Connection

Important information for Fallon Health physicians and providers

July 2022

What's new

ACO Partial Unified Formulary updates

- **Anticoagulants:** Xarelto suspension will be added to the UPPL as a PA required formulation
- **Asthma and Allergy Monoclonal Antibodies:** Tezspire will be added to the UPPL requiring prior authorization
- **CGRPs:** three new agents will be added to the guideline requiring PA: Nurtec, Quilipta, and Ubrelvy. Aimovig, Ajovy and Emgality will now be managed at parity for migraine prophylaxis
- **Growth Hormone Agents:** Skytrofa will be added to the UPPL as a PA required formulation
- **Antipsychotics:** Invega Hafyera will be added to the UPPL as a preferred product
- **Respiratory agents, Inhaled:** Xopenex HFA removed from the brand preferred over generic list
- **Targeted Immunomodulators:** Avsola and unbranded infliximab are designated a preferred infliximab formulation
- **Multiple Sclerosis Agents:** Tecfidera removed from the brand preferred over generic list ■

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In the July 2022 issue:

Important news for Corrected Claims for Zelis edited claims

Effective May 26, 2022, in an effort to streamline the corrected claims process and improve efficiency, Corrected Claim submissions for Zelis edits should be submitted directly to Fallon Health. For the quickest results, it is recommended that all corrected claims are sent electronically to Fallon Health using industry standard 837 submissions.

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

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

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

By Mail:

Fallon Health
Claims Adjustments
P.O. Box 211308
Eagan, MN 55121-2908

By Fax:

1-508-368-9890

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

By Mail:

Zelis Claims Integrity, Inc.
2 Crossroads Drive
Bedminster, NJ 07921
Attn: Appeals Department

By Fax:

1-855-787-2677

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

Important reminders

COVID-19 updates

Home covid tests

Fallon Health began covering over-the-counter COVID-19 tests for all Fallon members whose plan includes a pharmacy benefit as of January 15, 2022. Members can present their ID card at any network pharmacy to obtain an at-home test. Members can get up to 8 individual tests per month. Fallon Medicare Plus, Fallon Medicare Plus Central and Commercial plan members can submit for reimbursement for tests paid out of pocket.

For more information see our *website*.

Utilization Management/Prior Authorization reviews

Fallon Health has resumed full Utilization Management/Prior Authorization (UM/PA) review related to Acute Inpatient Hospital, Elective Surgeries and Post-Acute Admissions, with the exception of waiver of authorization for Covid-19 treatment for Commercial members pursuant to *Bulletin 2021-08*.

Federal Public Health Emergency

The Federal Public Health Emergency has been extended past mid-July. We will keep providers apprised of changes and implications. Please note: The President of the United States has signed legislation to continue telehealth for Medicare for five months after the end of the Federal Public Health Emergency.

Sequestration

CMS extended the suspension of the payment reduction through March 31, 2022. Fallon Health implemented the reduction on Fallon Medicare Plus and Fallon Medicare Plus Central applicable payments as follows:

- Effective 4/1/22-6/30/22 a 1% reduction
- Effective 7/1/22 a 2% reduction

Reminders for billing vaccine and monoclonal antibody administration

For Fallon Medicare Plus™, Fallon Medicare Plus™ Central, NaviCare SNP, and Summit ElderCare

- Providers submit a claim directly to Fallon Health for the administration (no longer bill the CMS Medicare Administrative Contractor).

For Fallon 365 Care, Berkshire Fallon Health Collaborative, Wellforce Care Plan, NaviCare SCO

- Providers submit a claim to Fallon Health for the vaccine administration with an accompanying claim line for the vaccine with an SL modifier and a charge of $0.00.

For Commercial members

- Providers submit a claim to Fallon Health for the vaccine administration. ■

What you should know about HOS-M

What is HOS-M

The HOS-M (Health Outcomes Survey-Modified) is a cross-sectional modified version of the Medicare HOS that contains 19 questions measuring the physical and mental health functioning of beneficiaries at a single point in time. The core components of the survey include The Veterans RAND 12-Item Health Survey (VR-12) and Activity of Daily Living (ADL) items.

