

# Connection

Important information for Fallon Health physicians and providers

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## What's new

### Provider payment processing transition to Zelis Payments Network

Zelis has completed an acquisition of Payspan, and later in 2026 Fallon Health will be moving to the Zelis Payments Network (ZPN). While many of our provider partners are currently using ZPN for preferred payment methods today, there will be some providers who will need to enroll to continue receiving electronic payments.

We will be sharing additional information soon, including the transition date and any actions required by the provider community. This transition provides multiple payment options and ease of access for our provider network. We're excited to offer access to ZPN later this year. ■

### Nurse triage vendor change

Fallon Health has changed its 24/7 nurse triage vendor from Amalgamated Medical Care Management to Call4Health, Inc.

Fallon Health has contracted with Call4Health, Inc. for 24/7 nurse triage services as of February 1, 2026. The services and contact information remain the same with no disruption to members. ■

## Important updates

### Integrated Home Care Services (IHCS) update

As previously communicated—from August 1, 2025, through March 31, 2026—Fallon Health/IHCS allowed hospital discharges requiring certain services that met applicable medical guidelines to be exempt from prior authorization. **Effective immediately, this exemption is being extended indefinitely.** IHCS will continue to monitor utilization of the services listed below. However, prior authorizations will not be required for these services.



## Exemption list

### Home Health Services

- Initial RN evaluation and up to 3 additional RN visits  
*Codes: G0299-550, G0299-551, T1030, T1001*
- Initial PT evaluation and up to 3 PT visits  
*Codes: G0151-424, G0151-421*
- Initial OT evaluation and up to 3 OT visits  
*Codes: G0152-0434, G0152-0431*

### DME equipment

- Cane – E0100, E0105
- Walker – E0135, E0143
- Shower chair – E0240
- Standard wheelchair rental (up to 1 month) – K0001
- Standard hospital bed rental (up to 1 month) – E0260

Although these services are exempt from prior authorization, **orders and referrals must still be submitted to IHCS**. If a member requires ongoing services beyond the initial exempted amounts, please contact IHCS to request prior authorization. **Please note:** Fallon Health and IHCS reserve the right to reinstate prior authorization requirements if concerns arise. Any such change would be communicated with appropriate advance notice.

### Additional information

To help streamline the referral and authorization process, IHCS is working with third-party vendors—CarePort, Availity, and Parachute—to allow hospitals to use their existing systems when submitting prior authorization requests.

- CarePort and Availity are currently available for providers. Any facility or provider using CarePort or Availity as a referral management platform can now select IHCS to submit a referral.
- Parachute is still in development. ■

## Fallon Health to transition from Assisted Living Facility (ALF) invoice billing to ALF claims submission for PACE members

Fallon Health is committed to supporting our provider community with streamlined, accurate, and secure billing processes. As part of this commitment—and in response to a significant increase in billing errors that have been affecting timely payments to facilities—we will be transitioning from Assisted Living Facility (ALF) invoice billing for PACE members, including services billed under code H0043, to ALF claims submission.

## Why this change is happening

Our internal review has shown that using spreadsheets for billing has led to increasing inaccuracies, which in turn has delayed payment processing. *Please note:* If you are contracted and submit claims for NaviCare® HMO SNP, you may continue using your existing process for PACE claims.

## Options for ALF billing:

- Submit claims through the Fallon Health provider portal (claims module).
- Submit claims through SFTP.
- Submit claims through a clearinghouse of your choice.
- Submit paper claims.

We can provide additional instructions or support based on the submission method you choose.

## Notice period

In accordance with operational policy standards for claims and payment modifications—and recognizing this represents a meaningful workflow change—we are issuing a 60-day notice to all Assisted Living Facility partners. This change will take effect on June 1, 2026.

## Support and training

We understand that this shift may raise questions. Fallon Health will be offering:

- Step-by-step guidance for portal claims submissions
- Assistance with portal registration or account access issues

If your facility requires assistance designating Super Users, resolving access issues, or navigating the portal, please reach out to Provider Relations.

## Next steps

You will receive further communication, including training resources and the finalized implementation date. We may also schedule dedicated time with your team depending on your facility's billing volume.

Thank you for your partnership and your ongoing commitment to providing high quality care. We appreciate your cooperation as we implement this improvement to ensure more efficient and accurate billing. If you have any questions, please contact your Fallon Health Provider Relations representative directly, or email [askfchp@fallonhealth.org](mailto:askfchp@fallonhealth.org). ■

## Updated Medicare Outpatient Observation Notice (MOON)

CMS has released an updated Medicare Outpatient Observation Notice (MOON), approved by the Office of Management and Budget for 3 years. The revised notice improves readability and design and is available in English and Spanish on CMS' Beneficiary Notices Initiative (BNI) webpage.

## Key dates

- Effective: Immediately
- Expires: February 28, 2029

Providers may continue using existing stock of the expired MOON through April 20, 2026.

**All providers must use the updated MOON no later than April 20, 2026.**

## Provider requirement

Hospitals and critical access hospitals (CAHs) must deliver a MOON to Medicare beneficiaries, including Medicare Advantage enrollees, who are receiving outpatient observation services, informing them they are not hospital inpatients.

For additional guidance, refer to [Section 400, Chapter 30 of the Medicare Claims Processing Manual](#). ■

## Fallon Health/MassHealth drug list summary update for April 2026

MassHealth evaluates the prior authorization (PA) status for drugs on an ongoing basis and updates the MassHealth Drug List accordingly. This Summary Update document identifies changes to the MassHealth Drug List for the rollout effective April 1, 2026.

Additional information about these agents may be available on the [MassHealth Drug List](#).

## Additions

Effective April 1, 2026, the following newly marketed drugs have been added to the MassHealth Drug List.

