



# Tufts Health One Care Prior Authorization, Notification, and No Prior Authorization Medical Necessity Guidelines

Effective: Ocotber 1, 2025

# **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 <u>MassHealth Guidelines for Medical Necessity Determination | Mass.gov</u>
- MassHealth DME Provider Manual can be found here <u>Durable Medical Equipment Manual for</u> MassHealth Providers | Mass.gov

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

Member eligibility can be verified electronically using Tufts Health Plan's <u>secure online provider portal</u>, 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

### 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. Prior authorization requests may be submitted by fax to 857-304-6304.

| Service               | Procedure Codes                     | Criteria Reference                           |
|-----------------------|-------------------------------------|--|
| Anterior Vertebral    | 22836, 22837, 0656T, 0657T          | Internal criteria is used. See               |
| Body Tethering        |                                     | Anterior Vertebral Body                      |
|                       |                                     | Tethering MNG for details on the             |
|                       |                                     | Provider Resource Center                     |
| Bariatric Surgery     | 43644, 43645, 43770-43775,          | InterQual® Criteria Used. See Bariatric      |
|                       | 43845-43848, 43860, 43865-          | Surgery MNG for details on the Provider      |
|                       | 43886-43888, 43999                  | Resource Center                              |
| Basivertebral Nerve   | 64628, 64629                        | CMS criteria used:                           |
| Ablation              |                                     | LCD - Intraosseous Basivertebral Nerve       |
|                       |                                     | Ablation (L39642) and Article - Billing and  |
|                       |                                     | Coding: Intraosseous Basivertebral Nerve     |
|                       |                                     | Ablation (A59466)                            |
| Blepharoplasty,       | Brow Ptosis Repair: 67900           | CMS Criteria Used:                           |
| Upper/Lower Eyelid,   | Upper Eyelid Blepharoptosis         | LCD - Blepharoplasty, Blepharoptosis and     |
| and Brow and/or       | <b>Repair:</b> 67901, 67902, 67903, | Brow Lift (L34528) and Article - Billing and |
| Eyelid Ptosis Repair) | 67904, 67906, 67908,                | Coding: Blepharoplasty, Blepharoptosis and   |
|                       | Blepharoplasty, Upper               | Brow Lift (A56908)                           |
|                       | Eyelid: 15822, 15823,               |  |
|                       | Blepharoplasty, Lower               |  |
|                       | Eyelid: 15820, 15821                |  |
| Continuous Glucose    | 0446T, 0447T, 0448T, A4238,         | CMS Criteria and MassHealth Criteria Used:   |
| Monitoring and        | A4239, A9274, A9276, A9277,         | Diabetes mellitus: LCD - Glucose Monitors    |
| Diabetes              | A9278, E2103                        | (L33822) and Article - Glucose Monitor -     |
| Management Devices    |                                     | Policy Article (A52464)                      |
|                       |                                     | For hypoglycemia due to a diagnosis other    |
|                       |                                     | than diabetes mellitus: MassHealth Medical   |

| Service  | Procedure Codes   | Criteria Reference  |
|--|---|---|
|  |   | Necessity Guidelines for Diabetes   |
|  |   | Management Devices- Continuous Glucose  |
|  |   | Monitoring and Insulin Pumps  |
| Custom Fabricated<br>Oral Appliances for<br>Obstructive Sleep<br>Apnea (OSA)   | E0486   | CMS and MassHealth criteria are used:<br>LCD - Oral Appliances for Obstructive Sleep<br>Apnea (L33611), Article - Oral Appliances for<br>Obstructive Sleep Apnea - Policy Article<br>(A52512), and MassHealth DME Provider<br>Manual  |
| Dental Procedures Requiring Hospital/ Facility-Based Care for Tufts Health Direct, Tufts Health Together, RITogether, and One Care | 41899   | Internal criteria is used. See Dental Procedures Requiring Hospital/ Facility- Based Care for Tufts Health Direct, Tufts Health Together, RITogether, and One Care MNG for details on the Provider Resource Center  |
| Endoscopic Sinus<br>Surgeries  | Sinusotomy, Frontal,<br>Endoscopic: 31276<br>Sinusotomy, Maxillary:<br>31256, 31267<br>Balloon Ostial Dilatation:<br>31295 31296, 31297, 31298<br>Ethmoidectomy,<br>Endoscopic: 31253, 31254,<br>31255, 31257, 31259  | InterQual® Criteria Used. See Endoscopic Sinus Surgeries MNG for details on the Provider Resource Center  |
| Gender Affirming<br>Services   | 11970, 11971, 15769, 15771- 15774, 15820-15823, 15876- 17380, 17999, 19303, 19318, 19325, 19350, 21120-21123, 21125, 21127, 21137-21139, 21208- 21210, 21282, 30400, 30410, 30420, 30430, 30435, 30450, 31599, 31750, 40799, 53410, 53415, 53420, 53425, 54300, 54400, 54401, 54405, 54520, 54660, 54690, 55175, 55180, 55899, 55970, 55980, 56620 56625, 56800, 56805, 56810, 57106, 57110, 57291, 57292, 57335, 58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541- 58544, 58550, 58552- 58554, 58570- 58573, 58661, 58720, 58940, 58999, 67900  ICD-10: F64-F64.9, Z87.890 | Internal criteria is used. See Gender Affirming Services MNG for details on the Provider Resource Center  |
| Hematopoietic Stem-<br>Cell Transplantation<br>(HSCT)  | 38204- 38207, 38230, 38232, 38240, 38241, 38243   | CMS Criteria Used for the following indications: Leukemia, Aplastic Anemia, Amyloidosis, Hodgkin's Disease, Severe Combined Immunodeficiency (multiple types), Wiskott-Aldrich Syndrome, Multiple Myeloma, Myelodysplastic Syndrome, Myelofibrosis, Neuroblastoma, Non- Hodgkin's Lymphoma, and |