Survey Administration and Eligibility

The HOS-M is distributed annually with this year's distribution expected to occur between July and October. The survey will be delivered to participants of Fallon Health's Programs of All-Inclusive Care for the Elderly (PACE), also called Summit ElderCare. Recipients are subject to the limitations below:

- All participants must be enrolled at the time of the survey
- Excludes participants who reside in nursing homes

- Excludes participants with end-stage renal disease
- Exclude participants who only have Medicaid

Why is HOS-M important for your patients?

One of the main goals of the HOS-M is to assess annually the frailty of the population enrolled in PACE organizations nationally. In keeping with CMS's goal to gather clinically meaningful data, the results of the survey are used to monitor participating health plan performance as well as to assist these plans and CMS in improving quality of care.

Please consider supporting your patients to provide honest and candid responses and encouraging them to reach out to family, caregivers or members of their Fallon Health PACE team for assistance in completing the survey.

For more information regarding the HOS-M or the administration of the survey to participants, please visit the official Health Outcome Survey website. ■

Genetic Testing Claims

Genetic testing refers to the laboratory analysis of DNA. Fallon Health requires prior authorization for genetic testing. For details of coverage criteria, please refer to the *Genetic Testing Medical Policy*.

Incoming genetic testing claims should include a DEX Z-Code™ identifier assigned to the test by the DEX™ Diagnostics Exchange. You can find more information on obtaining a DEX Z-Code™ *here*.

When submitting genetic testing claims:

- Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/ narrative field for the following professional claim field/types:
  - Loop 2400 or SV101-7 for the 5010A1 837P
  - Box 19 for the CMS1500 claim form
- Enter the appropriate DEX Z-Code™ identifier adjacent to the CPT code in the comment/ narrative field for the following facility claim field/types:
  - Line SV202-7 for 837I electronic claim
  - Block 80 for the UB04 claim form ■

Patient Hospital Admission, Discharge and Documentation

Hospital requirements

In accordance with CMS and EOHHS requirements, hospitals must share Admission and Discharge information with PCPs in near real time, either directly or through a health information exchange.

PCP requirements

PCPs must document receipt of notification of an inpatient admission and discharge in the patient's medical record on the day of admission or through 2 days after the admission (3 total days). This can be documented communication by phone call, email, fax, health information exchange, or shared electronic medical record system. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list
- Testing results, or documentation of pending tests or no tests pending
- Instructions for patient care post-discharge

The goal of this shared communication is to boost quality, efficiency, and continuity of care to help improve patient outcomes. If you have questions, please contact your Provider Relations Representative. ■

Billing reminders

- **To ensure more efficient claims processing,** please make sure your corrected claims are submitted after the previous claim had been finalized (i.e., paid or denied on your Remittance Advise Summary (RAS). Submitting multiple corrections prior to the finalization of the previous claim causes processing delays, manual review, and sequencing confusion.
- **Modifier 50** is used to report bilateral procedures performed during the same operative session by the same physician in either separate operative areas or in the same operative area. When billing these services, append the modifier 50 to the procedure code with one unit. The exception to this would be a procedure done twice on the same day—these should be reported with both RT and LT modifiers and should be billed on one line with two units without modifier 50.
- **Pathology billing—**when billing a pathology code done multiple times on the same date of service, bill the procedure on one claim line with multiple units. For example, if procedure 88305 was provided 5 times on one date of service, this would be billed on one line with 5 units. This will ensure your claim is not pended for manual review and will be processed more expeditiously.
- **Consistent with Medicare and Medicare guidelines,** DME providers should be billing on anniversary date when billing recurring supplies. This will help you to avoid receiving claim denials for exceeding quantity limits within the time period (i.e., per month, per 90-days or per year). ■

Directory update

Fallon Health is committed to ensuring we have the most accurate information in our provider directories. Fallon is doing this through the CAQH DirectAssure platform along with several other Massachusetts payers. For more information about DirectAssure, please visit *HCAS*.

Directory process reminders:

1. You must verify Fallon Health is a plan you do business with in the DirectAssure system.
2. You must review and attest to your directory information every 90 days. If you have not done so, CAQH is currently engaging providers to do this via email. **Your prompt attention to these emails is of the utmost importance to ensure that your patients have access to accurate provider demographic information when care is needed.**

Please note: if these steps have not been completed, your Provider Relations Representative will reach out to you directly. ■

Masshealth Gender-Affirming Care

In September 2021, MassHealth launched its Gender-Affirming Care for MassHealth Members webpage, providing information and resources about MassHealth coverage for gender-affirming care and other resources about health care for transgender and gender-diverse members.

