Connection

Important information for Fallon Health physicians and providers

October 2021

In the October 2021 issue:

Important updates

We want to hear from you

Fallon Health has partnered with The Center for the Study of Services (CSS), a Washington, DC-based independent survey research organization to conduct our 2021 Provider Satisfaction Survey. If you receive a fax or email inquiry over the next couple of weeks, we would appreciate you taking a few minutes to tell us how we are doing. Offices with multiple providers may receive more than one copy of the survey with the hope that we will receive several responses. ■

OptumRx is our new Pharmacy Benefits Manager (PBM)

Fallon Health will be changing our pharmacy benefits manager from CVS Caremark to OptumRx, effective January 1, 2022.

Prior authorizations

If you are requesting a prior authorization before January 1, 2022, you should submit the request to CVS Caremark. Any request on or after 1/1/2022 should be submitted to OptumRx. Active prior authorizations will be transferred from CVS Caremark to OptumRx automatically. For more information about OptumRx prior authorizations:

- Submitting a PA request
- PA guidelines and procedures
- PA forms

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Prescribing for mail order pharmacy

You have three options for prescribing with OptumRx Home Delivery starting January 1, 2022:

1. ePrescribe – Simply add the OptumRx profile in your electronic medical record (EMR) system using the following information: OptumRx Mail Service, 2858 Loker Ave East, Suite 100, Carlsbad, CA 92010NC PDP ID = 0556540; PID = P00000000020173.
2. Call an OptumRx pharmacist at 1-800-791-7658
3. Fax a completed form to OptumRx at 1-800-491-7997

Prescribing for specialty medications

1. Phone: 1-855-427-4682.
2. Address: P.O. Box 2975, Mission, KS 66201
3. Fax (for prescription submissions only – no PAs): 1-877-342-4596

For more details about submitting prescriptions to OptumRx, check out this *guide*.

Important information for your patients

- All Fallon members will receive new ID cards with the updated PBM information by the end of December.
- Fallon 365 Care, Wellforce Care Plan, Berkshire Fallon Health Collaborative, Commercial and MA Health Connector members with CVS Caremark specialty pharmacy will need to switch to OptumRx Specialty. Prescriptions with available refills will transition to OptumRx automatically, with the exception of controlled substances.
- Fallon Medicare Plus, Fallon Medicare Plus Central, Commercial and MA Health Connector members using CVS Caremark for mail order prescriptions will need to switch to OptumRx Home Delivery. Prescriptions with available refills will transition to OptumRx automatically, with the exception of controlled substances.
- All members with specialty and mail order medications transitioning to OptumRx will need to contact OptumRx after January 1 to set up their accounts and provide payment information.

For full contact information regarding prior authorizations, specialty pharmacy and mail order, please see the *end of this newsletter*.

We will share additional important information in the coming months and encourage you to visit our *website* for updates. ■

COVID-19 updates

Additional vaccine doses and boosters

As the Federal Drug Administration approves new vaccine doses and boosters, Fallon will update our system configuration and COVID-19 Frequently Asked Questions accordingly.

As a reminder when billing vaccines:

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

- Providers should bill the appropriate CMS Medicare Administrative Contractor directly for the administration of the vaccine

In 2022, all vaccine administration and monoclonal antibody administration billing for these products will be submitted to Fallon Health directly.

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

- Providers should 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

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

Preparing to resume submitting a PCP referral in ProAuth

When the federal public health emergency comes to an end, we will resume the need for a PCP referral submission into ProAuth for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, Fallon 365 Care and Berkshire Fallon Health Collaborative. In preparation, please ensure your ProAuth log-in is still active and you are familiar with the process. Please see our ProAuth FAQ for guidance.

We are here to support you as you care for your patients—our members. We will continue to monitor and assess potential impacts to our business and our provider partners as the state and federal government considers any further actions on measures established during the state of emergency and federal public health emergency. ■

MassHealth Provider Enrollment

Federal regulations set forth at 42 CFR § 438.602 require that all Managed Care Entity (MCE) network providers enter into a MassHealth provider contract. MassHealth has developed a specific provider contract for this purpose, called the MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract. This specific provider contract does not require Fallon Health network provider to render services to MassHealth fee-for-service members.

