Tufts Health Plan Senior Care Options Prior Authorization, Notification, and No Prior Authorization Medical Necessity Guidelines

Effective: October 1, 2026

Overview

The following tables list services and items requiring prior authorization and notification from Point32Health.

While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. When CMS and MassHealth do not provide guidance, the Plan internally developed medical necessity guidelines are used.

The following links can be used to find the criteria references below:

- CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) can be found: MCD Search (cms.gov)
- Medicare Benefit Policy Manual can be found 100-02 Medicare Benefit Policy Manual | CMS
- MassHealth Medical Necessity Determinations can be found here MassHealth Guidelines for Medical Necessity Determination | Mass.gov
- MassHealth DME Provider Manual can be found here Durable Medical Equipment Manual for MassHealth Providers | Mass.gov

Refer to the Referrals, Authorizations and Notifications chapter of the Senior Care Options Products Provider Manual for additional guidelines.

Member eligibility can be verified electronically using Tufts Health Plan's secure online provider portal, and detailed benefit coverage may be verified by contacting Provider Services.

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Prior Authorization Required Supporting clinical documentation pertinent to service request must be submitted to the FAX numbers below	Yes ☒ No ☐

The following tables list services and items requiring prior authorization:

- Table 1 includes DME, prosthetic items, procedures and services that require prior authorization through the Precertification Operations Department.
- Table 2 includes procedure codes that require prior authorization through the Behavioral Health Department.
- Table 3 includes Medicaid-only covered procedures, services, items and associated procedure codes that require prior authorization through the Precertification Operations Department.
- Table 4 includes drug and therapy codes managed by the Medical Policy Department require prior authorization from the Pharmacy Utilization Management Department.
- Table 5 includes vendor managed programs and services that require prior authorization through the Vendor Program.
- Table 6 includes procedure codes that the plan considers investigation and therefore are not covered by the Plan

TABLE 1

The following DME, prosthetic items, and procedure codes for procedures, services and items require prior authorization from the Precertification Operations Department. Inpatient prior authorization requests may be submitted by fax to 617-673-0705, outpatient requests must be submitted by fax to 617-673-0930.

Service	Procedure Codes	Criteria Reference
Acute Inpatient Rehab	Rehab Level 1–128 Rehab Level 2–129	CMS criteria is used: Medicare Benefit Policy Manual Chapter 1*
Long- Term Acute Care (LTAC)	LTAC Level- 120	CMS criteria is used: Medicare Benefit Policy Manual Chapter 1*
Skilled Nursing Facility (SNF)	SNF revenue codes Level 1A: 190 Level 1B: 191 Level 2: 192	CMS criteria is used: Medicare Benefit Policy Manual Chapter 8*
***Point32Health uses InterQual along with the CMS Medicare Benefit Policy Manual as a source of medical evidence to support medical necessity and level of care decisions as part of initial and concurrent review processes.**		
Basivertebral Nerve Ablation	64628, 64629	CMS criteria used: LCD - Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (L40302) and Article - Billing and Coding: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (A60324)
Blepharoplasty, Blepharoptosis, and Brow Lift	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908	CMS criteria is used: LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528) and Article - Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908)
Breast Reduction	19318	CMS criteria is used: LCD - Cosmetic and Reconstructive Surgery (L39051) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774)

Service	Procedure Codes	Criteria Reference
Cervical Fusion	22548, 22551, 22552, 22554, 22590, 22595, 22600	CMS criteria is used: LCD - Cervical Fusion (L39770) and Article - Billing and Coding: Cervical Fusion (A59632)
Deep Brain Stimulation for Essential Tremor and Parkinson Disease	61880, 61885, 61886, 61863, 61864, 61867, 61868	CMS criteria is used: NCD- Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24)
Dorsal Column Neurostimulation	63650, 63655, 63663, 63685, 95972	CMS criteria is used: NCD - Electrical Nerve Stimulators (160.7)
Epidural Steroid Injections for Pain Management	62321, 62323, 64479, 64480, 64483, 64484	CMS criteria is used: LCD - Epidural Steroid Injections for Pain Management (L39036) and Article - Billing and Coding: Epidural Steroid Injections for Pain Management (A58745)
FoundationOne CDX	0037U	CMS criteria is used: NCD - Next Generation Sequencing (NGS) (90.2)
FoundationOne Liquid CDX	0239U	CMS criteria is used: LCA MolDX: Molecular Diagnostic Tests (MDT) (A5777)
Functional Neuromuscular Stimulators	E0764, E0770	CMS criteria is used: NCD - Neuromuscular Electrical Stimulation (NMES) (160.12)
Genetic Testing	See Genetic Testing-Molecular Pathology Procedures MNG for details on the Provider Resource Center	CMS criteria is used: LCD - Molecular Pathology Procedures (L35000) and Article - Billing and Coding: Molecular Pathology Procedures (A56199) reference MNG for details
Glucose Monitors	E2102, A4238, E2103, A4239	CMS Criteria and MassHealth Criteria Used: Diabetes mellitus: LCD - Glucose Monitors (L33822) and Article - Glucose Monitor - Policy Article (A52464) For hypoglycemia due to a diagnosis other than diabetes mellitus: MassHealth Medical Necessity Guidelines for Diabetes Management Devices- Continuous Glucose Monitoring and Insulin Pumps
Guardant 360	0242U	CMS criteria is used: NCD - Next Generation Sequencing (NGS) (90.2)
Gynecomastia	19300	CMS criteria is used: LCD - Cosmetic and Reconstructive Surgery (L39051) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774)
Hyperbaric Oxygen Therapy	G0277, 99183	CMS criteria is used: NCD - Hyperbaric Oxygen Therapy (20.29)
Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	64582, 64583, and 64584	Internal criteria is used. See Hypoglossal Nerve Stimulation for TMP and SCO MNG on the Provider Resource Center
Implantable Neurostimulator-Sacral Nerve Stimulation for Urinary Incontinence	64561, 64581, 64590, 64595	CMS criteria is used: NCD- 230.18 Sacral Nerve Stimulation for Urinary Incontinence