- Andembry (garadacimab-gxii) – **PA**
- Blujepa (gepotidacin) – **PA**
- Brinsupri (brensocatib) – **PA**
- Dawnzera (donidalorsen) – **PA**
- Ekterly (sebetralstat) – **PA**
- Legembi Iqlik (lecanemab-irmb) – **PA**
- Lynkuet (elinzanetant) – **PA**
- Modeyso (dordaviprone) – **PA**
- Orlynvah (sulopenem etzadroxil/probenecid) – **PA**
- Papzimeos (zopapogene imadenovec-drba) – **PA; MB**
- Rhapsido (remibrutinib) – **PA**
- tramadol 75 mg – **PA**
- Vizz (aceclidine ophthalmic solution) – **PA**

## Change in prior authorization status

- a. Effective April 1, 2026, the following acetylcholinesterase inhibitor will require PA:
  - pyridostigmine bromide solution – **PA; A90**
- b. Effective April 1, 2026, the following drug cessation agent will no longer require PA within updated dose and duration limits:
  - buprenorphine sublingual tablet – **PA >5 days treatment/180 days and PA > 32 mg/day**
- c. Effective April 1, 2026, the following hereditary angioedema agents will no longer require PA within established quantity limits:
  - Berinert (c1 esterase inhibitor, human) – **PA > 14 injections/30 days**
  - Firazyr (icatibant) – **PA > 6 injections/30 days; #**
  - Kalbitor (ecallantide) – **PA > 12 injections/30 days; MB**
  - Ruconest (c1 esterase inhibitor, recombinant) – **PA > 8 injections/30 days**
- d. Effective April 1, 2026, the following chemotherapy agent will no longer require PA:
  - Gleostine (lomustine)
- e. Effective April 1, 2026, the following antiretroviral agent will no longer require PA:
  - Yeztugo (lenacapavir)

## New or revised therapeutic tables

Table 2 – Hormones - Gonadotropin-Releasing Hormone Analogs

Table 5 – Immunological Agents

Table 8 – Opioids and Analgesics

Table 10 – Dermatologic Agents - Acne and Rosacea

Table 18 – Cardiovascular Agents

Table 24 – Antipsychotics

Table 26 – Antidiabetic Agents

Table 27 – Antiemetics, Appetite Stimulants, and Anabolics

Table 31 – Cerebral Stimulants and Miscellaneous Agents

Table 33 – Inflammatory Bowel Disease Agents

Table 35 – Antibiotics and Anti-Infectives - Oral and Inhaled

Table 36 – Drug and Alcohol Cessation Agents

Table 38 – Antiretroviral/HIV Therapy

Table 40 – Respiratory Agents - Oral

Table 43 – Pulmonary Hypertension Agents

Table 52 – Multiple Sclerosis Agents

Table 53 – Otic Agents

Table 56 – Alzheimer’s Agents

Table 57 – Oncology Agents

Table 60 – Hereditary Angioedema Agents

Table 63 – Dermatologic Agents - Topical Chemotherapy, Genital Wart Treatment, and Miscellaneous Dermatologic Agents

Table 67 – Antiviral Agents

Table 71 – Pediatric Behavioral Health

Table 72 – Agents Not Otherwise Classified

Table 74 – Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

### Updated MassHealth Brand Name Preferred Over Generic Drug List

The MassHealth Brand Name Preferred Over Generic Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- a. Effective April 1, 2026, the following agents will be added to the MassHealth Brand Name Preferred Over Generic Drug List:
  - Cipro HC (ciprofloxacin / hydrocortisone); **BP**
  - Mavenclad (cladribine tablet) – **PA; BP**
  - Rowasa (mesalamine enema); **BP, A90**
- b. Effective April 1, 2026, the following agents will be removed from the MassHealth Brand Name Preferred Over Generic Drug List:
  - Cardura (doxazosin immediate-release); **#, M90**
  - Daytrana (methylphenidate transdermal) – **PA < 3 years or ≥ 21 years and PA > 1 unit/day; #**
  - Entresto (sacubitril/valsartan tablet) – **PA**
  - Sancuso (granisetron transdermal system) – **PA**

### Updated MassHealth Supplemental Rebate/Preferred Drug List

The MassHealth Supplemental Rebate/Preferred Drug List has been updated to reflect recent changes to the MassHealth Drug List.

- a. Effective April 1, 2026, the following antiretroviral agent will be added to the MassHealth Supplemental Rebate/Preferred Drug List:
  - Yeztugo (lenacapavir) – **PD**
- b. Effective April 1, 2026, the following targeted immunomodulators will be removed from the MassHealth Supplemental Rebate/Preferred Drug List:
  - Humira (adalimumab) – **PA**
  - Stelara (ustekinumab 45 mg/0.5 mL prefilled syringe, 90 mg/mL prefilled syringe, 45 mg/0.5 mL vial) – **PA**

### Updated MassHealth Quick Reference Guide

The MassHealth Quick Reference Guide has been updated to reflect recent changes to the MassHealth Drug List.

## Updated and New Pharmacy Initiatives

- Opioid and Pain Initiative

## Deletions

The following drugs have been removed from the MassHealth Drug List because they have been discontinued by the manufacturer.

- Abilify Mycite (aripiprazole tablet with sensor) – **PA**
- Atripla (efavirenz/emtricitabine/tenofovir); #, **A90**
- Delzicol DR (mesalamine 400 mg delayed-release capsule) – **PA**
- Fentora (fentanyl buccal tablet) – **PA**
- Finacea (azelaic acid gel) – **PA; A90**
- Idacio (adalimumab-aacf) – **PA**
- Ortikos (budesonide extended-release capsule) – **PA**
- Portrazza (necitumumab) – **PA; MB**
- Tarceva (erlotinib) – **PA; A90**
- Zyprexa Zydis (olanzapine 15 mg orally disintegrating tablet) – **PA < 10 years and PA > 2 units/day**
- Zyprexa Zydis (olanzapine 5 mg, 10 mg, 20 mg orally disintegrating tablet) – **PA < 10 years and PA > 1 unit/day**

## Abbreviations, acronyms, and symbols

**#** This designates a brand-name drug with FDA A-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA A-rated generic equivalent.

**MB** Medical Benefit. This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy.

**PA** Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the provider to receive reimbursement. **Note:** PA applies to both the brand name and the FDA A-rated generic equivalent of listed product.

**A90** Allowable 90-day supply. Dispensing up to a 90-day supply is allowed. May not include all strengths or formulations. Quantity limits and other restrictions may apply.

**BP** Brand Preferred over generic equivalents. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

**M90** Mandatory 90-day supply. After dispensing up to a 30-day supply initial fill, dispensing a 90-day supply is required. May not include all strengths or formulations. Quantity limits and other restrictions may also apply.

**PD** Preferred Drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class. ■

## PA change for CTs and brain MRIs managed by eviCore

Effective June 1, 2026, Fallon Health will no longer require prior authorizations for computed tomography (CT) or magnetic resonance imaging (MRI) of the brain for Fallon Medicare Plus™, NaviCare, Community Care and MassHealth ACO (Berkshire Fallon Health Collaborative, Fallon 365 Care, and Fallon Health-Atrius Health Care Collaborative). ■

## Upcoming changes to 835 reversal reporting and negative balance processing

Fallon Health is implementing updates to how claim reversals and negative balances are reported on the Electronic Remittance Advice (835). These changes are being made to ensure compliance with national TR3 guidelines and to improve your ability to reconcile adjustments. This change is slated for late summer/early fall.