Furthering this initiative, and through the Gender-Affirming Care Provider Self-Identification form that follows, MassHealth is collecting information from MassHealth providers who want to self-identify as providers of gender-affirming care. This form is intended to capture self-reported provider information for the purpose of informing MassHealth members of self-identified gender-affirming care providers participating in the MassHealth program, and the services they provide. Using the information collected, MassHealth may create a publicly available MassHealth gender-affirming care provider *directory*.

Any active MassHealth provider who provides gender-affirming care and would like to self-identify as a provider of gender affirming care may fill out the *form*. Please pass this along to any active MassHealth providers in your network who provide gender-affirming care.

Please note that this information is self-reported only. MassHealth reserves the right to verify any information submitted but assumes no obligation to do so. Any providers completing this form must report to MassHealth any changes to their status as self-reported providers of specified gender-affirming care (e.g., change of address, new services offered, etc.)

For more information about gender-affirming surgeries and hair removal as a treatment for gender dysphoria, visit Guidelines for Medical Necessity Determination for Gender-Affirming Surgery and Guidelines for Medical Necessity Determination for Hair Removal *here*.

If possible, it would be helpful to receive a response **within 90 days, by September 20, 2022,** although providers may complete the form at any time. ■

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, with the exception of 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.

Additional NaviCare benefits that all members receive, include:

- Unlimited transportation to medical appointments
- 140 one-way trips per calendar year to places like the grocery store, gym, religious services and more within a 30-mile radius of the member's home. Transportation may be arranged ideally 2 business days in advance by calling our Transportation Vendor CTS at 1-833-824-9440. The member/caregiver can arrange transportation, or our Navigators are also available to assist. *Continuing in 2022:* Members can qualify for mileage reimbursement for covered trips.
- Up to $400 per year in reimbursements for new fitness trackers, like a Fitbit or Apple Watch, and/or for qualified fitness equipment and/or a membership in a qualified health club or fitness facility. They also have a SilverSneakers™ gym membership.
- Up to $600 per year ($150 per calendar quarter) on the Save Now card, to purchase certain health-related items like fish oil, contact lens solution, cold/allergy medications, probiotics, incontinence products and more.
- The Healthy Food Card with the ability to earn up to $100 annually for completing such healthy activities as:
    - Welcome to Medicare/Annual physical or qualified wellness visits
    - Preventive vaccines, including:
        - Flu
        - Tdap
        - Pneumococcal vaccine
        - COVID-19
        - Shingles vaccine
- The Healthy Food Card enables members to purchase food/items such as, but not limited to: Canned vegetables, beans, rice and pastas, fresh vegetables and fruits, frozen and fresh meat, fish and poultry, refrigerated dairy and non-dairy products at participating retailers.

NaviCare members get 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 a coordinated care plan 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 Coordinator 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 patients through transition to older adulthood
- Helps connect patients with their Care Team and patients' mental 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 the above phone number.

To refer a patient to NaviCare or learn more about eligibility criteria, contact us at the NaviCare Marketing Line at 1-877-255-7108. ■

Doing business with us

Patient experience: Getting Needed Care and the impact on CMS Star Ratings

Important background information about CMS Star Ratings

The Star Ratings program was designed by CMS to:

1. Improve the quality of care that patients receive, and
2. Help patients evaluate their options based on quality.

Health plans are awarded between 1 and 5 Stars from CMS. Star Rating information is publicly available on the CMS website for Medicare eligibles to review to help assess overall health plan quality. Plans that achieve 4 Stars or higher are recognized as high performing plans that invest time and effort into improving the care of their members. These plans also have a much higher likelihood of retaining and growing membership.

Each year during the March to June timeframe, randomly selected members from participating Medicare Advantage plans such as Fallon Health receive a CAHPS survey that measures their experiences with both their health plan and with the care that they receive from their providers. CAHPS stands for Consumer Assessment of Healthcare Providers and Systems. There are nine CAHPS measures that count roughly one third toward a health plan's overall star rating score. CMS has recently put greater emphasis on member experience and increased the weight of these measures (from 2 to 4).

Getting Needed Care CAHPS measure

One CAHPS measure that providers can impact directly is Getting Needed Care.