Service	Procedure Codes	Criteria Reference
Implantable Neurostimulator-Sacral Nerve Stimulation for Fecal Incontinence	64561, 64581, 64590, 64595	CMS criteria is used: CMS LCA from a different jurisdiction to be used: Billing and Coding: Sacral Nerve Stimulation for urinary and Fecal Incontinence (A53359)
Incontinence Devices	53445	CMS criteria is used: NCD- 230.10 Incontinence Control Devices
Lower Limb Prostheses	L5827, L5828, L5856, L5857, L5858, L5980, L5981, L5987, L5973	CMS criteria will be used: LCD- Lower Limb Prostheses (L33878) and LCA- Lower Limb Prostheses Policy Article (A52496)
Lumbar Spinal Fusion	22533, 22558, 22612, 22630, 22633	CMS criteria is used (note this is an LCD from a different region): LCD - Lumbar Spinal Fusion (L37848) and Article - Billing and Coding: Lumbar Spinal Fusion (A56396)
Oral Airway Appliances for Obstructive Sleep Apnea (OSA)	E0485, E0486	CMS and MassHealth criteria are used: LCD - Oral Appliances for Obstructive Sleep Apnea (L33611), Article - Oral Appliances for Obstructive Sleep Apnea - Policy Article (A52512), and MassHealth DME Provider Manual
Osteogenesis Stimulators	E0747, E0748, E0749	CMS criteria is used: NCD - Osteogenic Stimulators (150.2), LCD - Osteogenesis Stimulators (L33796) and Article - Osteogenesis Stimulators - Policy Article (A52513) MassHealth DME Provider Manual
Out-of-Network Coverage at the In-Network Level of Benefits and Continuity of Care (All Plans)	See Inpatient Acute Level of Care MNG for details on the Provider Resource Center	CMS CY24 requirements used: 42 CFR 422.112(b)
Panniculectomy	15830, 15847, 15877	CMS criteria is used: LCD - Cosmetic and Reconstructive Surgery (L39051) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774)
Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture	22510, 22511, 22512, 22513, 22514, 22515	CMS criteria is used: LCD - Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569) and Article - Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (A56178)
Pneumatic Compression Device with Calibrated Gradient Pressure	E0652	CMS and MassHealth criteria is used: NCD - Pneumatic Compression Devices (280.6), and MassHealth DME Provider Manual
Power Mobility Devices and Accessories Note: Batteries do not	**Power Wheelchairs:** K0010-K0014, K0813-K0816, K0820-K0831, K0835-K0843, K0848-K0864, K0868-K0871, K0877-	CMS and MassHealth criteria is used: NCD - Mobility Assistive Equipment (MAE) (280.3)