### This update will:

- Improve your ability to reconcile adjustments back to specific claims.
- Provide clearer visibility into which claims contributed to a negative balance.
- Reduce reconciliation complexity for billing systems that require claim-level references.
- Allow multiple loops for PLB segments. (The new structure is fully supported by TR3 standards.)

### Why are we making these changes?

- These updates align Fallon Health with required 835 reporting guidelines and address provider feedback—particularly challenges reconciling aggregated negative balances in prior remits.
- By implementing both updates together, we aim to provide clearer and more consistent adjustment reporting.

### What providers need to do:

- No action is required at this time.

### However, you may want to:

- Inform your billing or clearinghouse teams of this information so they are aware this change will be coming.
- Update internal reconciliation workflows if they rely on the previous aggregated negative balance format.

Fallon Health will provide additional details, with examples, in July's *Connection* Newsletter. ■

# Product spotlight

## NaviCare® – Model of Care training

NaviCare utilizes both Medicare and Medicaid covered benefits and services to help our members function at the safest level in the most appropriate setting. Eligible members must be aged 65 or older, enrolled in MassHealth Standard (Medicaid) and enrolled in Medicare Part A and Part B. Prior to January 1, 2026, members could qualify for NaviCare with only MassHealth Standard (Medicaid). As of January 1, 2026, members must be enrolled in MassHealth Standard (Medicaid) as well as Medicare Part A and Part B.

NaviCare is available in every county in Massachusetts, except for Nantucket and Dukes, and there are \$0 copays for covered benefits.

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

### Benefits that all NaviCare members receive include:

- An entire individualized 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 with whom to communicate to have the best information possible for each NaviCare member. Care Team members visit and assess members in their homes with the members' consent and work closely with community providers and resources providing value to both our members and providers.
- Unlimited rides to and from medical appointments and places where members receive health care.
- 48 1-way rides to the pharmacy.
- Mileage reimbursement for friends and family who give rides when pre-approved.
- 100 1-way rides to run errands, visit friends, attend religious services, and more, for members who have a qualifying chronic condition.\*
- **\$400/year** to pay for fitness classes, a new fitness tracker, new cardiovascular fitness equipment, or a fitness/gym membership.
- Each calendar quarter, **Fallon Health will load \$375** onto a member's Save Now card so that they can buy over-the-counter (OTC) health and personal care items. They'll get up to \$1,500 during the year to use at select retail stores or for phone and online orders through Fallon Health's mail order partner, Medline.
- If members have a qualifying chronic condition: Each calendar quarter, a portion of their OTC benefit\*\* is set aside for them to buy healthy food. To learn more, contact Fallon Health.
- Telehealth visits for virtual primary care providers, specialists, or other health care providers.
  - 24/7 access to doctors by phone, internet, or mobile device—with Teladoc®.
  - 24/7 access to nurses, by phone, who can recommend where members should receive care or connect them to their doctor—with Care Connect.

- Outpatient behavioral health services (Covered through our contracted providers. No authorization required.)
- Covered prescription drugs and certain approved OTC drugs and items. Members may receive a 100-day supply of medications via mail order.
- Vision care and eyeglasses (\$403 annual eyewear allowance to buy up to 2 pairs of prescription eyeglasses, contacts, lenses, frames, or upgrade to anti-scratch lenses).
- Hearing aids and batteries.
- Comprehensive dental services designed to maintain and improve member's oral health, including but not limited to:
  - Preventive services: routine oral examinations, cleanings, and X-rays
  - Basic services: fillings, extractions, and periodontal treatments
  - Major services: crowns, bridges, and dentures
  - Pre-authorization requirements: certain dental procedures require pre-authorization to ensure they are medically necessary and appropriate. For services to be covered, the dental provider must get prior authorization (approval in advance) from DentaQuest. Members have access to the DentaQuest network of dental providers.
- Durable medical equipment (DME), such as wheelchairs, crutches, walkers, and related supplies. Members are allowed 1 Seat Lift Chair per lifetime after prior authorization, up to \$900.
- Diabetic services and supplies.

*\*The \$200 (per calendar quarter) food benefit and 100 annual one-way rides to run errands, visit friends, attend religious services, and more, are part of a special supplemental program for the chronically ill. To qualify, enrollees must have chronic-condition diagnoses documented with Fallon Health, such as cardiovascular disorders, chronic and disabling behavioral health conditions, chronic lung disorders, diabetes, and neurologic disorders. This is not a complete list of eligible chronic conditions. Not all members with an eligible condition will qualify. Other eligibility and coverage criteria also apply.*

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

## **Care Team members and their roles include:**

### **Navigator**

- Provides information to your patient about benefits and services.
- Assists with care plan development, reviews and obtains consent for care plans.
- Assists patients with provider access and service coordination.
- Provides care coordination around patient care transitions.

### **Nurse Case Manager or Advanced Practitioner**

- Assesses clinical and daily functional needs.
- Supports patient in accessing the care they need when transitioning between or out of facility settings.
- Provides education about chronic disease and medication management.

### **Primary Care Provider**

- Provides overall clinical direction.

- Provides primary medical services including acute and preventive care.
- Orders prescriptions, supplies, equipment, and home-based services and supports.
- Documents and complies with advance directives in alignment with the patient's wishes for future treatment and health care decisions.
- Provides input into patient's care plan and receives periodic care plans for review and involvement.

**Geriatric Support Services Coordinator** *(as needed)*

*(Employed by local ASAPs for community-based patients)*

- Evaluates need for services to help patient remain at home and coordinates those services.
- Helps patient with completion and submission of MassHealth, Medicare, or other financial documents.
- Connects patient with community resources.

**Behavioral Health Case Manager** *(as needed)*

- Identifies and coordinates services to support patient's emotional health and well-being.
- Supports patient through transition phases of older adulthood.
- Helps connect patient with their Care Team, mental-health providers, and substance-use counselors, if needed.
- Supports patient through life transitions such as offering resources related to grief and loss, Alzheimer's/dementia resources, and family caregiver support.

**Clinical Pharmacist** *(as needed)*

- Visits patients after care transitions to perform a medication reconciliation and teach them proper medication use.
- Participates in case conferences for patients with complex medication profiles.
- Supports patients after care transitions; may complete medication reconciliations via telehealth, provides additional education and resources around medication management.
- Collaborates with providers to ensure a safe, effective medication regimen is in place. The goal is to prevent medication errors, complications, or adverse outcomes when possible.