If you have heard from us recently asking that you complete this process, please go to mass.gov/forms/mce-nonbilling-network-only-contract within 30 days of receiving the notice. If you do not enter into a MassHealth provider contract, Fallon Health may be required to terminate our network provider contract with you. If you have questions, please email askfchp@fallonhealth.org. ■

What's new

Medicaid ACO Individual Consideration Codes

Effective December 1, 2021, pursuant to the Medicaid Regulation 101 CMR 317.00: Rate for Medicine Services:

317.04: Maximum Allowable Fees – Medical Services (1) Drugs, Medications, Supplies, and Laboratory Specimen Collections. (a) Payment rates for drugs, vaccines, and immune globulins administered in a physician's office are equal to the fee listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File. For drugs, vaccines, and immune globulins administered in a physician's office that are not listed in the Quarterly ASP Medicare Part B Drug Pricing File, codes are listed in 101 CMR 317.04(4) with payment set by I.C., which shall apply until such time as the code is listed in the Quarterly ASP Medicare Part B Drug Pricing File.

Until rates are established by Medicare, all codes considered Individual Consideration (IC) will pay the default rate according to the provider's contract with the Plan. In the event that the provider contract does not have a default rate noted, payment will be 40% of charges. ■

Massachusetts DOI Bulletin 2021-06: Coverage for PANDAS and PANS

Per state mandate (Chapter 260, Acts of 2020), and effective for commercial plans issued or renewed on or after January 1, 2022, Massachusetts insurers are required to provide coverage for the treatment and diagnosis of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS). This includes treatment with intravenous immunoglobulin (IVIg) therapy for insured health plan members. This state mandate applies to Fallon's Community Care product only. ■

Summit ElderCare Patient Paid Amount (PPA) Change

Effective December 1, 2021, nursing facilities should be prepared to obtain the PPA for Summit ElderCare members from MassHealth via the Medicaid Management Information System (MMIS) or via direct correspondence from MassHealth. ■

NaviCare benefit changes for 2022

Please see below for upcoming benefit changes for NaviCare benefits, effective January 2022.

- Acupuncture for Chronic Low Back Pain no longer requires authorization up to the 20th visit
- Expanded emergent and urgent coverage to worldwide to mirror Fallon Medicare Plus, including emergent transportation
- Fitness reimbursement has been expanded to cover new cardiovascular fitness equipment
- Coverage and home delivery of annual Health and Wellness kits for all members has been added
- OTC Save Now Card benefit has been increased from $120 per quarter to $150 per quarter

- Part D medications now have a 100-day supply instead of a 90-day supply.
  - 90 days still applies to Part B and some drugs have up to a 30-day limited supply as noted in the formulary
- Remote Access Technology Services have been expanded to include: Telephone evaluation and management services provided by physicians, including primary and specialty care physicians, and other qualified health care professionals, including physician assistants, nurse practitioners, clinical nurse specialists and nurse midwives
- Healthy Food Reward and Incentive program now includes the COVID-19 vaccine among the list of eligible preventive vaccines
- Vision benefit limit has been increased from $240 to $570 for supplemental eyewear, including up to two pairs of eyeglasses annually ■

CareConnect – nurse triage enhancements to help members get connected to their PCP

Fallon Health is focused on connecting members with their PCPs for both in-person and virtual visits when members might otherwise seek care in the Emergency Room (ER) or Urgent Care for ambulatory sensitive conditions. Member ID cards will be updated with the Care Connect Nurse Triage phone number for 2022. Our 24-hour Nurse Call Line is available to our members seven days a week, 365 days a year and is now conducting warm transfers to PCP offices for members who might benefit from consultation or a visit with their PCP in 72 hours or less.