| Service                                     | Procedure Codes                             | Criteria Reference   |
|---|---|--|
| 2311100                                     | 111000000                                   | Sickle Cell Disease  |
|   |   | NCD - Stem Cell Transplantation (Formerly                                  |
|   |   | 110.8.1) (110.23)  |
|   |   |  |
|   |   | For all other indications, internal  |
|   |   | criteria is used. See  |
|   |   | Hematopoietic Stem Cell  |
|   |   | Transplantation MNG for details  |
|   |   | on the Provider Resource   |
|   |   | <u>Center</u> .  |
| High-Cost Durable                           |   | CMS and MassHealth Criteria Used:  |
| Medical Equipment                           | Strollers: E1231-E1238                      | Strollers:   |
| (DME), Adaptive                             |   | LCD - Manual Wheelchair Bases (L33788)                                     |
| Strollers and Speech                        |   | and Article - Manual Wheelchair Bases -                                    |
| Generating Devices                          |   | Policy Article (A52497)  |
|   | Speech generating devices:                  | Speech generation devices:   |
|   | E2500, E2502, E2504, E2506,                 | LCD - Speech Generating Devices (SGD)                                      |
|   | E2508, E2510, E2511, E2512,                 | (L33739) and MassHealth Guidelines for                                     |
|   | E2599                                       | Augmentative and Alternative   |
|   |   | Communication Devices, Including Speech-                                   |
|   |   | Generating Devices   |
| Home Health Care                            | G0151- G0153, G0155-                        | MassHealth Criteria Used:  |
| Services for Tufts                          | G0158, G0162, G0299,                        | MassHealth Guidelines for Medical  |
| Health Together, Tufts                      | G0300, G0493, G0494,                        | Necessity Determination for Home Health                                    |
| Health RI Together,                         | G2168, G2169, T1002, T1003,                 | Services   |
| and One Care                                | T1502, T1503, 99501, 99211<br>T2042-T2046   | CMC and Manal In althought and I lead                                      |
| Hospice Services for Tufts Health Together, | Revenue Codes: 0650, 0651,                  | CMS and MassHealth Criteria Used: Medicare Benefit Policy Manual Chapter 9 |
| Tufts Health RI                             | 0652, 0659                                  | and Hospice Manual for MassHealth  |
| Together and Tufts                          | 0032, 0039                                  | Providers  |
| Health One Care                             |   | Tioviders  |
| Human Leukocyte                             | 81370-81383                                 | InterQual® Criteria Used. See Human  |
| Antigen Genotyping                          | 0.0.000                                     | Leukocyte Antigen Genotyping for Tufts                                     |
| for Tufts Health Direct,                    |   | Health Direct, Tufts Health Together, Tufts                                |
| Tufts Health Together,                      |   | Health RI Together, Tufts Health One Care                                  |
| Tufts Health RI                             |   | MNG for details on the Provider Resource                                   |
| Together, Tufts Health                      |   | Center   |
| One Care                                    |   |  |
| Hyperbaric Oxygen                           | 99183, G0277                                | CMS Criteria Used:   |
| Treatment                                   |   | NCD - Hyperbaric Oxygen Therapy (20.29)                                    |
| Hysterectomy, Certain                       | Hysterectomy, Abdominal,                    | CMS Criteria and InterQual® used:  |
| Elective                                    | <b>+/- BSO</b> : 58150, 58152               |  |
|   | Hysterectomy, Vaginal, +/-                  | Hysterectomy for injury of illness:  |
|   | <b>BSO:</b> 58260, 58262                    | Article - Sterilization (A59060)   |
|   | 58270, 58290, 58291                         | Libertan demonstration all all and the second                              |
|   | Hysterectomy,                               | Hysterectomy for all other indications:                                    |
|   | Laparoscopically Assisted                   | InterQual criteria is used. See Hysterectomy,                              |
|   | Vaginal (LAVH), +/- BSO:                    | Certain Elective MNG for details on the                                    |
|   | 58263, 58290- 58292, 58294,                 | Provider Resource Center   |
|   | 58550, 58552- 58554<br><b>Hysterectomy,</b> |  |
|   | Open/Laparoscopic                           |  |
|   | Supracervical (LSH), +/-                    |  |
|   | BSO:  |  |
|   | DOU:  |  |

| Service  | Procedure Codes  | Criteria Reference   |
|--|--|--|
|  | 58180- 58544 Hysterectomy, Total Laparoscopic (TLH), +/- BSO: 58570-58573  |  |
| Intensity Modulated<br>Radiation Therapy           | 77385, 77386, G6015, G6016   | Internal criteria is used. See Intensity Modulated Radiation Therapy MNG on the Provider Resource Center.  |
| Implantable<br>Neurostimulators                    | <b>Gastric Stimulation:</b> 43647, 43881, 64590  | Gastric Stimulation: InterQual criteria is used: See Implantable Neurostimulators MNG for details on the Provider Resource Center  |
|  | Stereotactic Introduction,<br>Subcortical Electrodes:<br>617202, 61850, 61860, 61863,<br>61864, 61867, 61868, 61885,<br>61886, 61889   | Stereotactic Introduction, Subcortical Electrodes: NCD - Electrical Nerve Stimulators (160.7)  |
|  | Spinal Cord Stimulator<br>Insertion: 63650, 63655,<br>63663, 63685   | Spinal Cord Stimulator Insertion: NCD -<br>Electrical Nerve Stimulators (160.7)  |
| Inpatient Acute and                                | Sacral Nerve Stimulator for Urinary Incontinence Temporary Trail and Permanent: 64561, 64581 Sacral Nerve Stimulator for Fecal Incontinence Temporary Trail and Permanent: 64561, 64581  Vagus Nerve Stimulation: 61885, 61886, 61888, 64553, 64568  See Inpatient Acute Level of  | Sacral nerve Stimulator for Urinary Incontinence Temporary Trail and Permanent: NCD - Sacral Nerve Stimulation For Urinary Incontinence (230.18) Sacral nerve Stimulator for Fecal Incontinence Temporary Trail and Permanent: Internal Criteria Used. See Implantable Neurostimulators MNG for details on the Provider Resource Center Vagus Nerve Stimulation: NCD - Vagus Nerve Stimulation (VNS) (160.18)  CMS and InterQual® Criteria Used: |
| Post-Acute Levels<br>of Care<br>(Medical/Surgical) | Care MNG for details on the Provider Resource Center   | Medicare Benefit Policy Manual Chapter 1 and Chapter 6. See Inpatient Acute and Post Acute Levels of Care (Medical/ Surgical) MNG for InterQual details on the Provider Resource Center.   |
| Lower Limb<br>Prostheses                           | L5000 - L5020, L5050 - L5060, L5100 - L5105, L5150 - L5160, L5200 - L5230, L5250 - L5270, L5280 - L5341, L5500 - L5505, L5510 - L5600, L5610 - L5617, L5618 - L5629, L5630 - L5653, L5654 - L5699, L5700 - L5707, L5710 - L5783, L5785 - L5795, L5810 - L5858, L5910 - L5968, L5970 - L5973, L5974 - L5999, L5856 L5857, L5858, L5973, L7510 L7520 | CMS Criteria Used: Basic coverage determinations: LCD - Lower Limb Prostheses (L33787)  Internal Coverage criteria for microprocessors of the knee and ankle/ foot. See Lower Limb Protheses MNG for details on the Provider Resource Center   |
| Magnetic Resonance<br>Elastography (MRE)           | 76391  | Internal criteria is used. See Magnetic Resonance Elastography (MRE) for Chronic   |