Service	Procedure Codes	Criteria Reference
require prior authorization and are covered according to Medicare guidelines	K0880, K0884-K0886, K0890-K0891, K0898-K0899, E0983, E0984, E0986, E1002-E1010, E1012, E1239, E2298, E2310-E2313, E2321-E2331, E2340-E2343, E2351, E2368-E2370, E2373-E2377 **Power Operated Vehicles:** E1230, K0800-K0802, K0806-K0808, K0812 **Power Wheelchair Components:** E2300 and *E2301	LCD - Power Mobility Devices (L33789) and Article - Power Mobility Devices - Policy Article (A52498) LCD - Wheelchair Options/Accessories (L33792) and Article - Wheelchair Options/Accessories - Policy Article (A52504) MassHealth DME Provider Manual https://www.mass.gov/files/documents/2018/10/26/dme-21-bulletin.pdf https://www.mass.gov/orgs/executive-office-of-health-and-human-services * MassHealth Medical Necessity Guidelines for Standers
Proton Beam Therapy	77520, 77522, 77523, 77525	CMS criteria is used: LCD - Proton Beam Therapy (L35075) and Article - Billing and Coding: Proton Beam Therapy (A56827)
Rhinoplasty	30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462	CMS criteria is used: LCD - Cosmetic and Reconstructive Surgery (cms.gov) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774)
Septoplasty	30520	CMS criteria is used: LCD - Cosmetic and Reconstructive Surgery (cms.gov) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774)
Speech Generating Devices	E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599	CMS and MassHealth criteria is used: NCD - Speech Generating Devices (50.1), LCD - Speech Generating Devices (SGD) (L33739) and Article - Speech Generating Devices (SGD) - Policy Article (A52469) and MassHealth DME Provider Manual
Tonic Motor Activation for the Treatment of Restless Leg Syndrome	A4544, E0743	Internal criteria is used. See Tonic Motor Activation for the Treatment of Restless Leg Syndrome MNG on the Provider Resource Center
Transurethral Waterjet Ablation of Prostate	C2596, 52597	CMS criteria is used: LCD - Transurethral Waterjet Ablation of the Prostate (L38682) and Article - Billing and Coding: Transurethral Waterjet Ablation of the Prostate (A58209)
ThyroSeq	0026U	CMS criteria is used: LCD - Biomarkers for Oncology (L35396) and Article - Billing and Coding: Biomarkers for Oncology (A52986)
Ultraviolet Light Therapy Systems	E0691-E0694	CMS and MassHealth criteria is used: NCD - Durable Medical Equipment Reference List (280.1) and MassHealth DME Provider Manual

Service	Procedure Codes	Criteria Reference
Unlisted Procedure Codes	A9999, E0676, E1399, K0009, K0108, L0999, L1499, L2999, L3649, L3999, L7499, L5999, L8039, L8048, L8499, L8699, L9900	
Upper Limb Prostheses	L6026, L6700, L6715, L6880, L6881, L6882, L7007, L7008, L7009, L7045, L7170, L7180, L7181, L7185, L7186, L7190, L7191, L7259	CMS criteria is used: CMS criteria is used: Medicare Benefit Policy Manual Chapter 15 Social Security Act §1862A1A
Varicose Veins	36465, 36466, 36468, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 37799	CMS criteria is used: LCD - Treatment of Varicose Veins of the Lower Extremities (L34536), LCD - Varicose Veins of the Lower Extremity, Treatment of (L33575), Article - Billing and Coding: Treatment of Varicose Veins of the Lower Extremities (A56914), and Article - Billing and Coding: Treatment of Varicose Veins of the Lower Extremity (A52870)

TABLE 2

The following procedures, services and items require prior authorization from the Behavioral Health Department. Prior authorization requests may be submitted by fax to 617-673-0930.

Service	Procedure Codes	Criteria Reference
Transcranial Magnetic Stimulation (TMS) for Tufts Health OneCare, Tufts Medicare Preferred and Tufts Health Plan Senior Care Options	90867, 90868, 90869	Medicare Behavioral Health InterQual® Criteria Used. See Transcranial Magnetic Stimulation (TMS) for Tufts Health One Care, Tufts Medicare Preferred and Tufts Health Plan Senior Care Options MNG on the Provider Resource Center

TABLE 3

The following Medicaid-only covered procedures, services and items require prior authorization from the Precertification Operations Department. Prior authorizations can be submitted by fax only to 617-673-0930.

Before submitting the prior authorization request to Tufts Health Plan SCO, contact Provider Services to identify the appropriate Tufts Health Plan SCO care manager to coordinate services.

Refer to the MassHealth Guidelines for Medical Necessity Determinations and MassHealth Provider Manual Series to access complete Medicaid guidelines and clinical criteria that will be used in making coverage decisions for the services below.

Service	Procedure Codes	Medicaid Reference
Acupuncture for pain management beyond 20 visits per member per year	97810, 97811, 97813, 97814	MassHealth criteria is used: https://www.mass.gov/lists/physician-manual-for-masshealth-providers#subchapter-4:-physician-providers-regulations-

Home Accessibility Adaptations	S5165	MassHealth criteria is used: https://www.mass.gov/regulations/130-CMR-63000-home-and-community-based-services-waiver-services
DME	DME Medicaid-only covered DME items with billed charges $1000 or greater. For DME items billed as monthly rentals, prior authorization is required if the cost to purchase the item outright is $1000 or greater	MassHealth criteria is used: MassHealth DME Provider Manual

TABLE 4

The following drug and therapy codes managed by the Medical Policy Department require prior authorization from the Pharmacy Utilization Management Department. Prior authorization requests may be submitted by fax to 617-673-0956.