The Nurse Call Line triages members along a hierarchy of interventions, including, but not limited to, the following:

- Patient education for healthy decisions and/or self-management
- Referral to PCP or other treating clinician's office for non-urgent care
- Assistance with PCP office visit and virtual visit scheduling
- After hours paging of member's PCP for urgent needs
- Assistance with Urgent Care appointments
- Referral to the ER for emergent conditions

Members can call the Nurse Triage Line any time. Industry-standard guidelines are used by the nurse to assess the member's condition and to determine and facilitate the best care solutions. ■

Product spotlight

NaviCare® – Model of Care training

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

Every NaviCare member has a customized 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 are available to all members include:

- Unlimited transportation to medical appointments
- 140 one-way trips per calendar year to places like the grocery store, gym, and to attend religious services within a 30-mile radius of the member's home. Transportation may be arranged at least two business days in advance by calling our Transportation Vendor CTS at 1-833-824-9440. The member/caregiver can arrange transportation and Fallon's Navigators are also available to assist. Members' caregivers can qualify for mileage reimbursement for covered trips.
- Up to $400 per year in fitness reimbursements to a qualified fitness facility and/or health tracker and a free SilverSneakers™ gym membership. New in 2022: Fitness reimbursement has been expanded to cover new cardiovascular fitness equipment.
- ***New in 2022:*** $600 per year 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 ability to earn up to $100 annually with the Fallon Healthy Food program for completing healthy activities such as:
    - Welcome to Medicare/Annual physical or qualified wellness visits
    - Preventive vaccines such as annual flu vaccine, Tdap, pneumococcal vaccine and the Shingles vaccine
- The Healthy Food Card can be used by members to purchase healthy food items at participating retailers, including: canned vegetables, beans, rice and pastas, fresh vegetables and fruits, frozen and fresh meat, fish and poultry.

NaviCare members have their own 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 patients 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 your 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. ■

Important reminders

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 between April and June to participants and enrollees in both Fallon Health NaviCare HMO SNP and Summit ElderCare subject to the limitations below:

- NaviCare HMO SNP
  - 1200 randomly selected enrollees enrolled at the time of the survey
  - Excludes enrollees who reside in nursing homes
  - Excludes enrollees with end-stage renal disease
  - Excludes enrollees who only have Medicaid
- Summit ElderCare
  - All participants 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 both Medicare Advantage D-SNP plans and 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 or Summit ElderCare care teams for assistance in completing the survey.

For more information regarding the HOS-M or the administration of the survey to members and participants, please visit the official Health Outcome Survey website at HOSOnline.org/en/hos-modified-overview. ■

Medicare guidelines for non-emergency medical transportation

As a reminder, Fallon follows Medicare guidelines for determining coverage of non-emergency medical transportation, at a minimum. The below is adapted from the coverage summary provided by our MAC. You may review additional information on their website at ngsmedicare.com.

Non-Emergency Medical Transportation Requirements:

- The transport must be to receive a medically necessary covered service or to return from such a service.
- The vehicle used must be a covered vehicle.
- Ambulance services are not covered if the member could be safely transported by other means such as a private vehicle or wheelchair van. Coverage for wheelchair van transportation is limited to plans with a wheelchair van transportation benefit.
- The destination must be a covered destination.

- Documentation should also include a description of the member's condition and functional status or physical assessment at time of transport and why other methods of transportation are contraindicated. Please ensure all documentation to support medical necessity of the billed service is submitted for review.
- A run sheet (trip sheet) which clearly documents the member's name and date of service, name and credentials of crew members, monitoring required during transport, and mileage associated with transport which includes the point of pick up and destination (place and address) is required for review. ■

Revised discharge planning requirements for MassHealth ACO, NaviCare and Summit ElderCare members

Effective September 1, 2021, Pursuant to MassHealth Acute Inpatient Hospital Bulletin 186 and Managed Care Entity Bulletin 64, there are revised discharge planning requirements and related reporting requirements for members experiencing, or who are at risk of, homelessness.