| Service  | Procedure Codes   | Criteria Reference  |
|--|---|---|
| for Chronic Liver  |   | Liver Disease on the Provider Resource  |
| Disease  |   | <u>Center</u>   |
| Manual Wheelchairs<br>for Tufts Health<br>Together, Tufts Health<br>RI Together and Tufts<br>Health One Care | K0003-K0007, E1161  | CMS criteria used: LCD - Manual Wheelchair<br>Bases (L33788) and Article - Manual<br>Wheelchair Bases - Policy Article (A52497)   |
| Minimally Invasive   | Cryoablation, Prostate:   | CMS and InterQual criteria is used:   |
| Procedures for the Treatment of Benign Prostatic Hypertrophy   | Water vapor therapy: 53854 Urethral Lift: 52540-52441 Prostatectomy, Transurethral Ablation (TUNA): 53850, 53852, 52450 Water Vapor Therapy, Aquablation: 0421T and C2596   | Cryoablation, prostate: NCD - Cryosurgery of Prostate (230.9) Water Vapor Therapy, Aquablation: LCD - Fluid Jet System Treatment for LUTS/BPH (L38367) and Article - Billing and Coding: Fluid Jet System Treatment for LUTs/BPH (A56797) All others InterQual criteria is used. See Minimally Invasive Procedures for the Treatment of Benign Prostatic Hypertrophy MNG for details on the Provider Resource |
| 11.11.0.4.11.4   |   | Center  |
| Mobile Outpatient Cardiac Telemetry (MOCT)   | 93228, 93229  | InterQual® Criteria Used. See Mobile Outpatient Cardiac Telemetry (MOCT) MNG for details on the Provider Resource Center  |
| Non-Emergency  | A0425 A0426, A0428, A0430,  | CMS Manual used:  |
| Medical  | A0431, A0435  | Medicare Benefit Policy Manual Chapter 10   |
| Transportation:<br>Ground/ Air   | PA is not required when<br>submitted with one of the<br>following modifiers: DH, EH,<br>GH, HD, HG, HH, HJ, JH, NR,<br>PH, RH, RN   |   |
| Orthognathic Surgery<br>for Severe Oral-<br>Maxillofacial<br>Functional Disorders                            | Bone Augmentation, Mandible: 21125, 21127 Bone Augmentation, Maxilla: 21208 Orthognathic Surgery: 21120, 21121, 21122, 21123, 21141, 21142, 21143, 21145, 21146, 21147, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21215, 21244, 21245, 21215, 21299 Orthognathic Surgery (Pediatric): 21141, 21142, 21143, 21145, 21146, 21147, 21195, 21196 Additional codes: 21209, 21210, 21230, D7940, D7941, D7943-D7947, D7950, D7993-D7996 | InterQual® Criteria Used. See Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders MNG for modifications on the Provider Resource Center   |
| Osteogenesis<br>Stimulators,<br>Noninvasive  | Osteogenesis Stimulator,<br>Electrical Noninvasive, Not<br>Spinal Application: E0747,<br>20974  | CMS criteria used: NCD - Osteogenic<br>Stimulators (150.2), LCD - Osteogenesis<br>Stimulators (L33796), and Article -<br>Osteogenesis Stimulators - Policy Article<br>(A52513)  |

| Service                                      | Procedure Codes  | Criteria Reference  |
|--|--|---|
|  | Osteogenesis Stimulator,                                 |   |
|  | Electrical Noninvasive,                                  |   |
|  | Spinal Application: E0748,                               |   |
|  | 20974  |   |
|  | Osteogenesis Stimulator,                                 |   |
|  | Low Intensity Ultrasound,<br>Noninvasive: E0760, 20979   |   |
| Out-of-Network                               | See Inpatient Acute Level of                             | CMS CY24 requirements used: 42 CFR  |
| Coverage at the In-                          | Care MNG for details on the                              | 422.112(b)  |
| Network Level of                             | Provider Resource Center                                 | 122.112(0)  |
| Benefits and                                 |  |   |
| Continuity of Care (All                      |  |   |
| Plans)                                       |  |   |
| Outpatient Physical                          | PT eval: 97161-97165                                     | CMS Criteria used: LCD - Outpatient   |
| Therapy, Occupational                        | <b>OT eval</b> : 97165-97168                             | Physical and Occupational Therapy Services  |
| Therapy and Speech                           | <b>ST</b> : 92507, 92508, 92521,                         | (L34049) and Article - Billing and Coding:  |
| Therapy                                      | 92522- 92524, 92526, 92610<br>Additional codes: 97010,   | Outpatient Physical and Occupational Therapy Services (A56566)                    |
|  | 97012, 97014, 97016, 97018,                              | Therapy dervices (Addadd)   |
|  | 97022, 97024, 97026, 97028,                              |   |
|  | 97032-97036, 97039, 97110,                               |   |
|  | 97112, 97113, 97116, 97124,                              |   |
|  | 97129, 97130, 97139, 97140,                              |   |
|  | 97150, 97530, 97533, 97535,                              |   |
|  | 97542, 97750, 97755, 97760,                              |   |
| Ovugon and                                   | 97761, 97763  Home Oxygen Therapy,                       | CMS Criteria is used: LCD - Oxygen and  |
| Oxygen and Respiratory Therapy               | Portable System: E0430,                                  | Oxygen Equipment (L33797) and Article -   |
| Equipment                                    | E0431, E0433, E0434, E0435,                              | Oxygen and Oxygen Equipment - Policy  |
|  | E0443, E0444, E1391, K0738                               | Article (A52514)  |
|  | Home Oxygen Therapy,                                     | , , ,   |
|  | Stationary System: E0424,                                |   |
|  | E0425, E0439- E0442, E1390,                              |   |
| Percutaneous                                 | E1391<br>64566   | CMS criteria used: LCD - Posterior Tibial   |
| Posterior Tibial Nerve                       | 04300  | Nerve Stimulation for Voiding Dysfunction   |
| Stimulation (PTNS)                           |  | (L33396) and Article - Billing and Coding:  |
|  |  | Posterior Tibial Nerve Stimulation for Voiding                                    |
|  |  | Dysfunction (A57453)  |
| Positive Airway                              | E0470, E0471, E0601                                      | CMS criteria is used: LCD - Positive Airway                                       |
| Pressure (PAP)                               |  | Pressure (PAP) Devices for the Treatment of                                       |
| Devices for Tufts                            |  | Obstructive Sleep Apnea (L33718) and  |
| Health RI Together and Tufts Health One      |  | Article - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive |
| Care   |  | Sleep Apnea - Policy Article (A52467)   |
| Power Operated                               | K0800, K0801, K0802, K0806,                              | CMS criteria used: LCD - Power Mobility   |
| Vehicles (POVs) for                          | K0807, K0808   | Devices (L33789 and Article - Power Mobility                                      |
| Tufts Health Together,                       |  | Devices - Policy Article (A52498)   |
| Tufts Health RI                              |  |   |
| Together and Tufts                           |  |   |
| Health One Care                              | K0010 K0011 K0012 K0001                                  | CMS critoria in upodu LCD - Davier Makiliki                                       |
| Power Wheelchairs for Tufts Health Together, | K0010- K0014, K0813- K0864,<br>K0868-K0886, K0890-K0891, | CMS criteria is used: LCD - Power Mobility Devices (L33789), NCD - Seat Elevation |
| Tufts Health RI                              | 10000-10000, 10000-10001,                                | Equipment (Power Operated) on Power   |
| านเงาเธลเนาเป                                | 1  | Legalphilient (1 ower Operated) on Fower  |