PCPs are welcome to provide input to their patient's care plan at any time by contacting NaviCare Enrollee Service at 1-877-700-6996 (TRS 711). They're available 8 a.m. to 8 p.m., Monday through Friday (7 days a week, Oct. 1 through March 31). You may also speak directly with the NaviCare Navigators and/or Nurse Case Managers that may be embedded in your practices. If you're interested in having a Navigator and/or Nurse Case Manager embedded in your practice, please contact us at 1-877-700-6996.

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

## NaviCare Model of Care success

### A trusted voice, a timely intervention

When a NaviCare member began feeling unwell, she reached out to someone she trusted—her Navigator, who speaks her primary language and understands her unique needs. After discussing

her symptoms, the Navigator quickly recognized the urgency of the situation and advised her to seek immediate medical care. He promptly located the closest appropriate facility, coordinated transportation, and ensured the member arrived safely. The member was admitted to the hospital, where she was diagnosed with a stroke.

During discharge planning, the Navigator contacted the member's primary care physician's office to coordinate follow-up care. In speaking with the nurse in the PCP's clinic, he learned that the member had not been fully compliant with parts of her medication regimen and had also expressed feelings of loneliness.

The Navigator immediately mobilized the member's care team. Working closely with the Nurse Case Manager (NCM) and Geriatric Support Services Coordinator (GSSC), he helped develop and implement a comprehensive care plan centered on the member's personal goals. Within 1 week, the member was enrolled in an Adult Day Health (ADH) program, addressing both her social needs and the need for ongoing medical oversight. In addition, in-home supports were put in place, including assistance with shopping, laundry, and light housekeeping, as well as personal care and Visiting Nurse Association (VNA) services to support medication management.

Throughout the rollout of these services, the Navigator remained in close, consistent communication with the member, adjusting the frequency and scheduling of supports to ensure the care plan truly met her needs. Through education, collaboration, and strong relationship-building—conducted in the member's primary language—the Navigator helped ensure consistent oversight for her complex medical conditions.

The result? The member continues to live safely at home. She feels reassured, supported, and more connected, and she is once again enjoying life. She has expressed deep gratitude for the care and support she has received. ■

## Important reminders

### Have you registered for the new provider portal yet?

As a contracted provider, you now have access to our new and improved provider portal, designed to streamline your administrative tasks and give your practice the tools needed to work more efficiently with our plan.

#### What you can do in the provider portal

Once you are an approved user, you can:

- Access eligibility and benefit verification
- Access claim status checks
- Submit CMS-1500 claims
- Track authorization and referral status

- And much more

### Who can sign up?

Each provider group—defined by its Tax Identification Number (TIN)—must designate a Super User (Practice Administrator). The Super User manages access for the entire organization.

### Super users are responsible for:

- Serving as the primary contact for portal access.
- Creating and maintaining all user accounts, including third-party billers.
- Assigning user roles for claims, eligibility, benefits, and authorizations.

### Important registration notes

- Individual self-registrations are not accepted and will be denied.
- All users must be added by the group's designated Super User.
- Super Users should register at [fallonprovider.healthtrioconnect.com](https://fallonprovider.healthtrioconnect.com).
- The Provider Portal is for contracted providers only.
- Vendored providers (Carelton, EyeMed, ASH) and non-contracted providers will be denied access.

### Provider portal vs. ProAuth—what's the difference?

Understanding the distinction between the 2 systems will help ensure you're using the right tool for the right task:

#### Provider portal

- View referrals
- View authorizations
- Access eligibility, benefits, and claims information
- Submit CMS-1500 claims

#### ProAuth

- Enter/submit referrals
- Enter/submit prior authorizations
- Submit new registrations at [fallonhealth.org/providertools/ProAuthRegistration](https://fallonhealth.org/providertools/ProAuthRegistration).

**Note:** Not all provider types are eligible for ProAuth access. **Excluded provider types include:** SNF, Acute Rehab, LTACH, Home Health, and Adult Foster Care.

## Key functions and where to access them

Task	Where to find it	Who can register
<b>Eligibility and Benefits</b>	Provider portal	Super Users (They add additional staff)
<b>Claims – Viewing</b>	Provider portal	Super Users (They add additional staff)
<b>Claims – Submission</b>	Provider portal	Super Users (They add additional staff)
<b>Referrals – Viewing</b>	Provider portal	Super Users (They add additional staff)
<b>Prior Authorizations – Viewing</b>	Provider portal	Super Users (They add additional staff)
<b>Referrals – Entering/Submitting</b>	ProAuth	Staff who submit or request referrals
<b>Prior Authorizations – Entering/Submitting</b>	ProAuth	Staff who submit or request authorizations

If your practice has not yet designated a Super User or the Super User has not registered for portal access, we encourage you to do so as soon as possible. This ensures your team has the tools needed to work efficiently and stay connected with our plan. ■

### Reminder: Timely submission of clinical records for appeals

Timely submission of requested clinical documentation is essential to ensure we can complete appeal reviews promptly and accurately. We appreciate your prompt attention and partnership in supporting timely and accurate completion of these reviews.

Fallon Health requests the clinical documentation necessary to conduct an appeal review and to support activities related to treatment, payment, or authorizations. Under HIPAA regulations (45 CFR 164.502), these disclosures to Fallon Health are permitted without patient authorization. Additionally, the Information Blocking regulations issued by the Office of the National Coordinator for Health Information Technology (45 CFR 171.103) require the release of this information. ■

### Reminder: Keep your CAQH provider data up to date

**Please share this important reminder with the individual in your practice who manages enrollment, provider updates, or maintains your CAQH profile.**

Massachusetts health plans rely on the CAQH Provider Data Portal to ensure provider directory information is accurate. This central resource streamlines data management and helps patients find the right providers when they need care.

## Why 90-day attestation matters

Providers are required to validate and attest to their CAQH data every 90 days, **even if nothing has changed**. Regular attestation is essential to maintaining:

- **Accurate patient access:** Ensures patients can find and contact the correct provider at the correct location.
- **Regulatory compliance:** Health plans must meet strict federal and state accuracy standards.
- **Reduced follow-up requests:** Timely attestation minimizes reminder emails and calls to your practice.

## What you need to do

- Log in to the CAQH Provider Data Portal and review/attest to your information.
- Forward this reminder to another team member who handles this process.

## Important: Check your participating status

Please confirm that your participating status is correct for each individual practice location.

Errors can cause disruptions, including:

- **Unintentional terminations:** For example, indicating you *do not* accept Fallon Health where you participate.
- **Unnecessary calls/emails to your offices:** Selecting that you *do* accept Fallon Health at a non-participating location can trigger Fallon Health outreach for clarification.