These procedures are designed to enable hospitals to identify this vulnerable population in a timely fashion after admission and ensure that these members have access to the post-hospital care (including an appropriate place to live) or services that they need. The Executive Office of Health and Human Services created a helpful tool kit for the hospital discharge planning staff. ■

Corrected claims billing reminder

We know correcting claims is sometimes unavoidable. Below are some helpful hints on how to ensure your corrections are processed as expeditiously as possible:

- All corrections need to be submitted within 120 days of the Remittance Advise Summary (RAS) date.
- When sending in paper corrections, please make sure you fill out a *request for claim review form* with all required fields completed.
- When submitting electronic corrections it is of the utmost importance to match certain data points from the original claim, including:
  - Accurately referencing the original **Claim Number**
  - Retaining the same **Billing Provider** information
  - Retaining the same **Patient Control Number/Medical Record Number** from the original claim
  - Retaining the same **Claim Start Date** (Date of Service)
- Correcting claims using the required matching criteria noted above decreases processing time.
- Electronic corrections should be submitted with a correct bill type or frequency code 7 accordingly.

Should you need further information or have questions, please contact your Provider Relations Representative. ■

Doing business with us

Prior authorization process enhancement (ProAuth tool)

Effective September 1, 2021, Fallon implemented a wide-scale use of the ProAuth tool for submission of authorization requests and submission of relevant clinical information. Providers should use ProAuth for submission of any service that requires prior authorization. ProAuth can be used for both standard and expedited requests.

ProAuth is an effective and efficient tool for submitting authorization requests. Some of the benefits are:

- Review turnaround time is faster than faxed requests
- Statuses are updated in real time – as soon as a decision is made
- Providers have 24/7 access

If you are not currently set up with ProAuth, it is important you do so by either:

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

Fallon Health is providing education and training via online webinars. Please see our website for available dates and times.

- ProAuth should not to be used for post-acute requests, such as Skilled Nursing Facility, Acute Rehabilitation Hospital and Long Term Acute Care Hospital requests. Those requests need to be submitted by using the Skilled Nursing Facility Admission Review Request form and faxing supporting clinical documentation to the Utilization Management department at 1-508-368-9014.

If you have any issues or concerns, please contact your Provider Relations Representative directly for assistance.

Need help? See our ProAuth FAQs webpage for answers to common questions. ■

Provider Directory

The most up to date provider directory information can be found on our *website*. If you would like to request a copy of a printed directory, please submit a Materials Request Form indicating which directory you need. ■

Update on our commercial plan changes for 2022

- Beginning January 1, 2022, Fallon will only offer plans on our Community Care network through the Massachusetts Health Connector. Our Direct Care, Select Care, Steward Community Care and Preferred Care plans are being discontinued.
- Fallon will continue to offer standard Health Connector plans in all four metallic tiers (Platinum, Gold, Silver and Bronze) to individuals/families and small businesses on the Community Care network.

- We anticipate that the majority of our Connector membership will be enrolled in subsidized ConnectorCare plans already being offered on Fallon's Community Care network.
- The Community Care network is smaller than the Direct Care and Select Care networks so it is very important that your Fallon Health patients confirm that their providers are available in this network. To do so, members can visit *fallonhealth.org/findphysician/* or they can use the Massachusetts Health Connector's provider search tool and find out which of the various plans offered on the Connector include their providers.
- Fallon Health's Community Care network is available in parts of Middlesex, Norfolk and Worcester counties, and in one town in Bristol County (Mansfield). The Community Care network includes Reliant Medical Group, Harrington Healthcare, Lowell General PHO, select PCPs and specialists affiliated with MetroWest HealthCare Alliance and other local providers. ■

Preventive behavioral health services for members younger than 21

On September 1, 2021, Fallon began covering short-term preventive behavioral health services for children and youth who have behavioral health symptoms, as evidenced by a positive behavioral health screening, even if they do not meet criteria for a behavioral health diagnosis. Preventive behavioral health services must be recommended by a physician or other licensed practitioner practicing within their scope of licensure to recommend such services.

Fallon will cover up to six sessions of preventive behavioral health services per member without prior authorization. After the first six sessions, Fallon may require the provider to submit documentation to support the clinical appropriateness of ongoing preventive services.

Fallon will cover preventive behavioral health services, using the following billing codes:

Community- or school-based outpatient providers:

- 90853 Group psychotherapy (other than multiple-family group).