| Service              | Procedure Codes               | Criteria Reference                           |
|----------------------|-------------------------------|--|
| Together and Tufts   | K0898, K0899, E1002-E1012,    | Wheelchairs (280.16), LCD - Wheelchair       |
| Health One Care      | E2298, E2301, E2610           | Options/Accessories (L33792), and NCD -      |
| Treattr One Care     | L2290, L2301, L2010           | Mobility Assistive Equipment (MAE) (280.3)   |
| Procedures for the   | Endovenous Ablation, Lower    | CMS criteria is used:                        |
| Treatment of         | Extremity Superficial Truncal | LCD - Treatment of Varicose Veins of the     |
| Symptomatic Varicose | or Perforator Vein: 36473,    | Lower Extremities (L34536), LCD - Varicose   |
| Veins                | 36474, 36475, 36476, 36478,   | Veins of the Lower Extremity, Treatment of   |
| Venis                | 36479                         | (L33575), Article - Billing and Coding:      |
|                      | Phlebectomy, Lower            | Treatment of Varicose Veins of the Lower     |
|                      | Extremity Superficial         | Extremities (A56914), and Article - Billing  |
|                      | Tributary Varicose Vein:      | and Coding: Treatment of Varicose Veins of   |
|                      | 37765, 37766                  | the Lower Extremity (A52870)                 |
|                      | Ligation and Division +/-     | the Lower Extremity (A32070)                 |
|                      | Stripping or Excision, Lower  |  |
|                      | Extremity Superficial Vein:   |  |
|                      | 37700, 37718, 37722, 37780,   |  |
|                      | 37785                         |  |
|                      | Subfascial Endoscopic         |  |
|                      | Perforator Surgery (SEPS):    |  |
|                      | 37500, 37735, 37760           |  |
|                      | Sclerotherapy, Lower          |  |
|                      | Extremity Superficial         |  |
|                      | Tributary Varicose Vein:      |  |
|                      | 36465, 366466, 36470, 36471,  |  |
|                      | S2202, 36482, 36483           |  |
| Proton Beam Therapy  | 77520, 77522, 77523, 77525    | CMS criteria is used: LCD - Proton Beam      |
| (PBT)                | 77020, 77022, 77020, 77020    | Therapy (L35075) and Article - Billing and   |
| (. 2.)               |                               | Coding: Proton Beam Therapy (A56827)         |
| Reconstructive and   | General Cosmetic and          | CMS, MassHealth, InterQual, and Internal     |
| Cosmetic Surgery     | Reconstructive Surgery:       | Criteria is used.                            |
|                      | 15836, 15839, 15877- 15879    |  |
|                      | (ICD-10 codes B20, E88.1)     | CMS criteria used for: General Cosmetic and  |
|                      | Rhinoplasty: 30400, 30410,    | Reconstructive Surgery, Rhinoplasty,         |
|                      | 30420, 30430, 30435, 30450    | Gynecomastia, Breast Implant Removal,        |
|                      | Gynecomastia: 19300           | Breast Reduction, Panniculectomy LCD -       |
|                      | Breast Implant Removal:       | Cosmetic and Reconstructive Surgery          |
|                      | 19328, 19330, 19370, 19371    | (L39051) and Article - Billing and Coding:   |
|                      | Breast Reconstruction/        | Cosmetic and Reconstructive Surgery          |
|                      | Reduction: 19316, 19318,      | (A58774)                                     |
|                      | 19340, 19342, 19355, 19357,   |  |
|                      | 19361, 19364, 19367, 19369    | MassHealth criteria is used for Redundant    |
|                      | Panniculectomy: 15830,        | Skin MassHealth Guidelines for Excision of   |
|                      | 15838, 15839                  | Excessive Skin and Subcutaneous Tissue       |
|                      | Redundant Skin: 15831-        | Mass.gov                                     |
|                      | 15835, 15837, 15838, 15839    |  |
|                      | Scar revision: 0479T, 0480T,  | InterQual criteria is used for Scar Revision |
|                      | 11042, 11043, 11400, 11401-   |  |
|                      | 11404, 11406, 11420- 11424,   | Internal criteria is used for: Hemangioma,   |
|                      | 11426, 11440-11444, 11446,    | Port Wine Stain Treatment, Hair Removal,     |
|                      | 13100-13102, 13120-1322,      | Labiaplasty, and Liposuction for Lipedema.   |
|                      | 13131-13132, 13151, 13152     | See Reconstructive and Cosmetic Surgery      |
|                      | (ICD-10 codes L90.5, L91.0)   | MNG for details on the Provider Resource     |
|                      | Hemangioma/ Port Wine         | <u>Center</u>                                |
|                      | Treatment: 17106-17108        |  |
|                      |                               |  |