Note: This list is not an all-encompassing list of medical benefit drugs that require prior authorization. Any medical benefit drug owned by the pharmacy department can be found at the Provider resource center. Additionally, the Plan has a New to Market Drug Medical Necessity Guideline to be utilized for any requests of new to market drugs that do not yet have coverage established by the Plan.

Service	Procedure Codes	Medicare Criteria Reference
Abecma	Q2055	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Adstiladrin	J9029	See Adstiladrin MNG on the Provider Resource Center.
Amtagvi	J3490	See Amtagvi MNG on the Provider Resource Center.
Aucatzyl	Q2058	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Breyanzi	Q2054	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Carvykti	Q2056	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Casgevy	J3392	See Casgevy MNG on the Provider Resource Center.
CGM: Freestyle and Dexcom Products	A4238, E2102	CMS Criteria and MassHealth Criteria Used: Diabetes mellitus: LCD - Glucose Monitors (L33822) and Article - Glucose Monitor - Policy Article (A52464) For hypoglycemia due to a diagnosis other than diabetes mellitus: MassHealth Medical Necessity Guidelines for Diabetes Management Devices-Continuous Glucose Monitoring and Insulin Pumps

Service	Procedure Codes	Medicare Criteria Reference
Encelto	J3403	See Encelto MNG on the Provider Resource Center.
Hemgenix	J1411	See Hemgenix MNG on the Provider Resource Center.
Kebilidi	J3590	See Kebilidi MNG on the Provider Resource Center.
Kymriah	Q2042	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Lyfgenia	J3394	See Lyfgenia MNG on the Provider Resource Center.
Omisigre	J3406	See Omisigre MNG on the Provider Resource Center.
Tecartus	Q2053	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Tecelra	Q2057	See Tecelra MNG on the Provider Resource Center.
Vyjuvek	J3401	See Vyjuvek MNG on the Provider Resource Center.
Yescarta	Q2041	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Zevaskyn	J3389	See Zevaskyn MNG on the Provider Resource Center.
Zynteglo	J3393	See Zynteglo MNG on the Provider Resource Center.

TABLE 5

The following codes are managed by various Vendor Managed Programs and services that require prior authorization through the Vendor Program.

Service	Procedure Codes	Criteria Reference
None		

TABLE 6

The following procedure codes are considered investigation and therefore are not covered by the Plan.

Service	Procedure Codes	Coverage Guideline
Medicare Non-Covered Investigational Services	See MNG for details	See Medicare Non-Covered Investigational Services MNG on the Provider Resource Center

Notification Required IF REQUIRED, concurrent review may apply	Yes ☒ No ☐

The following tables list services and items requiring notification:

- Table 7 includes DME, prosthetic items, and associated procedure codes that require notification through the Precertification Operations Department.
- Table 8 includes procedure codes that require notification through the Behavioral Health Department.
- Table 9 includes procedures, services and items require prior notification to the Tufts Health Plan SCO care manager.
- Table 10 includes Medicaid-only covered procedures, services, items and associated procedure codes that require notification through the Tufts Health Plan SCO care manager.

TABLE 7

The following medical, rehabilitation and behavioral health/substance use disorder inpatient admissions require inpatient notification to the Inpatient Admission Team in the Precertification Department via fax at 617-673-0705. Concurrent medical necessity review, following the notification period, may be required.

Service	Procedure Codes	Criteria Reference
Acute Hospital at Home	See MNG	See Acute Hospital at Home MNG on the Provider Resource Center
Acute Inpatient		CMS criteria is used: Medicare Benefit Policy Manual Chapter 1*
Long-term acute care (LTAC) inpatient admissions	LTAC Level – 120	CMS criteria is used: Medicare Benefit Policy Manual Chapter 1*
Skilled Nursing Facility (SNF)	SNF revenue codes Level 1A: 190 Level 1B: 191 Level 2: 192	CMS criteria is used: Medicare Benefit Policy Manual Chapter 8*
Institutional Long-Term Care (LTC)	Institutional LTC revenue code 199	CMS criteria is used: Medicare Benefit Policy Manual Chapter 8*
***Point32Health uses InterQual along with the CMS Medicare Benefit Policy Manual as a source of medical evidence to support medical necessity and level of care decisions as part of initial and concurrent review processes.**		

TABLE 8

The following behavioral health services require notification to the Behavioral Health Department. 24-hr levels of care require concurrent medical necessity review following the notification period. Inpatient notifications may be submitted by fax to 617-673-0705, outpatient notifications must be submitted by fax to 617-673-0930.