Emails are sent to any address listed in your CAQH profile, so please ensure your contact information is up to date.

## Large groups: Roster option available

If your organization prefers to complete attestations through a roster submission rather than individually, CAQH offers a large-group option. Please reach out to CAQH directly to explore this.

**Maintaining accurate provider data is a shared responsibility—and a critical one. ■**

# Doing business with us

## Claims editing—Zelis

### What triggers a claim review?

A Zelis claim review is triggered when submitted claim data meets the criteria of a configured edit. Each edit has its own logic and parameters, varying by line of business, Fallon Health's payment policies, and claim type. Edits are developed using nationally recognized coding and reimbursement guidance (CMS/NCCI, CPT/HCPCS, FDA sources, clinical references).

### Common triggers include:

- Procedure combinations not permitted under National Correct Coding Initiative (NCCI) guidelines
- Diagnosis codes that do not support the billed procedure
- Modifier usage that does not meet CPT or CMS criteria
- Units or frequency billed above allowed thresholds
- Place of service inconsistencies
- Drug dosages billed outside typical dosing recommendations

### Is there a provider portal available for claim review outcomes or appeals?

There is no separate provider-facing portal for accessing claim review results. Zelis edits applied to a claim will reflect as such on the RAS.

Procedure	MOD	EAPG	Service Dates	S/F	Billed	Rejected	Deduct	Copay	Approved	Withheld/Sequest	Refund/Interest	Adj Net Amt
93880				N		6135	0.00	0.00	0.00	0.00	0.00	0.00
<b>Claim Totals</b>							<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Adjusted Claims Totals</b>												<b>0.00</b>

Edit Code: 6135 Claim Line: 1 Edit Description: Zelis Edit Procedure not compatible with diagnosis

When a claim is appealed through Zelis, Zelis will send the appeals determination letter to the provider. Should an appeal be approved through Zelis, you will see the claim reprocessed without Zelis on a future RAS.

### How can providers track or follow up on claim reviews?

- All provider inquiries on Zelis edits should be directed to Zelis by calling 1-866-489-9444.
- Corrected claims are sent to and processed by Fallon Health. Review the RAS for applicable reason codes and rationale.
- Appeals for a Zelis edit should be sent to Zelis. For questions related to a Zelis appeal, including appeals status, you may contact Zelis at 1-866-489-9444.

### Can supporting policies or reference information be shared?

Claim review determinations are based on recognized national authorities, including:

- CMS National Correct Coding Initiative (NCCI)
- CPT/HCPCS coding guidance
- FDA-approved drug labeling
- Other widely accepted clinical and reimbursement references

There is not a single reference document that outlines the possible claim edits.

### What is the expected turnaround time for claim reviews?

Timelines depend on several factors including the type of review (automated editing, itemized bill review, clinical review, DRG/outlier review) and completeness of required documentation.

General expectations include:

- Automated claim editing: Near real-time completion
- Itemized bill review: Dependent on documentation received
- Clinical review: Varies based on case complexity

If there is a specific need for escalating an urgent claim, you can reach out to your Provider Relations Representative. ■

## Claim edit/processing updates

### Effective June 1, 2026 and July 1, 2026

To support accurate claims processing and timely payment, we are implementing several updates to our claims review rules. These changes are designed to align with national coding guidelines and help reduce avoidable denials. Please review the updates below and share this information with your billing staff.

#### Changes: Effective June 1, 2026

- **Add-on codes billed without a base code**  
Claims for add-on services must be submitted with the appropriate primary (base) procedure code.
  - **What's changing:** This review will now include vaccine administration codes. If a vaccine administration code is submitted without the corresponding vaccine product code, the claim line will be denied.
  - **What you can do:** Ensure that vaccine administration codes are billed together with the applicable vaccine code for the same date of service.
- **Professional Component Modifier (-26) Required in Certain Settings**  
Some procedures performed in facility settings require a professional component modifier (-26) to indicate the physician's professional services. This will apply to PC indicators 1 (effective 4/1/26) or 6 (effective 6/1/26).
  - **What's changing:** This review will now also apply to the following places of service: 02, 19, 23, 26, 31, 34, 51, 52, 53, 56, 61, and 66. (*POS 21, 22, 24 were effective 4/1/26*)
  - Claim lines submitted without modifier -26, when required in these settings, may be denied.
  - **What you can do:** Review your coding practices to ensure modifier -26 is appended when billing professional services in applicable facility locations.

#### New claims review rules effective July 1, 2026

- **Ancillary Services Related to Non-Covered Procedures**  
Ancillary services may not be separately payable when they are related to a non-covered service.
  - **How this works:** If a primary procedure is denied as non-covered (for example, experimental or investigational), related ancillary services—such as anesthesia—may also be denied, even if billed by a different provider or on a different date (depending on the procedure).
  - **Example:** A claim for two surgical procedures is denied as experimental. An anesthesia service billed for the same date of service will also be denied because it is related to the non-covered procedures.

- **Therapy Services – Facility Billing**

Audits claim to ensure therapy procedure codes are billed with the appropriate therapy modifier and revenue code, and that untimed therapy procedures are reported correctly for the date of service.

- **What's required:**

- GP – Physical Therapy
    - GO – Occupational Therapy
    - GN – Speech-Language Pathology

Claims submitted without the correct therapy modifier may be denied.

- **What you can do:** Confirm that therapy services include the correct modifier based on the therapy discipline.

- **3-Day Pre-Admission Diagnostic Services Policy**

Certain outpatient services provided shortly before an inpatient admission may be included in the inpatient stay and are not separately reimbursable.

- **How this works:** Diagnostic services, clinical diagnostic laboratory tests, and other related outpatient services billed by the same hospital on the day of admission or within 3 days prior to an inpatient admission may be denied.
  - **What you can do:** Review outpatient claims billed close to an inpatient admission to ensure they meet billing guidelines.

- **Frequency limits across providers and date ranges**

Some services are limited by frequency according to CPT or HCPCS guidelines.

