1276	Bmi documented outside normal parameters, no follow-up plan documented, no reason given
M1277	Colorectal cancer screening results documented and reviewed
M1278	Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented
M1279	Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given
M1280	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy
M1281	Blood pressure reading not documented, reason not given
M1282	Patient screened for tobacco use and identified as a tobacco non-user
M1283	Patient screened for tobacco use and identified as a tobacco user
M1284	Patients age 66 or older in institutional special needs plans (snp) or residing in long term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period
M1285	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified
M1286	Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason
M1287	Bmi is documented below normal parameters and a follow-up plan is documented
M1288	Documented reason for not screening or recommending a follow-up for high blood pressure
M1289	Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)
M1290	Patient not eligible due to active diagnosis of hypertension
M1291	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
M1292	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period
M1293	Bmi is documented above normal parameters and a follow-up plan is documented
M1294	Normal blood pressure reading documented, follow-up not required
M1295	Patients with a diagnosis or past history of total colectomy or colorectal cancer
M1296	Bmi is documented within normal parameters and no follow-up plan is required
M1297	Bmi not documented due to medical reason or patient refusal of height or weight measurement

Code	Description
M1298	Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter
M1299	Influenza immunization administered or previously received
M1300	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)
M1301	Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)
M1302	Screening, diagnostic, film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed
M1303	Hospice services provided to patient any time during the measurement period
M1304	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period
M1305	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period
M1306	Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period
M1307	Documentation stating the patient has received or is currently receiving palliative or hospice care
M1308	Influenza immunization was not administered, reason not given
M1309	Palliative care services provided to patient any time during the measurement period
M1310	Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user
M1311	Anaphylaxis due to the vaccine on or before the date of the encounter
M1312	Patient not screened for tobacco use
M1313	Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period
M1314	Bmi not documented and no reason is given
M1315	Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified
M1316	Current tobacco non-user
M1317	Patients who are counseled on connection with a csp and explicitly opt out
M1318	Patients who did not have documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening or documentation that there was no contact with a csp
M1319	Patients who had documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening
M1320	Patients who screened positive for at least 1 of the 5 hrsns
M1321	Patients who were not seen within 7 weeks following the date of injection for follow up or who did not have a documented iop or no plan of care documented if the iop was >25 mm hg
M1322	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop =<25 mm hg for injected eye

Code	Description
M1323	Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop >25 mm hg and a plan of care was documented
M1324	Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant)
M1325	Patients who were not seen for reasons documented by clinician for patient or medical reasons (e.g., inadequate time for follow-up, patients who received a prior intravitreal or periocular steroid injection within the last six (6) months and had a subsequent iop evaluation with iop <25mm hg within seven (7) weeks of treatment)
M1326	Patients with a diagnosis of hypotony
M1327	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 8 weeks
M1328	Patients with a diagnosis of acute vitreous hemorrhage
M1329	Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 8 weeks after initial acute pvd encounter
M1330	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)
M1331	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks from initial exam
M1332	Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 2 weeks
M1333	Acute vitreous hemorrhage
M1334	Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 2 weeks after initial acute pvd encounter
M1335	Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up)
M1336	Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks
M1337	Acute pvd
M1338	Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period
M1339	Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period
M1340	Index assessment completed using the 12-item whodas 2.0 or sds during the denominator identification period
M1341	Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period
M1342	Patients who died during the performance period
M1343	Patients who are at pam level 4 at baseline or patients who are flagged with extreme straight line response sets on the pam
M1344	Patients who did not have a baseline pam score and/or a second score within 6 to 12 month of baseline pam score