Service	Procedure Codes	Criteria Reference
Behavioral Health Inpatient and 24-Hour Level of Care Determinations	See Behavioral Health Inpatient and 24-Hour Level of Care Determinations MNG on the Provider Resource Center for Services that Require notification	InterQual® and American Society of Addictive Medicine (ASAM)
Inpatient Behavioral Health and Substance Abuse	Behavioral Health revenue codes: 114, 124	See Behavioral Health Inpatient and 24-Hour Level of Care Determinations on the Provider Resource Center

Service	Procedure Codes	Criteria Reference
	Substance abuse revenue codes: 116, 126	
Observation/ holding beds	99218	See Behavioral Health Inpatient and 24-Hour Level of Care Determinations on the Provider Resource Center
Residential substance abuse treatment	H0017	See Behavioral Health Inpatient and 24-Hour Level of Care Determinations on the Provider Resource Center
Community support program (CSP) including specialized CSP services: • Community Support Program for Homeless Individuals (CSP-HI) • Community Support Program for Individuals with Justice Involvement (CSP-JI) • Community Support Program Tenancy Preservation Program (CSP-TPP)	H2015 H2016-HH H2016 HK H2016 HE	See Community Support Programs including Specialized Community Support Program MNG for details on the Provider Resource Center

TABLE 9

The following procedures, services and items require prior notification to the Tufts Health Plan SCO care manager. Please contact Provider Relations at 800-279-9022 to identify the appropriate Tufts Health Plan SCO care manager.

Service	Procedure Codes	Criteria Reference
Home Health Care Services	G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0162, G0299, G0300, G0493, G0494, 99211	
Sleep Studies	G0398, G0399, G0400, 95800, 95801, 95805, 95806, 95807, 95808, 95810, 95811	
Sleep Supplies, such as PAP therapy equipment and related supplies	**CPAP:** E0601 **BiPAP**: E0470, E0471 **CPAP and BIPAP Supplies**: A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, E0562	

TABLE 10

The following Medicaid-only covered procedures, services and items requires notification to the Tufts Health Plan SCO care manager. Please contact Provider Relations at 800-279-9022 to identify the appropriate Tufts Health Plan SCO care manager.

Service	Procedure Codes	Medicaid Criteria Reference
Adult Day Health	S5100, S5100-TG, S5100-U1, S5102, S5102-TG, S5102-U1, T2003	Adult Day Health Manual for MassHealth Providers
Adult Foster Care	S5140, S5140-TF, S5140-TG, S5140-U5, S5140-U6, S5140-TG-U6, S5140-U7, S5140-TG-U7, T1028	Adult Foster Care Manual for MassHealth Providers
Bed hold in a skilled nursing facility (SNF), while member hospitalized	Revenue code 185	Nursing Facility Manual for MassHealth Providers
Chore services	S5120	Home- and Community-Based Services Manual for MassHealth Providers
Companion services	S5135	Home- and Community-Based Services Manual for MassHealth Providers
Day Habilitation	H2014, H2014-22, H2014-TF, H2014- TG, H2014-U1, H2014-U2, T2003	Home- and Community-Based Services Manual for MassHealth Providers
Evaluation and stabilization in a SNF, escalated services in lieu of member hospitalization	Revenue code 194	Nursing Facility Manual for MassHealth Providers
Fiscal intermediary (FI)	T1019, T1019-TU, T1019-TV, T1020	Personal Care Manual for MassHealth Providers
Grocery shopping and delivery	T1019 (personal care services)	Home- and Community-Based Services Manual for MassHealth Providers
Home delivered meals	S5170	Home- and Community-Based Services Manual for MassHealth Providers
Homemaker	S5130, S5131	Home- and Community-Based Services Manual for MassHealth Providers
Laundry	S5175	Home- and Community-Based Services Manual for MassHealth Providers
Personal care management	99456, 99456-TS, T1023, T2022	Personal Care Manual for MassHealth Providers
Personal Care Attendant	T1019	Personal Care Attendant Services Manual For MassHealth Providers and Mass.gov Personal Care Attendant Program Operating Standards
Personal Care Attendant – complex care	T1019 with modifier TG	Home- and Community-Based Services Manual for MassHealth Providers
Personal care services	S5125, S5126	Home- and Community-Based Services Manual for MassHealth Providers

Service	Procedure Codes	Medicaid Criteria Reference
Personal emergency Response System	S5160, S5161, S5199, T1505	Home- and Community-Based Services Manual for MassHealth Providers
Respite services (all places of service)	H0045, S5150, S5151, S9125, T1005	Home- and Community-Based Services Manual for MassHealth Providers
Social day care	T1019 (personal care services)	Home- and Community-Based Services Manual for MassHealth Providers
Supported housing group adult foster care (GAFC) personal care and administration	H0043	https://www.mass.gov/doc/adult-foster-care-regulations/download
Therapeutic leave day in a SNF	Revenue code 183	Nursing Facility Manual for MassHealth Providers
Tobacco cessation services	Classes: S9453 Counseling: G0436 (10 min.), G0437 (more than 10 min.)	About 1-800-QUIT-NOW | Mass.gov
Transitional living services	T1020-U1	Personal Care Manual for MassHealth Provider
Wander response system	A9280	Home- and Community-Based Services Manual for MassHealth Providers

Prior Authorization Required	Yes ☐ No ☒

The following tables list services and items requiring no prior authorization:

- Table 11 includes services and procedures that do not require prior authorization; however, a post service edit may apply.