Primary care providers with embedded behavioral health clinician:

- 90832 Psychotherapy with patient and/or family member
- 90834 Psychotherapy with patient and/or family member
- 90846 Family psychotherapy (conjoint psychotherapy) (without patient present)
- 90847 Family psychotherapy (conjoint psychotherapy) (with patient present)
- 90849 Multiple-family group psychotherapy
- 90853 Group psychotherapy (other than multiple-family group)

All claims for preventive behavioral health services, regardless of provider type, must be submitted with modifier EP on the claim. All claims must include the most clinically appropriate ICD diagnosis code, including, as appropriate, Z codes which may be used as the primary diagnosis, when clinically appropriate. Preventive behavioral health services provided to the caregiver-child dyad should be billed under the child's MassHealth ID when such services are directly related to the needs of the child and such services are delivered to the infant and caregiver together.

MassHealth anticipates that allowing providers in community-based settings, primary care, and schools to provide preventive services is an opportunity to address and mitigate negative impacts of the pandemic, and to further healthy developmental outcomes for MassHealth-enrolled youth. Further guidance on the implementation of these services within the School-Based Medicaid Program will be issued later this month. ■

Quality focus

Disease Management Program empowers your patients

The Fallon Health Disease Management Program is a proactive, patient-centered program for individuals diagnosed with chronic diseases—including asthma, diabetes, chronic obstructive pulmonary disease (COPD), cardiac disease and heart failure. It reinforces standards of care by providing health education, health coaching and self-management skills. We work toward empowering your patients to take a more active role in improving and maintaining their health.

We welcome referrals for your patients, our Fallon members, to our Disease Management Program and look forward to working with you. For more information or to make a referral, please call our team at 1-800-333-2535, ext. 69898, Monday through Friday from 8:30 a.m. to 5:00 p.m. You also may use our online Disease Management/Health Promotions Referral Form.■

Access to complex case management

Another program we offer to your patients who need a lot of care and resources is the Complex Case Management Program. You may refer a patient to this program if he/she has a "critical event or diagnosis"—for example, a car accident, a fall that results in serious injury, cancer or serious health decline. We'll do a brief assessment to confirm eligibility.

Our nurse case managers and social workers coordinate their care in collaboration with caregivers and you. We want to help ensure that your patients receive all the appropriate services and have access to all the resources needed to resolve their health issues in the best way possible.

For more information, or to ask about enrolling in the program, you may call us at 1-800-333-2535, ext. 78002 (TRS 711), Monday-Friday, 8:30 a.m.-5:00 p.m. Or you may use our online Case Management Referral Form.

Thank you for your referrals. ■

Important links to information about care

Our Clinical Practice Guidelines are available here.

We hope you'll take this time to explore fallonhealth.org to learn how we work with you and your patients to ensure the quality and safety of clinical care. If you'd like to receive a copy of this information, please call Provider Relations at 1-866-275-3247, option 4.

- Clinical criteria for utilization care services. Fallon uses national, evidence-based criteria reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by physicians. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care. Criteria are available here or as a paper copy upon request.
- Learn more about our quality programs. Fallon is proud of its long history of quality accomplishments, including our accreditation from the National Committee for Quality Assurance. A detailed description of our quality programs, goals and outcomes is available *here*. We also welcome suggestions from our physicians about specific goals or projects that may further improve the quality of our care and services.
- Know our members' rights. Fallon members have the right to receive information about an illness, the course of treatment and prospects for recovery in terms that they can understand. They have the right to actively participate in decisions regarding their own health and treatment options, including the right to refuse treatment. View a complete list of Fallon members' rights and responsibilities *here*.

Utilization Management incentives

Fallon Health affirms the following:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage.
- Fallon Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization. ■

Coding corner

Coding updates

Effective June 24, 2021, the following codes were configured as *deny vendor liable excluding Commercial, Medicare, NaviCare and PACE:*

Code	Description
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) 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

Effective July 30, 2021, the following codes were configured as *deny vendor liable excluding Commercial:*

Code	Description
Q0240	Injection, casirivimab and imdevimab, 600 mg
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses

Effective August 12, 2021, the following codes were configured as *deny vendor liable excluding Commercial and Medicaid:*

Code	Description
0003A	Pfizer-Biontech Covid-19 Vaccine Administration – Third Dose
0013A	Moderna Covid-19 Vaccine Administration – Third Dose