| Service  | Procedure Codes   | Criteria Reference  |
|--|---|---|
|  | Hair Removal: 17380, 17999<br>(ICD-10 codes F64-F64.9,<br>Z87,890)<br>Labiaplasty: 56620 (ICD-10<br>codes N90.60, N90.61,<br>N90.69)<br>Liposuction for Lipedema:<br>15878, 15879 |   |
| Solid Organ<br>Transplant: Heart   | 33940, 33944, 33945   | CMS and MassHealth criteria used:<br>NCD - Heart Transplants (260.9) and<br>MassHealth Guidelines for Organ Transplant<br>Procedures  |
| Solid Organ Transplant: Intestinal (Small Bowel, Simultaneous Small Bowel-Liver) and Multivisceral | 44132, 44133, 44135, 44136,<br>44715, 44720, 44721  | CMS and MassHealth criteria used: NCD - Intestinal and Multi-Visceral Transplantation (260.5) and MassHealth Guidelines for Organ Transplant Procedures   |
| Solid Organ<br>Transplant: Kidney  | 50300, 50320, 50323, 50325,<br>50327- 50329, 50340, 50360,<br>50365, 50370, 50380, 50547  | MassHealth criteria is used: MassHealth<br>Guidelines for Organ Transplant Procedures   |
| Solid Organ<br>Transplant:<br>Liver  | 47135, 47140-47147  | CMS and MassHealth criteria is used: NCD -<br>Adult Liver Transplantation (260.1) and<br>MassHealth Guidelines for Organ Transplant<br>Procedures   |
| Solid Organ<br>Transplant:<br>Lung   | 32850- 32856, 33930, 33933,<br>33935  | MassHealth criteria is used: MassHealth<br>Guidelines for Organ Transplant Procedures   |
| Solid Organ Transplant: Pancreas- Kidney Pancreas Transplant and Pancreas Islet Cell Transplant    | 48160, 48550-48552, 48554, 50300, 0548T, 0585T, 0586T   | CMS and MassHealth criteria used: NCD -<br>Pancreas Transplants (260.3) and<br>MassHealth Guidelines for Organ Transplant<br>Procedures   |
| Stereotactic<br>Radiosurgery and<br>Stereotactic Body<br>Radiotherapy                              | 61796, 61797, 61798, 63620,<br>63621, 77371-77373, 77432,<br>77435, G0339, G0340  | CMS criteria is used: LCD - Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L35076) and Article - Billing and Coding: Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (A56874) |

| Service  | Procedure Codes  | Criteria Reference   |
|--|--|--|
| Surgical Procedures<br>for the Treatment<br>Obstructive Sleep<br>Apnea     | Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement, and Hyoid Suspension: 21193-21196, 21198, 21206 Uvuloplatopharyngoplasty (UPPP): 41245  Hypoglossal Nerve               | CMS and Internal criteria is used. CMS criteria is used for: maxillomandibular Advancement (MMA)/ Mandibular Advancement (MA), Genioglossus Advancement (GA)/Hyoid Suspension, and uvulopalatopharyngoplasty (UPPP): LCD - Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526)  Internal Criteria is used for Hypoglossal   |
|  | <b>Stimulation:</b> 64568, 64582-64584   | Nerve Stimulation. See Surgical Procedures for the Treatment Obstructive Sleep Apnea MNG for details on the Provider Resource Center   |
| Surgical Treatments<br>for Lymphedema and<br>Lipedema                      | 15832, 15833, 15836, 15839,<br>15877- 15879, 38999<br>ICD-10 codes: I89.0, E65,<br>E88.2, Q82.0  | Internal Criteria is used. See Surgical Treatments for Lymphedema and Lipedema MNG for details on the Provider Resource Center   |
| Temporomandibular<br>Joint (TMJ) Disorder<br>Treatment                     | Arthroplasty, Temporomandibular Joint (TMJ): 21240, 21242, 21243 Arthroplasty, Temporomandibular Joint (TMJ): 29800, 29804 Arthroplasty, Temporomandibular Joint (TMJ): 21193-21196, 21244- 21249, 21255 | InterQual is used. See Temporomandibular Joint (TMJ) Disorder Treatment MNG for details on the Provider Resource Center  |
| Tonic Motor Activation<br>for the Treatment of<br>Restless Leg<br>Syndrome | A4544, E0743   | Internal criteria is used. See Tonic Motor Activation for the Treatment of Restless Leg Syndrome MNG on the Provider Resource Center   |
| Upper Limb Prosthesis  | L6000-L6020, L6026, L6028-<br>L6039, L6050- L6714, L6721-<br>L6810, L6880-L7406, L7499,<br>L7510, L7520  | Internal Criteria is used. See Upper Limb Prothesis MNG for details on the Provider Resource Center  |
| Vertebroplasty and<br>Kyphoplasty  | 22510-22515  | CMS and InterQual criteria is used. CMS criteria is used for vertebroplasty or kyphoplasty for osteoporotic vertebral compression factures: LCD - Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569) InterQual is used for all other vertebroplasty or kyphoplasty indications. See Vertebroplasty and Kyphoplasty MNG for details on the Provider Resource Center |
| Video Capsule<br>Endoscopy   | 91110, 91111, 91299  | MassHealth criteria is used: MassHealth<br>Guidelines for Capsule Endoscopy  |

# 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 857-304-6304.

| Service                  | Procedure Codes     | Criteria Reference                     |
|--------------------------|---------------------|--|
| Psychological and        | 96130, 96131, 96132 | Medicare Behavioral Health InterQual®  |
| Neuropsychological       | 96133, 96136, 96137 | Criteria Used. See Psychological and   |
| Testing and Assessment   | 96138, 9613, 96146  | Neuropsychological Testing and         |
|                          |                     | Assessment MNG for InterQual details   |
|                          |                     | on the Provider Resource Center        |
| Transcranial Magnetic    | 90867, 90868, 90869 | Medicare Behavioral Health InterQual®  |
| Stimulation (TMS) for    |                     | Criteria Used. See Transcranial        |
| Tufts Health OneCare,    |                     | Magnetic Stimulation (TMS) for Tufts   |
| Tufts Medicare Preferred |                     | Health OneCare, Tufts Medicare         |
| and Tufts Health Plan    |                     | Preferred and Tufts Health Plan Senior |
| Senior Care Options      |                     | Care Options MNG for InterQual details |
| ·                        |                     | on the Provider Resource Center        |

## TABLE 3

The following Medicaid-only covered procedures, services, items and associated procedure codes that require prior authorization through the Precertification Operations Department. Prior authorization requests may be submitted by fax to 857-304-6304.