Getting Needed Care is comprised of two questions:

- In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

Patient experience can be positively impacted by provider offices by utilizing the following industry-identified best practices:

- Offering patients assistance in scheduling appointments with specialists before they leave the office
- Reviewing the health plan's authorization and requirements, and, if needed, submitting a prior authorization request on behalf of the patient

- Following up with patients to confirm that referrals to specialists have been approved and provide assistance if needed
- Ensuring patients understand what to do if care is needed afterhours
- Expanding office hours and telehealth capabilities
- Leaving open slots for urgently needed appointments
- Encouraging patients to participate actively in the discussion regarding their care plan ■

Coding corner

Coding updates

Effective September 1, 2022, the following code will be *covered with prior authorization* for Fallon Medicare Plus, NaviCare and PACE plan members.

Code	Description
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)

Effective September 1, 2022, the following codes will be *covered with prior authorization* for commercial, Fallon Medicare Plus, NaviCare and PACE plan members.

Effective September 1, 2022, the following codes will be *deny vendor liable* for MassHealth ACO plan members.

Code	Description
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie
A9530	Iodine I-131 sodium iodide solution, therapeutic, per mCi
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 mCi
A9600	Strontium sr-89 chloride, therapeutic, per millicurie
A9604	Samarium sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries

Effective September 1, 2022, the following codes will *require prior authorization* for all lines of business.

Code	Description
A9590	Iodine I-131, iobenguane, 1 millicurie
A9606	Radium ra-223 dichloride, therapeutic, per microcurie

Effective September 1, 2022, the following code *will not require prior authorization*.

Code	Description
S2411	Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome

Effective September 1, 2022, the following code *will be covered* for commercial, MassHealth ACO, NaviCare and PACE plan members. *Prior authorization is not required*.

Effective September 1, 2022,the following code *is not covered* for Fallon Medicare Plus plan members.

Code	Description
L8010	Breast prosthesis, mastectomy sleeve

Effective September 1, 2022, the following code *will be covered* for MassHealth ACO, NaviCare and PACE plan members. Prior authorization is not required.

Effective September 1, 2022, the following code is *not covered* for commercial or Fallon Medicare Plus plan members.

Code	Description
L8031	Breast prosthesis, silicone or equal, with integral adhesive

Effective September 1, 2022, the following code will *be covered for all lines of business. Prior authorization is not required*.

Code	Description
L8032	Nipple prosthesis, prefabricated, reusable, any type, each

Effective September 1, 2022, the following code will *not be covered* for commercial and Fallon Medicare Plus plan members.

Effective September 1, 2022, the following code will be *deny vendor liable* for MassHealth ACO, NaviCare and PACE plan members.

Code	Description
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each

Effective September 1, 2022, the following code *will be covered* for MassHealth ACO, NaviCare and PACE plan members. *Prior authorization is required*.

Code	Description
L8035	Custom breast prosthesis post mastectomy, molded to patient

Effective September 1, 2022, providers *need 90 day notice*.

Code	Description
V2525	Contact lens, hydrophilic, dual focus, per lens

Effective September 1, 2022, the following code will be configured as *deny vendor liable*. Please use HCPCS code G0455 to report preparation with instillation of fecal microbiota by any method:

Code	Description
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen

Effective September 1, 2022, the following codes will *require prior authorization:*

Code	Description
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed
C2624	Implantable wireless pulmonary pressure sensor with delivery catheter, including all system components

Effective July 1, 2022, the following codes will be configured as *not a covered benefit* for Medicaid:

Code	Description
A9596	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie

Effective July 1, 2022, the following code will be *deny vendor liable* for Medicaid and all lines of business *will require plan prior authorization:*

Code	Description
C9098	Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie

Effective July 1, 2022, the following codes *will require plan prior authorization:*

Code	Description
G0308	Creation of subcutaneous pocket with insertion of 180 day implantable interstitial glucose sensor, including system activation and patient training
G0309	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 180 day implantable sensor, including system activation
Q4259	Celera dual layer or celera dual membrane, per square centimeter
Q4260	Signature apatch, per square centimeter
Q4261	Tag, per square centimeter
0323U	Infectious agent detection by nucleic acid (DNA and RNA), central nervous system pathogen, metagenomic next-generation sequencing, cerebrospinal fluid (CSF), identification of pathogenic bacteria, viruses, parasites, or fungi
0324U	Oncology (ovarian), spheroid cell culture, 4-drug panel (carboplatin, doxorubicin, gemcitabine, paclitaxel), tumor chemotherapy response prediction for each drug
0325U	Oncology (ovarian), spheroid cell culture, poly (ADP-ribose) polymerase (PARP) inhibitors (niraparib, olaparib, rucaparib, velparib), tumor response prediction for each drug