- **What's changing:** Claims will be reviewed across multiple dates of service and across providers. If the total quantity billed exceeds the allowable frequency for a code or group of codes, additional services may be denied.
  - **Examples:**
    - Holter Monitoring (93224): CPT guidelines allow up to 48 hours of continuous monitoring. If the service is billed on consecutive dates without appropriate modifiers (such as modifier 52 for reduced services), the second claim may be denied.
    - Annual Nursing Facility Assessment (99318): This service is payable once annually (with a grace period). A second submission within the same annual timeframe may be denied.
    - Interprofessional Consultations (99446–99447): These services should not be billed more than once within a 7-day period. Multiple contacts related to the same consultation should be reported using a single code. Additional submissions within 7 days may be denied. ■

# Quality focus

## The Medicare CAHPS Survey—what you should know

The Medicare CAHPS Survey is an annual, CMS-sponsored survey sent to a random sample of our Fallon Medicare Plus and NaviCare HMO SNP members. It measures how members feel about their health care and their health plan over the past 6–12 months.

### What the survey measures

Members are asked about their experiences with:

- **Access to care** – How easy it was to get appointments, tests, specialists and other services, and how quickly patients received urgent or routine care.
- **Communication** – How clearly and respectfully their providers communicated.
- **Care coordination** – How well information and services were coordinated. Whether or not doctors had proper medical records, communicated results, and managed ongoing care effectively.
- **Customer service** – These overall summary questions ask members to rate the care they receive from their doctors and services provided by their health plan.
- **Prescription access** – How easy it was to fill needed medications.
- **Preventive care** – Vaccinations such as flu and pneumonia.
- **Overall ratings** – Satisfaction with their health plan, drug plan, and providers.

### Survey timing

Fallon Health is partnering with Press Ganey to send the survey to 4,000 members during the first week of March, and data collection will remain open through May. The survey includes 63 questions, with 9 directly tied to Medicare Star Ratings.

### How providers can help

Even small changes in daily interactions make a big difference in how patients rate their experience.

### Encourage your patients to participate

If patients mention receiving the survey, kindly encourage them to complete it.

If you have any questions, please contact your Fallon Health Provider Relations representative directly, or email [askfchp@fallonhealth.org](mailto:askfchp@fallonhealth.org). ■

# Coding Corner

## Top 5 commonly missed Hierarchical Condition Categories (HCCs)

Capturing chronic conditions every calendar year is essential for accurate risk scores. Yet many diagnoses are still overlooked. Here are 5 HCCs often missed and quick fixes to capture them:

**1. Morbid obesity**

Often noted only as a BMI in the vitals, not as an assessed condition.

Example: *"Morbid obesity—monitoring weight, counseling provided."*

**2. CKD stage 3-5**

Include the stage every year and tie it to the assessment.

Example: *"CKD stage 3b: stable, continue ACE inhibitor."*

**3. Chronic conditions not reassessed**

Use visits to address chronic conditions like COPD, CHF, or diabetes, even if stable.

Example: *"COPD: no recent exacerbations, continue inhaler regimen."*

**4. Diabetes with complications**

Document connection between the condition and its complication.

Example: *"Type 2 diabetes with peripheral neuropathy (E11.42)."*

**5. Major depression**

Use a quick stability note to briefly follow-up on chronic condition.

Example: *"Major depression: stable, continue sertraline." ■*

## Change of coverage for code E0468

For all lines of business except for MassHealth per CMS Transmittal R13611CP: This transmittal states E0468 needs to be covered effective June 9, 2025, for Medicare. PACE, NaviCare, and Community Care will also follow suit. This will stay *deny vendor liable* for MassHealth ACO.

## Coding updates

**Effective July 1, 2026**, the following codes will be removed from the Fallon Health Auxiliary Fee Schedules:

Code	Description
96110	Developmental Screen
96110-U1	Developmental Screen
96110-U2	Developmental Screen
96110-U3	Developmental Screen
96110-U4	Developmental Screen

96110-U5	Developmental Screen
96110-U6	Developmental Screen
96110-U7	Developmental Screen
96110-U8	Developmental Screen
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed

**Effective June 1, 2026**, the following code is *not covered* for Fallon Medicare Plus and Community Care:

Code	Description
A7523	Tracheostomy shower protector each

**Effective June 1, 2026**, the following codes will be *payable with prior authorization* for MassHealth ACO and NaviCare:

Code	Description
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	TRML DSTRJ IOS BVN EA ADDL

**Effective June 1, 2026**, the following code will *deny vendor liable* for Fallon Medicare Plus, NaviCare, Summit ElderCare PACE, and Community Care (passthrough status expired):

Code	Description
C2596	Probe, image-guided, robotic, waterjet ablation

**Effective June 1, 2026**, the following code will *vendor liable* for Community Care:

Code	Description
0537U	Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative

**Effective June 1, 2026**, the following codes will *deny vendor liable* for Medicare Advantage with CMS indicator "I":

Code	Description
83992	ASSAY FOR PHENCYCLIDINE

99501	HOME VISIT, POSTNATAL
S0190	MIFEPRISTONE ORAL 200 MG
S0191	MISOPROSTOL ORAL 200 MCG
S0199	MED INDUCED AB ORAL INGEST MED
S0302	CMPL EARLY PRD SCREEN DX&TX SRVC
S1040	CRANIAL REMOLD ORTHOS PED CUST FAB
S2260	INDUCD AB 17-24 WEEKS ANY SURG METH
S8424	GRADENT PRESS AID SLEEVE READY MADE

**Effective June 1, 2026**, the following codes will *require prior authorization* for Fallon Medicare Plus, NaviCare, and Community Care:

Code	Description
A4295	Intermittent urinary catheter; straight tip, hydrophilic coating, each
A4296	Intermittent urinary catheter; coude (curved) tip, hydrophilic coating, each
A4297	Intermittent urinary catheter; hydrophilic coating, with insertion supplies

**Effective June 1, 2026**, the following code will *deny vendor liable* for Fallon Medicare Advantage and NaviCare with CMS indicator "1":

Code	Description
A4590	SPECIAL CASTING MATERIAL

**Effective June 1, 2026**, the following code will *require prior authorization* for Fallon Medicare Plus, NaviCare, and Community Care:

Code	Description
L8513	Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each

**Effective June 1, 2026**, the following codes will *require prior authorization* for NaviCare, MassHealth ACO, and Community Care:

Code	Description
A6535	Gradient compression stocking, thigh length, 40 mmhg or greater, each
E0618	Apnea monitor, without recording feature

Effective June 1, 2026, the following codes will *require prior authorization* for NaviCare and MassHealth ACO:

Code	Description
A6536	Gradient compression stocking, full length/chap style, 18-30 mmhg, each
A6537	Gradient compression stocking, full length/chap style, 30-40 mmhg, each
A6538	Gradient compression stocking, full length/chap style, 40 mmhg or greater, each
A6540	Gradient compression stocking, waist length, 30-40 mmhg, each
A6541	Gradient compression stocking, waist length, 40 mmhg or greater, each
A7523	Tracheostomy shower protector, each