TABLE 11

The following procedure codes do not require prior authorization from the Plan. The criteria represent a medically necessary service. Post- service edits may apply.

Service	Procedure Codes	Coverage Guideline
Intravitreal Implants and Corticosteroid Inserts for Ophthalmic Conditions	67027, 67028, J1096, J7313, J7311, J7312, J7314 ICD-10 codes	See Intravitreal Implants and Corticosteroid Inserts for Ophthalmic Conditions on the Provider Resource Center
Remote Patient Monitoring	99091, 99453, 99454, 99457, 99458 ICD-10 codes	See Remote Patient Monitoring MNG for Tufts Together, Tufts Health One Care, and Tufts Health Senior Care Options on the Provider Resource Center
Removal of Benign Skin Lesions	17000, 17003, 17004, 17100, 17111 ICD-10 codes	See Removal of Benign Skin Lesions MNG on the Provider Resource Center
Upper Gastrointestinal Endoscopy	42300, 43202, 43231, 43233, 43235, 43237,	See Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy,

(Esophagogastroduodenoscopy, EGD)	43238, 43239, 43242, 43249, 43259 ICD-10 codes	EGD) MNG on the Provider Resource Center

Approval And Revision History

May 15, 2024: Reviewed by the Medical Policy Approval Committee (MPAC)
June 13, 2024: Reviewed and Approved by the Joint Medical Policy and Health Care Service Utilization Management Committee (UM Committee)

- April 15, 2020: Reviewed by IMPAC. PA of FoundationOne, Hyperbaric Oxygen Therapy, Doral Column Neurostimulation and ThyroSeq deferred until 1/1/21. Items temporarily removed from list to reflect this.
- September 15, 2020: Reviewed by IMPAC. PA of FoundationOne, Hyperbaric Oxygen Therapy, Doral Column Neurostimulation and ThyroSeq, Removal of PA for Hearing Aids effective1/1/21.
- December 16, 2020: Reviewed by IMPAC. Removal of CMS NGS LCD for Drugs and Biologicals, Coverage of for Label and Off-Label (L33394) from Modified T-Cell Therapies Section.
- January 28, 2021: Addition of Hearing Aids back to Table 3, for PA requirement effective April 1, 2021.
- April 1, 2021: Coding update to Table 1, Modified T-Cell Therapies, Per AMA CPT®, effective April 1, 2021 the following code(s) added: Q2053.
- July 21, 2021: Reviewed by IMPAC. Removal of link to Modified T-Cell Therapies MNG. Added link to National Coverage Determination (NCD) for Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24), effective July 23, 2021. Addition of codes C9076 and J9999. Addition of Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid, Durable Medical Equipment Bulletin 21 to Power Mobility Devices section.
- July 15, 2021: Reviewed and approved at IMPAC, Notification and Concurrent review will be required for all 24-hr levels of care. Removal of services that do not require notification: Electroshock therapy, IOP, PHP, Psychiatric Day Treatment, Recovery coach, Recovery Navigator, SOAP, Short Term Crisis Counseling and Specialing. These changes are effective 1/1/22.
- October 20, 2021: Reviewed by IMPAC. Removal of Hearing Aids from PA effective 1/1/22. Addition of HGNS for OSA to Table 1.
- June 30, 2022, AMA CPT® coding update. Quarterly Code update removal of C9076, replaced by Q2054, addition of C9098 to be effective July 1, 2022.
- July 20, 2022, Reviewed by MPAC. Update to category of Therapeutic Continuous Glucose Monitors (CGMs) on Table 1. Updated name to reflect updated LCD “Glucose Monitors” and addition of codes E2102 and A4238 to be effective November 1, 2022.
- August 22, 2022: Reviewed and approved by MPAC. Addition of SNF services, Removal of Modified T Cell Therapy from Table 1, Addition of rTMS to Table 2. These changes are to be effective January 1, 2023
- August 22, 2022: Reviewed and Approved by Medical Policy Approval Committee (MPAC). Note added to SNF services on Table 1, indicating that prior authorization is required. This is effective 1/1/23.
- January 1, 2023-AMA CPT and HCPCS quarterly coding update. Removal of end dated codes K0553 and K0554, replaced with new codes E2103 and A4239, to be effective January 1, 2023.
- May 17, 2023: Reviewed and approved by MPAC. Table 3, CSP language revised to include specialized CSP Services (CSP-JI, CSP-HI, CSP-TPP) effective 4/1/2023. Language regarding CSP for CHI and SIF removed for effective date July 1, 2023.
- August 30, 2023: Revision to Informational Notes-Addition of link to Provider Resource Center for Pharmacy Management Program

- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- May 15, 2024: Template updated to combine SCO PA and SCO Notification list into 1 MNG, added table 4, and table 10.
- June 13, 2024: Reviewed and approved by the UM Committee effective July 1, 2024
- June 20, 2024: Coding updated per AMA HCPCS for Zynteglo to J3393 and Lyfgenia to J3394, added Amtagvi under table 4, and updated criteria references for Lyfgenia, Hemgenix, Zynteglo, Roctavian, and Adstiladrin effective July 1, 2024
- July 22, 2024: Reviewed by MPAC, added AposTherapy System as a no Prior Authorization Guideline effective April 1, 2025.
- September 17, 2024: Services reviewed and approved by the UM Committee to
    - add Intensity Modulated Radiation Therapy, Proton Beam Therapy, Transurethral Waterjet Ablation of Prostate, Varicose Veins, Acute Inpatient Rehabilitation, Blepharoplasty, Blepharoptosis, Brow Lift, Breast Reduction, Gynecomastia, Rhinoplasty, Panniculectomy, Guardant 360, Epidural Steroid Injections for Pain Management, Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture, Lumbar Spinal Fusion, Cervical Fusion, and Genetic Testing to prior authorization
    - added code E2298 to prior authorization under Power Mobility Devices,
    - update Hypoglossal Nerve Stimulator coding, added 64582, 64583, and 64584 and removed 64568, 0466T, 0467T, 0468T
    - added link to New to Market Medical Necessity Guideline in table 3
    - Removed LCD and LCA from Pneumatic Compression Device with Calibrated Gradient Pressure due to them retiring
    - added Removal of Benign Skin Lesion to the no prior authorization list, effective January 1, 2025
- October 17, 2024: Reviewed by MPAC
    - add Intensity Modulated Radiation Therapy, Proton Beam Therapy, Transurethral Waterjet Ablation of Prostate, Varicose Veins, Acute Inpatient Rehabilitation, Blepharoplasty, Blepharoptosis, Brow Lift, Breast Reduction, Gynecomastia, Rhinoplasty, Panniculectomy, Guardant 360, Epidural Steroid Injections for Pain Management, Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture, Lumbar Spinal Fusion, Cervical Fusion, and Genetic Testing to prior authorization
    - added code E2298 to prior authorization under Power Mobility Devices,
    - update Hypoglossal Nerve Stimulator coding, added 64582, 64583, and 64584 and removed 64568, 0466T, 0467T, 0468T
    - added link to New to Market Medical Necessity Guideline in table 3
    - Removed LCD and LCA from Pneumatic Compression Device with Calibrated Gradient Pressure due to them retiring
    - added Removal of Benign Skin Lesion to the no prior authorization list, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, criteria from September UM Committee approved, updated hypoglossal nerve stimulation to internal criteria, removed prior authorization from CAR-T administration codes, and added Acute Hospital at Home as a notification MNG effective January 1, 2025. Added Basivertebral Nerve Ablation, Deep Brain Stimulation for Essential Tremor and Parkinson's Disease and Implantable Neurostimulation: Sacral Nerve Stimulation to prior authorization effective March 1, 2025
- December 18, 2024: Reviewed by MPAC, updated hypoglossal nerve stimulation to internal criteria, removed prior authorization from CAR-T administration codes, and added Acute Hospital at Home as a notification Medical Necessity Guideline (MNG), effective January 1, 2025. Added Basivertebral Nerve Ablation, Deep Brain Stimulation for Essential Tremor and Parkinson's Disease and Implantable Neurostimulation: Sacral Nerve Stimulation to prior authorization, effective March 1, 2025
- January 1, 2025: Coding updated effective January 1, 2025: the following code was added for Casgevy: J3392.
- January 15, 2025: Reviewed by MPAC, removed 77387 and G6017 under Intensity Modulated Radiation Therapy from prior authorization retroactive to January 1, 2025.