Code	Description
M1345	Patients who had a baseline pam score and a second score within 6 to 12 month of baseline pam score
M1346	Patients who did not have a net increase in pam score of at least 6 points within a 6 to 12 month period
M1347	Patients who achieved a net increase in pam score of at least 3 points in a 6 to 12 month period (passing)
M1348	Patients who achieved a net increase in pam score of at least 6-points in a 6 to 12 month period (excellent)
M1349	Patients who did not have a net increase in pam score of at least 3 points within 6 to 12 month period
M1350	Patients who had a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter
M1351	Patients who had a suicide safety plan initiated, reviewed, or updated and reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation
M1352	Suicidal ideation and/or behavior symptoms based on the c-ssrs or equivalent assessment
M1353	Patients who did not have a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter
M1354	Patients who did not have a suicide safety plan initiated, reviewed, or updated or reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation
M1355	Suicide risk based on their clinician's evaluation or a clinician-rated tool
M1356	Patients who died during the measurement period
M1357	Patients who had a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment
M1358	Patients who did not have a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment
M1359	Index assessment during the denominator period when the suicidal ideation and/or behavior symptoms or increased suicide risk by clinician determination occurs and a non-zero c-ssrs score is obtained
M1360	Suicidal ideation and/or behavior symptoms based on the c-ssrs
M1361	Suicide risk based on their clinician's evaluation or a clinician-rated tool
M1362	Patients who died during the measurement period
M1363	Patients who did not have a follow-up assessment within 120 days of the index assessment
M1364	Calculated 10-year ascvd risk score of= 20 percent during the performance period
M1365	Patient encounter during the performance period with hospice and palliative care specialty code 17
M1366	Focusing on women's health mips value pathway
M1367	Quality care for the treatment of ear, nose, and throat disorders mips value pathway
M1368	Prevention and treatment of infectious disorders including hepatitis c and hiv mips value pathway
M1369	Quality care in mental health and substance use disorders mips value pathway
M1370	Rehabilitative support for musculoskeletal care mips value pathway

Effective January 1, 2024, the following code will be *covered with prior authorization* for all lines of business:

Code	Description
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure) ▮

Payment policies

Revised policies – Effective January 1, 2024

The following policy has been revised; details about the change is indicated in the policy.

- **Inpatient Medical Review and Payment Policy –** Under Policy, updated coverage for inpatient admissions for Medicare Advantage plan members per Final Rule (CMS-4201-F); under Reimbursement, added new subsection for Inpatient admission prior to Medicare entitlement; also under Reimbursement, added new subsection for Transfer Per Diem for MassHealth ACO members. ▮

Revised policies – Effective March 1, 2024

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

- **Non-Covered Services –** Updated code report (generated 01/02/2024).
- **Telehealth Services –** MassHealth ACO – Updated to reflect coverage, reimbursement and billing/coding requirements in accordance with MassHealth All Provider Bulletin 379 (October 2023).
- **Speech Therapy –** Policy updated to include subsections for (1) Flexibilities after the end of the COVID-19 FPHE for MassHealth ACO members, and (2) CMS flexibilities for Medicare Advantage, NaviCare and PACE plan members; added new subsection for incident to services under Reimbursement; updated procedure code table under Billing/coding guidelines and added new table for SLP services that may be delivered via telehealth for MassHealth ACO members.
- **Personal Care Attendant –** Under Coding and billing guidelines, updated Personal Care Management (PCM) Billable Codes and Personal Care Attendant (PCA) Billable Codes.
- **Preventive Services –** Under Coding/billing guidelines, updated codes for screening mammography, also under Coding/billing guidelines, updated to include instructions related to the use of new ICD-10-CM diagnosis code Z29.81 for encounters related to HIV pre-exposure prophylaxis (PrEP).
- **Modifier –** Updated information on modifier 62 in Level 1 CPT Modifier Table.
- **Podiatry Services –** Under Policy, added links to applicable Medicare guidance and updated Limitations; under Reimbursement, added that effective for dates of service on or after March 1, 2024, the Plan will align with the National Government Services Billing and Coding Article for Routine Foot Care and Debridement of Nails (A54602) with respect to the ICD-10-CM diagnosis codes that will support medical necessity for routine foot care; under Billing/coding guidelines, clarified requirements for billing and coding of routine foot care and removal of benign lesions (warts). ▮

New policies – Effective March 1, 2024

- **COVID-19 Remote Patient Monitoring –** Introduced as new payment policy.
- **Hospice Services –** MassHealth ACO and NaviCare SCO (Medicaid-only) – Introduced as new payment policy.

Medical policies

Revised policies – Effective January 1, 2024

(no changes to coverage criteria)

- **Medical Technology Assessment**

Revised policies – Effective March 1, 2024

- **Gender Affirming Surgery**
- **Bariatric Surgery**

New policies – Effective March 1, 2024

- **Skysona** (elivaldogene autotemcel)

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