Effective June 1, 2026, the following codes will *require prior authorization* for Fallon Medicare Plus, NaviCare, MassHealth ACO, and Community Care:

Code	Description
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4320	Irrigation tray with bulb or piston syringe, any purpose
A6532	Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each
A4395	Ostomy deodorant use ostomy pouch solid per tab
A4408	Ostomy skin barrier, with flange (solid, flexible or accordian), extended wear, with built-in convexity, larger than 4 x 4 in, each
A6204	Composite dressing, sterile, pad size more than 16 sq in, but less than or equal to 48 sq in, with any size adhesive border, each dressing
A6254	Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq in, with any size adhesive border, each dressing
E0148	Walker, heavy-duty, without wheels, rigid or folding, any type, each
E2212	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each
K0042	Standard size footplate replacement only, each
E0635	Patient lift, electric, with seat or sling
A4328	Female external urinary collection device; meatal cup, each
E0940	Trapeze bar, freestanding, complete with grab bar
E0912	Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, freestanding, complete with grab bar
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control

**Effective April 1, 2026**, the following codes will be configured as *covered with prior authorization* for all lines of business, except MassHealth ACO, which is *deny vendor liable*:

Code	Description
A4318	Female external urinary collection cup, with or without ring attachment, per day
A6548	Accessory to custom gradient compression garment, silicone band, any size
C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array
C8008	Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator
C8009	Removal of hypoglossal nerve neurostimulator array and pulse generator
C8010	Percutaneous placement of permanent common carotid embolic protection device, including all system components and imaging guidance; bilateral
C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components
C8012	Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
C8013	Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver
G0681	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; first 25 sq cm or less of wound surface area
G0682	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute for a wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
G0683	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
G0684	Application of a premarket approval (pma), 510(k), 361 human cells, tissues or cellular and tissue-based products (hct/p) non-sheet form skin substitute graft for a wound surface greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
L2221	Addition to lower extremity orthosis, ankle system, microprocessor-controlled feature plantarflexion and/or dorsiflexion, includes power source
L5992	All lower extremity prosthesis, foot shell for modular foot/non-solid ankle cushion heel (sach) replacement only

**Effective April 1, 2026**, the following code will be configured as *covered without prior authorization* for all lines of business, except MassHealth ACO, which is *deny vendor liable*:

Code	Description
C1743	Scaffold, endovascular non-coronary, resorbable drug eluting, with delivery system (implantable)

**Effective April 1, 2026**, the following codes will be configured as *NOT covered* for all lines of business, except MassHealth ACO, which is *deny vendor liable*:

Code	Description
A8005	Powered, cable driven grip assist glove, hand, finger, includes microprocessor, pressure sensors, all components and accessories, custom fitted
A8006	Powered, cable driven grip assist glove, hand, finger, includes pressure sensors, glove replacement only

**Effective April 1, 2026**, the following codes will be configured as *deny vendor liable* for all lines of business:

Code	Description
0614U	Inborn error of metabolism (primary mitochondrial disease), mitochondrial analysis of 4 enzyme complexes by stained blue native polyacrylamide gel electrophoresis (PAGE), frozen tissue (muscle, liver, heart, cultured skin fibroblasts), diagnostic qualitative result
0615U	Borrelia burgdorferi (Lyme disease), antibody detection of 26 recombinant protein groups, by immunoassay, IgM
0616U	Neurology (dementia), DNA methylation analysis of more than 30,000 sites, whole blood, algorithm reported as positive or negative risk
0617U	Cardiovascular (atherosclerotic cardiovascular disease [ASCVD]), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk
0618U	Psychiatry (bipolar disorder), DNA methylation analysis of more than 10,000 sites, whole blood, algorithm reported as positive or negative risk
0619U	Pulmonary (chronic obstructive pulmonary disease [COPD]), DNA methylation analysis of more than 18,000 sites, whole blood, algorithm reported as positive or negative risk
0620U	Oncology (hepatocellular carcinoma), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk
0621U	Infectious disease (Lyme borreliosis), DNA methylation analysis of more than 10,000 sites, whole blood, algorithm reported as positive or negative risk
0622U	Psychiatry (major depressive disorder), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk
0623U	Autoimmune (multiple sclerosis), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk

<b>0624U</b>	Hepatology (nonalcoholic steatohepatitis [NASH]), DNA methylation analysis of 5,000 sites, whole blood, algorithm reported as positive or negative risk
<b>0625U</b>	Endocrinology (osteoporosis), DNA methylation analysis of more than 5,000 sites, whole blood, algorithm reported as positive or negative risk
<b>0626U</b>	Neurology (Parkinson disease), DNA methylation analysis of more than 20,000 sites, whole blood, algorithm reported as positive or negative risk
<b>0627U</b>	Psychiatry (schizophrenia), DNA methylation analysis of more than 15,000 sites, whole blood, algorithm reported as positive or negative risk
<b>0628U</b>	Nephrology (kidney disease-related genetic conditions), genomic analysis, renal disease panel, saliva, DNA, next-generation sequencing of 449 genes, reported as pathogenic or likely pathogenic variants of uncertain significance or risk alleles
<b>0629U</b>	Infectious disease (tuberculosis), DNA, analysis of 1 target by PCR with clustered regularly interspaced short palindromic repeat (CRISPR)-based probe detection, plasma or serum, qualitative report as detected or not detected
<b>0630U</b>	Oncology (breast), mRNA, gene expression profiling by microarray of 80 genes (80 content and 465 housekeeping), utilizing formalin-fixed paraffin-embedded tissue (FFPE), algorithm reported as an index that is diagnostic of a molecular subtype (luminal, basal, Her2)
<b>A2040</b>	Microlyte painguard, per square centimeter
<b>A2041</b>	Foundation drs+ duo, per square centimeter
<b>A2042</b>	Foundation drs+ solo, per square centimeter
<b>A2043</b>	Biobrane, per square centimeter
<b>A2044</b>	Biobrane glove, each
<b>A2045</b>	Novashield or novogen wound matrix, per square centimeter
<b>A4479</b>	Electronic transanal irrigation system, includes electronic pump, water reservoir, tubing, and accessories, without catheter, any type
<b>A9294</b>	Prescription digital cognitive and/or behavioral therapy, biofeedback, fda cleared, per course of treatment
<b>G0680</b>	Detection and quantification of coronary artery calcium and/or aortic valve calcification from algorithmic analysis of computed tomography of the chest with report
<b>M0233</b>	Intravenous infusion, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, includes infusion and post administration monitoring, first dose
<b>M0234</b>	Intravenous infusion, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, includes infusion and post administration monitoring, second dose
<b>Q0238</b>	Injection, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-

	invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, 1 mg
Q4418	Biolab membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4419	Biolab membrane wrap lite flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4421	Biolab membrane wrap solo, per square centimeter (add-on, list separately in addition to primary procedure)
Q4422	A/c wrap, per square centimeter (add-on, list separately in addition to primary procedure)
Q4423	Biolab tri-membrane wrap flow, per square centimeter (add-on, list separately in addition to primary procedure)
Q4424	Revive ft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4425	Revive tl, per square centimeter (add-on, list separately in addition to primary procedure)
Q4426	Dermabind tl + or dermabind tl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4427	Dermabind dl n or dermabind dl + or dermabind dl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4428	Dermabind sl n or dermabind sl + or dermabind sl x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4429	Dermabind ch n or dermabind ch x, per square centimeter (add-on, list separately in addition to primary procedure)
Q4435	Renati membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4436	Renati ac membrane, per square centimeter (add-on, list separately in addition to primary procedure)
Q4437	Revival ac, per square centimeter (add-on, list separately in addition to primary procedure)
Q4438	Prelect, per square centimeter (add-on, list separately in addition to primary procedure)
Q4439	Instagraft, per square centimeter (add-on, list separately in addition to primary procedure)
Q4440	Curamatrix, per square centimeter (add-on, list separately in addition to primary procedure)

Effective March 15, 2026, the following code is covered with a post service claim edit for all lines of business:

Code	Description
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg

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

Code	Description
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); bilateral
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

**Effective July 1, 2025**, the following code is *payable with prior authorization* for all lines of business:

Code	Description
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)

**Effective July 1, 2025**, the following codes are *deny vendor liable* for all lines of business with EI status, except MassHealth ACO and NaviCare:

Code	Description
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	TRML DSTRJ IOS BVN EA ADDL

**Effective April 1, 2025**, the following codes are *payable with prior authorization* for MassHealth AC, Summit ElderCare PACE, and NaviCare:

Code	Description
E1022	Wheelchair transportation securement system, any type, includes all components and accessories
E1023	Wheelchair transit securement system, includes all components and accessories

Effective April 1, 2025, the following codes are *payable with prior authorization* for MassHealth ACO:

Code	Description
A4453	Rectal catheter with or without balloon, for use with any type transanal irrigation system, each
E1032	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface
E1033	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type
E1034	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type
A6515	Gradient compression wrap with adjustable straps, full leg, each, custom
A6516	Gradient compression wrap with adjustable straps, foot, each, custom
A6517	Gradient compression wrap with adjustable straps, below knee, each, custom
A6518	Gradient compression wrap with adjustable straps, arm, each, custom
A6519	Gradient compression garment, not otherwise specified, for nighttime use, each
A6611	Gradient compression wrap with adjustable straps, above knee, each, custom
L0720	Cervical-thoracic-lumbar-sacral-orthoses (CTLSSO), anterior-posterior-lateral control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1933	Ankle foot orthosis (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, off-the-shelf
L1952	Ankle foot orthosis (AFO), spiral, (Institute of Rehabilitative Medicine-type), plastic or other material, prefabricated, off-the-shelf
L5827	Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping



# Payment policies

## Revised policies – Effective June 1, 2026

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

- **Non-Covered Services** – Updated code report (generated 04/02/2026).
- **Claims Processing Software** – Under Reimbursement, added new sections for the following edits: Frequency across provider and datespan, Ancillary procedures and Lifetime event; removed Missing modifier 26 which is not being activated at this time.
- **Radiology/Diagnostic Imaging** – Under Reimbursement, updated Prior authorization requirements for outpatient high-tech imaging effective June 1, 2026; under Billing/coding guidelines, Mammography services, added ICD-10-CM diagnosis code requirements for screening mammography; under Billing/coding guidelines, added new section for Screening breast MRI and screening breast ultrasound for Community Care and MassHealth ACO members.
- **Dental Services** – Fallon Medicare Plus and NaviCare – Under Policy, Supplemental dental benefits, updated paragraph describing dental services for NaviCare, effective January 1, 2026, dental services are covered under Medicare supplemental benefits effective January 1, 2026.
- **Inpatient Medical Review and Payment Policy** – Under Reimbursement, all-inclusive payment rate, added, effective July 1, 2026, outpatient diagnostic services provided within three days before an acute inpatient hospital admission will be denied and not separately reimbursed.
- **Vaccines** – Updated Policy section to indicate that effective September 3, 2025, the Plan covers childhood and adult vaccines in accordance with Massachusetts Department of Public Health (DPH) guidance for Community Care and MassHealth ACO members. ■

# Medical policies

## Revised policies – Effective March 1, 2026

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

- **Bariatric Surgery**
- **Medical Technology Assessment**
- **Prenatal Screening**
- **Skysona (elivaldogene autotemcel)**
- **Transplants, Solid Organ**
- **Prostatic Urethral Lift**
- **Skin Substitutes**

### Revised policies – Effective April 1, 2026

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

- **Prenatal Screening**
- **Gender Affirming Surgery**
- **Genetic Testing**

### Retired policies – Effective April 1, 2026

The following policy has been retired; details about the changes are indicated on the policy.

- **Bronchial Thermoplasty**

# Our products\*

## Medicare Advantage

**Fallon Medicare Plus HMO** – for Medicare beneficiaries across the state—from Boston to the Berkshires\*\*.

4 plans to choose from:

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

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

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

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

## Medicare Supplement

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

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

## Individual and small group

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

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

## MassHealth ACO

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

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

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

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

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

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

# Our products\* *(continued)*

## PACE program

**Summit ElderCare** – Fallon Health’s PACE (Program of All-Inclusive Care for the Elderly) provides medical care, social supports, adult day health, in-home services, transportation, and health insurance in 1 program—for people age 55 and older, who qualify for a nursing home level of care.

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

## Special Needs Plan

**NaviCare HMO SNP** – Fallon Health’s Medicare Advantage Special Needs Plan (SNP) for people who have MassHealth Standard and Medicare Parts A and B.

Combines MassHealth (Medicaid) and Medicare benefits, including Medicare Part D prescription drug coverage. NaviCare members can’t be enrolled in another health insurance plan, except Medicare and MassHealth. ■

*\*These are the products Fallon Health currently offers and they are not necessarily indicative of what you are contracted for with Fallon Health. Products may change for 2026. If you have questions regarding products you are contracted for, please contact your Provider Relations Representative.*

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

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### Questions?

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