- February 2025: Reviewed by MPAC, removed 77301, 77338 under Intensity Modulated Radiation Therapy from prior authorization retroactive to January 1, 2025.
- February 19, 2025: Reviewed by MPAC, added clarifying line to table 1 and 7 about using InterQual to support medical necessity and added table 6 and Medicare Non-Covered Investigational Services MNG effective April 1, 2025.
- March 2025: Reviewed by the UM Committee
    - removed 77301, 77387, 77338, G6017 under Intensity Modulated Radiation Therapy from prior authorization retroactive to January 1, 2025
    - removed 93970 and 93971 under varicose veins from prior authorization retroactive to January 1, 2025
    - added Aucatzyl and Tecelra to table 4 effective April 1, 2025
    - added clarifying line to table 1 and 7 about using InterQual to support medical necessity
    - added table 6 and Medicare Non-Covered Investigational Services MNG, moved all other tables down 1 effective April 1, 2025
- March 2025: Per CMS HCPCS the following code added to prior authorization under upper limb protheses in table 1: L6028, L6029, L6030, L6031, L6032, L6033, L6037, L6700, L7406; the following codes added to prior authorization in table 4 Aucatzyl: C9301, Tecelra Q2057, effective April 1, 2025
- May 21, 2025: Reviewed by MPAC to remove the following codes from PA: 22800, 22802, 22808, 22810, 22812 effective October 1, 2025
- June 2025: Coding updated per AMA HCPCS for Aucatzyl to Q2058 effective July 1, 2025
- June 13, 2025: Reviewed at UM Committee added no PA guidelines Intravitreal Implants and Corticosteroid Inserts for Ophthalmic Conditions and Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD) effective September 1, 2025 and PA guideline for Tonic Motor Activation for the Treatment of Restless Leg Syndrome effective August 1, 2025
- June 13, 2025: Reviewed at UM Committee, removed PA from 22800, 22802, 22808, 22810, 22812 under cervical fusion effective October 1, 2025
- October 1, 2025: Per CMS HCPCS the following codes added to prior authorization: L6034, L6035, L6036, L6038, L6039 under upper limb prosthesis effective October 1, 2025; added Encelto and Kebilidi to table 4 effective October 1, 2025.
- December 8, 2025: Reviewed by UM Committee, added PCA- complex care (T1019 modifier TG) to table 10 effective January 1, 2026; removed about 147 codes from prior authorization associated with a standard prosthetic build, services have been moved to covered, intent of services now is to just manage myoelectric and complex components of the prosthetic effective February 1, 2026
- December 17, 2025: Reviewed by MPAC, added PCA- complex care (T1019 modifier TG) to table 10 effective January 1, 2026
- December 30, 2025: Intensity-Modulated Radiation Therapy removed from table 1, codes 77385, 77386, G6015, G6016 end- dated by CMS effective December 31, 2025, these codes were not replaced by any new codes; per new coding guidelines, category III CPT code 0421T updated to code 52597 and removed end-dated CPT code 37500, effective January 1, 2026
- February 24, 2026: Administrative update
- February 18, 2026: Reviewed by MPAC to include the following changes:
    - Incontinence Devices (53445), Septoplasty (30520), FoundationOne Liquid CDx (0239U), Lower Limb Prostheses (L5827, L5828, L5856, L5857, L5858, L5980, L5981, L5987, L5973) added to prior authorization effective June 1, 2026
    - Implantable Neurostimulator- Sacral Nerve Simulator criteria updated and split into Urinary Incontinence and Fecal Incontinence due to difference in CMS criteria and added prior authorization to 64561 and 64581 effective June 1, 2026
    - Added E0747 to Osteogenesis Stimulators effective June 1, 2026
    - added code 43249 to Upper Gastrointestinal Endoscopy MNG effective June 1, 2026
    - Zevaskyn added to prior authorization effective April 1, 2026
    - Removed Roctavian from prior authorization effective May 1, 2026
- March 10, 2026: Reviewed by UM Committee to include the following changes:
    - Incontinence Devices (53445), Septoplasty (30520), FoundationOne Liquid CDx (0239U), Lower Limb Prostheses (L5827, L5828, L5856, L5857, L5858, L5980, L5981, L5987, L5973) added to prior authorization effective June 1, 2026

    - Implantable Neurostimulator- Sacral Nerve Simulator criteria updated and split into Urinary Incontinence and Fecal Incontinence due to difference in CMS criteria and added prior authorization to 64561 and 64581 effective June 1, 2026
    - Added E0747 to Osteogenesis Stimulators effective June 1, 2026
    - added code 43249 to Upper Gastrointestinal Endoscopy MNG effective June 1, 2026
    - Zevaskyn added to prior authorization effective April 1, 2026
    - Removed Roctavian from prior authorization effective May 1, 2026
- June 15, 2026: Reviewed by UM Committee, added Personal Care Attendants to table 10 to clarify notification requirements. Included Mass.gov Personal Care Attendant Program Operating Standards as a reference for meal preparation cannot exceed 7 hours per week in alignment with MassHealth criteria effective August 1, 2026
- June 17, 2026: Reviewed by MPAC, added Personal Care Attendants to table 10 to clarify notification requirements effective August 1, 2026
- July 15, 2026: Reviewed by MPAC, Included Mass.gov Personal Care Attendant Program Operating Standards as a reference for meal preparation cannot exceed 7 hours per week in alignment with MassHealth criteria effective August 1, 2026
- August 19, 2026: Reviewed by MPAC, Basivertebral nerve ablation CMS criteria updated and updated Omisigre code to J3406 per AMA HCPCS update effective October 1, 2026
- September 15, 2026: Reviewed by UM Committee, Basivertebral nerve ablation CMS criteria updated and updated Omisigre code to J3406 per AMA HCPCS update effective October 1, 2026