Effective October 1, 2021, the following codes *will be covered* and *will require plan prior authorization:*

Code	Description
0255U	Andrology (infertility), sperm-capacitation assessment of ganglioside GM1 distribution patterns, fluorescence microscopy, fresh or frozen specimen, reported as percentage of capacitated sperm and probability of generating a pregnancy score
0256U	Trimethylamine/trimethylamine N-oxide (TMA/TMAO) profile, tandem mass spectrometry (MS/MS), urine, with algorithmic analysis and interpretive report
0257U	Very long chain acyl-coenzyme A (CoA) dehydrogenase (VLCAD), leukocyte enzyme activity, whole blood
0258U	Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of 50-100 genes, skin-surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics
0259U	Nephrology (chronic kidney disease), nuclear magnetic resonance spectroscopy measurement of myo-inositol, valine, and creatinine, algorithmically combined with cystatin C (by immunoassay) and demographic data to determine estimated glomerular filtration rate (GFR), serum, quantitative
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
0261U	Oncology (colorectal cancer), image analysis with artificial intelligence assessment of 4 histologic and immunohistochemical features (CD3 and CD8 within tumor-stroma border and tumor core), tissue, reported as immune response and recurrence-risk score
0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score
0263U	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 16 central carbon metabolites (ie, Î±-ketoglutarate, alanine, lactate, phenylalanine, pyruvate, succinate, carnitine, citrate, fumarate, hypoxanthine, inosine, malate, S-sulfocysteine, taurine, urate, and xanthine), liquid chromatography tandem mass spectrometry (LC-MS/MS), plasma, algorithmic analysis with result reported as negative or positive (with metabolic subtypes of ASD)
0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes
0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping and whole genome sequencing
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid

Code	Description
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid
0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), blood, buccal swab, or amniotic fluid
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid
0275U	Hematology (heparin-induced thrombocytopenia), platelet antibody reactivity by flow cytometry, serum
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid
0279U	Hematology (von Willebrand disease [VWD]), von Willebrand factor (VWF) and collagen III binding by enzyme-linked immunosorbent assays (ELISA), plasma, report of collagen III binding
0280U	Hematology (von Willebrand disease [VWD]), von Willebrand factor (VWF) and collagen IV binding by enzyme-linked immunosorbent assays (ELISA), plasma, report of collagen IV binding
0281U	Hematology (von Willebrand disease [VWD]), von Willebrand propeptide, enzyme-linked immunosorbent assays (ELISA), plasma, diagnostic report of von Willebrand factor (VWF) propeptide antigen level
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes
0283U	von Willebrand factor (VWF), type 2B, platelet-binding evaluation, radioimmunoassay, plasma
0284U	von Willebrand factor (VWF), type 2N, factor VIII and VWF binding evaluation, enzyme-linked immunosorbent assays (ELISA), plasma

Effective October 1, 2021, the following codes will *require plan prior authorization:*

Code	Description
J1305	Injection, evinacumab-dgnb, 5mg
J1426	Injection, casimersen, 10 mg
J1448	Injection, trilaciclib, 1mg
J9247	Injection, melphalan flufenamide, 1mg

Effective October 1, 2021, the following codes *will require plan prior authorization:*

Code	Description
A4453	Rectal catheter for use with the manual pump-operated enema system, replacement only
C1831	Personalized, anterior and lateral interbody cage (implantable)
C9081	Idecabtagene vicleucel, up to 460 million autologous anti-bcma car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
C9779	Endoscopic submucosal dissection (esd), including endoscopy or colonoscopy, mucosal closure, when performed
C9780	Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance
K1022	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm
K1024	Non-pneumatic compression controller with sequential calibrated gradient pressure
K1025	Non-pneumatic sequential compression garment, full arm
K1026	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment
P9025	Plasma, cryoprecipitate reduced, pathogen reduced, each unit
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
Q4251	Vim, per square centimeter
Q4252	Vendaje, per square centimeter
Q4253	Zenith amniotic membrane, per square centimeter
S9432	Medical foods for non-inborn errors of metabolism
0018M	Transplantation medicine (allograft rejection, renal), measurement of donor and third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score