| Service            | Procedure Codes                      | Medicaid Reference  |
|--------------------|--------------------------------------|---|
| Home Accessibility | S5165                                | MassHealth Criteria Used:   |
| Adaptations        |                                      | 130 CMR 630.00: Home- and Community-Based   |
|                    |                                      | Services Waiver Services  |
| Long-Term Services | 99509, G0156, H0043,                 | MassHealth Criteria Used:   |
| & Supports (LTSS)  | H2014, S5100, S5101,                 | Home Care (including Grocery and delivery   |
| for One Care       | S5102, S5120, S5121,                 | services, Home delivered meals) 651 CMR 3.00:   |
|                    | S5130, S5131, S5135,                 | Home Care Program   |
|                    | S5136, S5140, S5165,                 | Adult Foster Care and Group Adult Foster Care:  |
|                    | S5170, S5175, S9977,<br>T1999, T1019 | 130 CMR 408.000: Adult Foster Care <b>Adult Day Health:</b> 130 CMR 404.00: Adult Day |
|                    | 1 1999, 11019                        | Health Services   |
|                    |                                      | Home and Community Based Services   |
|                    |                                      | (including Chores Service, Companion Service,   |
|                    |                                      | Home Health Aide, Homemaker, Independent  |
|                    |                                      | Living Skills Training, Personal Care Services,                                       |
|                    |                                      | Supportive Home Care Aide, Laundry Services)  |
|                    |                                      | 130 CMR 630.00: Home- and Community-Based   |
|                    |                                      | Services Waiver Services  |
|                    |                                      | <b>Day Habilitation:</b> 101 CMR 348.00: Rates for Day                                |
|                    |                                      | Habilitation Services   |
|                    |                                      | Home Health: Home Health Agency Bulletin 54   |
|                    |                                      | Personal Care Attendant:  |
|                    |                                      | 130 CMR 422.00: Personal care Attendant Services                                      |
|                    |                                      | Billing and administration:   |
|                    |                                      | 130 CMR 450.000: Administrative and Billing   |
| Poonito            | H0045 T1005 S5150                    | Regulations Magallanth criteria is used   |
| Respite            | H0045, T1005, S5150,<br>S5151        | MassHealth criteria is used.<br>130 CMR 630.00: Home- and Community-Based             |
|                    | 33131                                | Services Waiver Services  |
|                    |                                      | Services vialiter Services  |

## **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 <u>Provider resource center.</u> 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 | Criteria Reference   |
|---------------------------------------|-----------------|--|
| Abecma                                | Q2055           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |
| Amtagvi                               | J3490           | See Amtagvi MNG on the <u>Provider Resource</u><br><u>Center.</u>  |
| Adstiladrin                           | J9029           | See Adstiladrin MNG on the <u>Provider Resource</u><br><u>Center.</u>  |
| Aucatzyl                              | Q2058           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |
| Breyanzi                              | Q2054           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |
| Carvykti                              | Q2056           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |
| Casgevy                               | J3392           | See Casgevy MNG on the Provider Resource Center.   |
| CGM: Freestyle and<br>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 |
| Encelto                               | J3403           | See Encelto MNG on the <u>Provider Resource</u><br>Center.   |
| Hemgenix                              | J1411           | See Hemgenix MNG on the Provider Resource Center.  |
| Kebilidi                              | J3590           | See Kebilidi MNG on the <u>Provider Resource</u><br><u>Center.</u>   |
| Kymriah                               | Q2042           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |
| Lyfgenia                              | J3394           | See Lyfgenia MNG on the Provider Resource Center.  |
| Omisigre                              | J3590           | See Omisigre MNG on the Provider Resource Center.  |
| Roctavian                             | J1412           | See Roctavian MNG on the Provider Resource Center.   |
| Tecartus                              | Q2053           | CMS Criteria Used:<br>NCD - Chimeric Antigen Receptor (CAR) T-cell<br>Therapy (110.24)   |

| Service  | Procedure Codes | Criteria Reference                           |
|----------|-----------------|--|
| Tecelra  | Q2057           | See Tecelra MNG on the Provider Resource     |
|          |                 | <u>Center.</u>                               |
| Vyjuvek  | J3401           | See Vyjuvek MNG on the Provider Resource     |
|          |                 | <u>Center.</u>                               |
| Yescarta | Q2041           | CMS Criteria Used:                           |
|          |                 | NCD - Chimeric Antigen Receptor (CAR) T-cell |
|          |                 | Therapy (110.24)                             |
| 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                       |
|------------------------|------------------------------|--|
| Evolent Cardiology     | See Evolent website for full |  |
| Expansion              | details RADMD   Tufts Health |  |
|                        | <u>Plan</u>                  |  |
| Genetic and Molecular  | See Carelon for coding       | Managed by Carelon                       |
| Diagnostic Testing for |                              | Current Genetic Testing Guidelines       |
| Tufts Health Direct,   |                              | Carelon Clinical Guidelines and Pathways |
| Tufts Health Together, |                              | (carelonmedicalbenefitsmanagement.com)   |
| Tufts Health RI        |                              |  |
| Together, Tufts Health |                              |  |
| One Care               |                              |  |
| Outpatient Diagnostic  | See Evolent for coding       | Managed by Evolent                       |
| Imaging/ Advanced      |                              | Welcome to RadMD.com   RADMD             |
| Imaging                |                              |  |
| Whole Genome           | 81425- 81427                 | Managed by Carelon                       |
| Sequencing             |                              | Current Genetic Testing Guidelines       |
|                        |                              | Carelon Clinical Guidelines and Pathways |
|                        |                              | (carelonmedicalbenefitsmanagement.com)   |

# **TABLE 6**

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

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

| Notification Required                            | Yes ⊠ No □ |
|--|------------|
| IF <u>REQUIRED</u> , concurrent review may apply |            |

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 7**

The following procedure codes require notification from the Precertification Operations Department. Prior authorization requests may be submitted by fax to 857-304-6304.

| Service                | Procedure Codes | Criteria Reference                |
|------------------------|-----------------|-----------------------------------|
| Acute Hospital at Home | See MNG         | See Acute Hospital at Home MNG on |
|                        |                 | the Provider Resource Center      |

### **TABLE 8**

The following procedure codes require notification through the Behavioral Health Department. Notifications can be sent by fax to 857-304-6304.

| Service                   | Procedure Codes    | Criteria Reference                               |
|---------------------------|--------------------|--|
| Behavioral Health         | See MNG            | InterQual® and American Society of Addictive     |
| Inpatient and 24-Hour     |                    | Medicine (ASAM) criteria is used. See            |
| Level of Care             |                    | Behavioral Health Inpatient and 24-Hour Level of |
| Determinations            |                    | Care Determinations MNG for details on the       |
|                           |                    | Provider Resource Center                         |
| Behavioral Health Level   | See MNG            | InterQual® and American Society of Addictive     |
| of Care for Non 24 Hour/  |                    | Medicine (ASAM) criteria is used. See            |
| Intermediate/Diversionary |                    | Behavioral Health Level of Care for Non 24       |
| Services                  |                    | Hour/ Intermediate/Diversionary Services MNG     |
|                           |                    | for details on the Provider Resource Center      |
| Community Support         | H2015, H2016-HH,   | MassHealth criteria represented on an internal   |
| Programs including        | H2016-HK, H2016-HE | MNG. See Community Support Programs              |
| Specialized Community     |                    | including Specialized Community Support          |
| Support Programs          |                    | Programs MNG for details on the Provider         |
|                           |                    | Resource Center                                  |
| Peer Recovery Coach       | H2016-HM           | MassHealth criteria represented on an internal   |
|                           |                    | MNG. See Peer Recovery Coach MNG on the          |
|                           |                    | Provider Resource Center                         |