Code	Description
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed
0328U	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations
0330U	Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab
0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alternations

Effective July 1, 2022, the following codes will be *deny vendor liable* for all lines of business:

Code	Description
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie
0714T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance
0715T	Percutaneous transluminal coronary lithotripsy (list separately in addition to code for primary procedure)
0716T	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (list separately in addition to code for primary procedure)

Code	Description
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (list separately in addition to code for primary procedure)
0725T	Vestibular device implantation, unilateral
0726T	Removal of implanted vestibular device, unilateral
0727T	Removal and replacement of implanted vestibular device, unilateral
0728T	Diagnostic analysis of vestibular implant, unilateral; with initial programming
0729T	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming
0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance
0731T	Augmentative AI-based facial phenotype analysis with report
0732T	Immunotherapy administration with electroporation, intramuscular
0733T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days
0734T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (list separately in addition to code for primary procedure)
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter
0737T	Xenograft implantation into the articular surface

Effective July 1, 2022, the following codes will *require plan prior authorization:*

Code	Description
J1306	Injection, inclisiran, 1 mg
J1551	Inj cutaquig 100 mg
J2356	Inj tezepelumab-ekko, 1 mg
J2779	Inj, susvimo 0.1 mg
J9331	Inj sirolimus prot part 1 mg
J9332	Inj efgartigimod 2 mg

Effective June 17, 2022, the following codes will be configured as *deny vendor liable for all lines of business:*

Code	Description
91311	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP , spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use
91308	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 m6 dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

Effective April 4, 2022, the following code was configured as *deny vendor liable for all lines of business:*

Code	Description
K1034	Provision of COVID-19 test, nonprescription self-administered and self-collected use, FDA-approved, authorized or cleared, one test count

Effective March 29, 2022, the following code was configured as *deny vendor liable for all lines of business:*

Code	Description
91309	Moderna COVID-19 Vaccine (blue cap) 50mcg/05ml (booster) ■

Payment policies

Revised policies – Effective September 1, 2022

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

- **Non-Covered Services –** Updated code report (generated 06/02/2022).
- **Code Review –** Updated Billing/coding guidelines to include information on Newly Issued CPT/HCPCS Codes.
- **Hospice –** Updated Policy section related to coverage for services delivered via telehealth for MassHealth ACO and NaviCare SCO members; removed instructions for reporting Q codes under Billing/coding guidelines.
- **Physical and Occupational (PT/OT) Therapy –** Updated Policy section with information about coverage for therapy services delivered via telehealth for MassHealth ACO members following the end of the state of emergency due to COVID-19.
- **Inpatient Medical Review –** Readmissions section under Reimbursement updated to include list of readmissions excluded from readmission review effective for dates of service on or after 09/01/2022.
- **Claims Editing Software –** Added Frequency validation (possible duplicate) to the list of edits; added Billing Tip: Billing Multiple Lines Instead of Multiple Units under Biling/coding guidelines.

- **Modifier –** Updated to include Billing/coding information for modifier 50.
- **Durable Medical Equipment –** Updated to reflect coverage for the repair of serviceable retired backup power wheelchairs for MassHealth members effective 07/01/2022.
- **Observation Services –** Clarified reimbursement for observation services under the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment for observation services under the Medicare Outpatient Prospective Payment System (OPPS) payment methodology. ■

New policies – Effective September 1, 2022

- **Medicare Fee Schedule Adjustment –** Introduced as a new policy.
- **Oxygen and Oxygen Equipment –** Introduced as a new policy. ■

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

Send information to:

Provider Relations
Fallon Health
10 Chestnut St.
Worcester, MA 01608

or

Email your Provider Relations Representative

Richard Burke
President and CEO

Dr. David Brumley
Chief Medical Officer
Vice President and Medical Director, Medical Affairs

Susan Keser
Vice President, Network Development and Management

Kathy Bien
Director, Provider Relations

fallonhealth.org/providers

Questions?

1-866-275-3247

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