Effective October 1, 2021, the following codes will be *deny vendor liable for all lines of business:*

Code	Description
K1021	Exsufflation belt, includes all supplies and accessories
Q9004	Department of veterans affairs whole health partner services

Effective October 15, 2021, the following code will *no longer be a covered benefit for Fallon Medicare Plus and Fallon Medicare Plus Central members:*

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

Effective December 1, 2021 the following codes will *not be a covered benefit:*

Code	Description
90626	Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use
90627	Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use
90758	Zaire ebolavirus vaccine, live, for intramuscular use ■

Payment policies

Revised policies – Effective December 1, 2021:

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

- **Emergency Department** - Added trauma response team activation for Medicare Advantage, NaviCare and PACE plan members under Reimbursement section
- **Preventive Services** – Updated to reflect that prior authorization is not required for LDCT for lung cancer screening (CPT 71271) for Medicare members.
- **Early Intervention** – Updated to include changes related to Autism Specialty Service Providers effective October 1, 2021.
- **Sleep Management** - Corrected hyperlinks to CareCentrix website, updated lists of included and excluded products.
- **Obstetrics and Gynecology** - Updated to include reimbursement for insertion of long-acting reversible contraception (LARC); added J7296 to the Plan's Auxiliary Fee Schedule effective October 1, 2021.
- **Inpatient Medical Review and Payment Policy** - Added information about billing/coding for immediate postpartum long-acting reversible contraception (LARC) devices; added information about reimbursement for newborn hearing screening rendered in an inpatient setting.
- **Vaccine Payment Policy** – Updated language related to physician billing for Part D vaccines.
- **Vision Services** – Updated to include billing information for ophthalmologic Avastin (bevacizumab).
- **Drugs and Biologicals** – Updated to include billing information for ophthalmologic Avastin bevacizumab).
- **Newborn Services** – Added information about reimbursement for newborn hearing screening rendered in an inpatient setting. ■

OptumRx contact information

Members

Mail order	Specialty pharmacy	Member reimbursement
Commercial: 1-844-720-0035 **FMP/NC/SE:** 1-844-657-0494 **FHW:** 1-844-722-1701 Hours of operation are 24 hours a day, seven days a week. **Address**: OptumRx P.O. Box 2975 Mission, KS 66201	**Phone**: 1-855-427-4682 Hours of operation are 24 hours a day, seven days a week.	**Online**: Optumrx.com **Fax:** 1-855-851-4561 **Mail (Commercial and ACO):** OptumRx P.O. Box 650334 Dallas, TX 75265 **Mail (FMP/NC/SE)**: OptumRx P.O. Box 650287 Dallas, TX 75265

Providers

Provider ePrescribe for mail order	Mail order	Specialty pharmacy
Pharmacy: OptumRx Mail Service **Address:** OptumRx Mail Service 2858 Loker Ave East, Suite 100, Carlsbad, CA 92010 **Identifiers:** NCPDP ID = 0556540, PID = P00000000020173	**Commercial**: 1-844-720-0035 **FMP/NC/SE:** 1-844-657-0494 **FHW:** 1-844-722-1701 **Address:** OptumRx P.O. Box 2975 Mission, KS 66201 **Fax**: 1-800-491-7997	**Phone**: 1-855-427-4682. **Address**: OptumRx P.O. Box 2975 Mission, KS 66201 **Fax (for prescription submissions only – no PAs)**: 1-877-342-4596

Prior authorization requests

Line of business	Phone / Fax	Mail	ePA
Commercial	1-844-720-0035 1-844-403-1029	Optum Prior Authorization Department P.O. Box 25183 Santa Ana, CA 92799	professionals.optumrx.com/prior-authorization
Medicaid	1-844-720-0033 1-844-403-1029		
Medicare **NaviCare** **Summit ElderCare**	1-844-657-0494 1-844-403-1028		
FHW PACE	1-844-722-1701 1-844-403-1028		

Pharmacy Helpline *(for pharmacy use)*

1-844-368-8734

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

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Questions?

1-866-275-3247

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