# Prior Authorization Required

| Yes | $\Box$ | No  | X |
|-----|--------|-----|---|
| 100 | ш      | INO |   |

### **TABLE 9**

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

| Service                 | Procedure Codes          | Coverage Guideline            |
|-------------------------|--------------------------|-------------------------------|
| Absorbent Products      | T4521-T4537, T4539-T4544 | See Absorbent Products MNG on |
|                         |                          | the Provider Resource Center  |
| Balloon Dilation of the | 69705, 69706             | See Balloon Dilation of the   |
| Eustachian Tube         |                          | Eustachian Tube MNG on the    |
|                         |                          | Provider Resource Center      |

| Service                          | Procedure Codes              | Coverage Guideline  |
|----------------------------------|------------------------------|---|
| Behavioral Health: Acupuncture   | H0014                        | See Behavioral Health: Acupuncture                              |
| Detoxification Level of Care     |                              | Detoxification Level of Care MNG on                             |
|                                  |                              | the Provider Resource Center                                    |
| Behavioral Health: Opioid        | H0020, H004 with TF          | See Behavioral Health: Opioid                                   |
| Treatment Services (Methadone    | modifier, H0005 with HQ      | Treatment Services (Methadone                                   |
| Maintenance) Level of Care       | modifier, T1006 with HR      | Maintenance) Level of Care MNG on                               |
| Maintenance) Level of Gare       | modifier                     | the Provider Resource Center                                    |
| Breast Pumps                     | E0602-E0604                  | See Breast Pumps MNG on the                                     |
| breast rumps                     | 20002-20004                  | Provider Resource Center  |
| Cardiac Event Monitors           | 33285, 33286, 93224-         | See Cardiac Event Monitors MNG                                  |
| Cardiao Everit Monitors          | 93227, 93241-93248,          | on the Provider Resource Center                                 |
|                                  | 93268, 93270- 93272,         | on the <u>Freduct Resource Center</u>                           |
|                                  | 93285, 93290-93292,          |   |
|                                  | 93294-93298, C1764           |   |
| Cardiovascular Disease Risk      | N/A                          | See Cardiovascular Disease Risk                                 |
| Test                             | 1 177 1                      | Test MNG on the Provider Resource                               |
| 1000                             |                              | Center  |
| Clinical Trials: Routine Costs   | Modifiers: Q1, Q0            | See Clinical Trials: Routine Costs                              |
| Oliffical Trials. Routific Gosts | ICD-10: Z00.6                | MNG on the Provider Resource                                    |
|                                  | 10D-10. 200.0                | Center  |
| Enteral Nutrition, Digestive     | B4105, B4149, B4150,         | See Enteral Nutrition, Digestive                                |
| Enzyme Cartridges and Special    | B4152- B4155, B4157-         | Enzyme Cartridges and Special                                   |
| Medical Formulas for Tufts       | B4162                        | Medical Formulas for Tufts Health                               |
| Health Together and Tufts        | D4 102                       |   |
| Health One Care                  |                              | Together and Tufts Health One Care MNG on the Provider Resource |
| Health One Care                  |                              | Center Provider Resource  |
| Fecal Microbial Transplant       | G0455, 44705                 | See Fecal Microbial Transplant                                  |
| (FMT) for Clostridium Difficile  | 00433, 44703                 | (FMT) for Clostridium Difficile                                 |
| Infection                        | ICD-10: A04.71, A04.72       | Infection MNG on the Provider                                   |
| IIIIection                       | 10D-10. A04.71, A04.72       | Resource Center   |
| Hyperthermic Intraperitoneal     | 96549, 96547, 96548          | See Hyperthermic Intraperitoneal                                |
| Chemotherapy (HIPEC)             | 30040, 30047, 30040          | Chemotherapy (HIPEC)MNG on the                                  |
| Chemotherapy (Till EO)           |                              | Provider Resource Center  |
| Intravitreal Implants and        | 67027, 67028, J1096,         | See Intravitreal Implants and                                   |
| Corticosteroid Inserts for       | J7313, J7311, J7312, J7314   | Corticosteroid Inserts for Ophthalmic                           |
| Ophthalmic Conditions            | ICD-10 codes                 | Conditions on the Provider Resource                             |
|                                  | ICD-10 codes                 | Center Center   |
| Intraoperative                   | 95940, 95942, G0453          | See Intraoperative  |
| Neurophysiological               | 00040, 00042, 00400          | Neurophysiological Monitoring MNG                               |
|                                  |                              | on the Provider Resource Center                                 |
| Monitoring                       |                              |   |
| Mohs' Micrographic Surgery       | 17311-17315                  | See Mohs' Micrographic Surgery                                  |
| (MMS)                            |                              | (MMS) MNG on the <u>Provider</u>                                |
|                                  |                              | Resource Center   |
| Percutaneous Left Atrial         | 33340                        | See Percutaneous Left Atrial                                    |
| Appendage Closure to Reduce      |                              | Appendage Closure to Reduce                                     |
| Stroke Risk in Patients with     | ICD-10 codes: I48.0, I48.11, | Stroke Risk in Patients with Atrial                             |
| Atrial Fibrillation (Watchman    | I28.19, I48.20, I48.21       | Fibrillation (Watchman Device)MNG                               |
| Device)                          |                              | on the Provider Resource Center                                 |
| Peroral Endoscopic Myotomy       | 43497                        | See Peroral Endoscopic Myotomy                                  |
| for Treatment of Esophageal      |                              | for Treatment of Esophageal                                     |
| Achalasia (POEM)                 |                              | Achalasia (POEM) MNG on the                                     |
|                                  |                              | Provider Resource Center  |

| Service                                      | Procedure Codes       | Coverage Guideline                   |
|--|-----------------------|--------------------------------------|
| Program of Assertive                         | H0040                 | See Program of Assertive             |
| Community Treatment (PACT)                   |                       | Community Treatment (PACT)           |
| Services                                     |                       | Services MNG on the Provider         |
|  |                       | Resource Center                      |
| Recovery Support Navigator                   | H2015-HF              | See Recovery Support Navigator       |
|  |                       | MNG on the <u>Provider Resource</u>  |
|  |                       | <u>Center</u>                        |
| Remote Patient Monitoring Tufts              | 99091, 99453, 99454,  | See Remote Patient Monitoring Tufts  |
| Health Together, Tufts Health                | 99457, 99458          | Health Together, Tufts Health One    |
| One Care, and Tufts Health                   | ICD-10 codes          | Care, and Tufts Health Senior Care   |
| Senior Care Options                          |                       | Options MNG on the Provider          |
|  |                       | Resource Center.                     |
| Scanning Computerized                        | 92132, 92133, 92134   | See Scanning Computerized            |
| Ophthalmic Diagnostic                        | ICD-10 codes          | Ophthalmic Diagnostic                |
| Imaging (SCODI)                              |                       | Imaging (SCODI) MNG on the           |
|  |                       | Provider Resource Center             |
| Subcutaneous Implantable                     | 33270-33273           | See Subcutaneous Implantable         |
| Cardioverter Defibrillator (S-               |                       | Cardioverter Defibrillator (S-ICD)   |
| ICD)   |                       | MNG on the <u>Provider Resource</u>  |
|  |                       | <u>Center</u>                        |
| Temporary Total Artificial Heart             | 33927- 33929, Q0480   | See Temporary Total Artificial Heart |
| System Bridge to Transplant                  |                       | System Bridge to Transplant MNG      |
|  |                       | on the Provider Resource Center      |
| Transcatheter Mitral Valve                   | 33418, 33419, 0345T   | See Transcatheter Mitral Valve       |
| Repair (TMVR)                                |                       | Repair (TMVR) MNG on the Provider    |
|  |                       | Resource Center                      |
| Tumor Treating Fields (TTF)                  | E0766, A4555          | See Tumor Treating Fields (TTF)      |
|  |                       | MNG on the <u>Provider Resource</u>  |
|  |                       | Center                               |
| Upper Gastrointestinal                       | 43200, 43202, 43231,  | See Upper Gastrointestinal           |
| Endoscopy                                    | 43233, 43235, 43237,  | Endoscopy                            |
| (Esophagogastroduodenoscopy,                 | 43238, 43239, 432422, | (Esophagogastroduodenoscopy,         |
| EGD)   | 43259                 | EGD) MNG on the <u>Provider</u>      |
|  | ICD-10 codes          | Resource Center                      |
| Urine Drug Testing                           | 80305- 80307, G0480-  | See Urine Drug Testing MNG on the    |
| 10/01/                                       | G0483                 | Provider Resource Center             |
| UVB Home Units for Skin                      | E0691-E0694           | See UVB Home Units for Skin          |
| Disease                                      |                       | Disease MNG on the <u>Provider</u>   |
| \\ \( \) \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ | 20007 04000           | Resource Center                      |
| Vitamin B12 Screening and                    | 82607, 84999          | See Vitamin B12 Screening and        |
| Testing                                      | ICD-10 codes          | Testing MNG on the <u>Provider</u>   |
| \  |                       | Resource Center                      |
| Vitamin D Screening and                      | 82306, 82652          | See Vitamin D Screening and          |
| Testing                                      | ICD-10 codes          | Testing 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)
Subsequent changes and endorsements:

- 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
- December 13, 2024: Reviewed and approved by the UM Committee, the following changes were made in addition to administrative updates effective January 1, 2025:
  - Moved all links to the overview
  - Added PA to Resonance Elastography (MRE) for Chronic Liver Disease, 36473 and
     36474 under Varicose Veins, Water Vapor Therapy, Aquablation, and Omisigre
  - Updated Bariatric Surgery from MassHealth criteria to InterQual criteria, updated
     Varicose Veins coding groupings
  - Added expanded cardiology program under Evolent
  - Removed prior authorization from CAR-T administration codes
  - Added Acute Hospital at Home to notification section
  - Effective March 1, 2025: added PA to Basivertebral Nerve Ablation, Intensity Modulated Radiation Therapy,
- December 18, 2024: Reviewed by MPAC, the following changes were made in addition to administrative updates effective January 1, 2025:
  - Moved all links to the overview
  - Added PA to Resonance Elastography (MRE) for Chronic Liver Disease, 36473 and
     36474 under Varicose Veins, Water Vapor Therapy, Aguablation, and Omisigre
  - Updated Bariatric Surgery from MassHealth criteria to InterQual criteria, updated
     Varicose Veins coding groupings
  - Added expanded cardiology program under Evolent
  - o Removed prior authorization from CAR-T administration codes
  - Added Acute Hospital at Home to notification section
  - Effective March 1, 2025: added PA to Basivertebral Nerve Ablation, Intensity Modulated Radiation Therapy,
- January 1, 2025: Coding updated effective January 1, 2025: the following code was added for Casgevy: J3392.
- March 2025: Reviewed by the UM Committee
  - o removed 77301, 77387, 77338, G6017 under Intensity Modulated Radiation Therapy from prior authorization retroactive to January 1, 2025
  - removed codes 14040, 14041, 14301, 14302 under Gender Affirming Services from prior authorization effective March 1, 2025
  - o added Aucatzyl and Tecelra to table 4 effective April 1, 2025
  - 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(s) added to prior authorization under lower limb protheses in table 1: L5827, 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
- June 13, 2025: Reviewed and approved at UM Committee, updated Aucatzyl code per AMA HCPCS coding to Q2058, updated CGM coding to be in alignment with Medical Necessity Guideline (MNG), updated Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders coding to account for InterQual update, added coverage to code 61889 under implantable neurostimulator, removed COVID-19 Antibody Testing and COVID-19 Monoclonal Antibody Therapy MNG as they have been retired effective July 1, 2025
- June 13, 2025: Reviewed at UM Committee added no PA guidelines Intravitreal Implants and Corticosteroid Inserts for Ophthalmic Conditions effective September 1, 2025, and PA guideline for Tonic Motor Activation for the Treatment of Restless Leg Syndrome effective August 1, 2025
- June 18, 2025: Reviewed at MPAC, updated Aucatzyl code per AMA HCPCS coding to Q2058, updated CGM coding to be in alignment with MNG, updated Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders coding to account for InterQual update, added coverage to code 61889 under implantable neurostimulator, removed COVID-19 Antibody Testing and COVID-19 Monoclonal Antibody Therapy MNG as they have been retired effective July 1, 2025

- September 17, 2025: Reviewed by UM Committee added Dental Procedures Requiring Hospital/Facility-Based Care for Tufts Health Direct, Tufts Health Together, RITogether, and One Care to PA section effective October 1, 2025, added code A4238 to Continuous Glucose Monitoring and Diabetes Management Devices effective September 1, 2025
- October 1, 2025: Per CMS HCPCS the following codes added to prior authorization: L6034, L6035, L6036, L6038, L6039 under upper limb prosthesis, and L5783 added to prior authorization under lower limb prosthesis, effective October 1, 2025; added Encelto and Kebilidi to table 4 effective October 1, 2025.