Harvard Pilgrim Health Care | TUFTS Health Plan

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

Effective: April 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 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 One Care 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. Prior authorization requests may be submitted by fax to 857-304-6304.

Service	Procedure Codes	Criteria Reference
Anterior Vertebral Body Tethering	22836, 22837, 0656T, 0657T	Internal criteria is used. See Anterior Vertebral Body Tethering MNG for details on the Provider Resource Center
Bariatric Surgery	43644, 43645, 43770-43775, 43845-43848, 43860, 43865-43886-43888, 43999	InterQual® Criteria Used. See Bariatric Surgery MNG for details on the Provider Resource Center
Basivertebral Nerve Ablation	64628, 64629	CMS criteria used: LCD - Intraosseous Basivertebral Nerve Ablation (L39642) and Article - Billing and Coding: Intraosseous Basivertebral Nerve Ablation (A59466)
Blepharoplasty, Upper/Lower Eyelid, and Brow and/or Eyelid Ptosis Repair)	**Brow Ptosis Repair:** 67900 **Upper Eyelid Blepharoptosis Repair:** 67901, 67902, 67903, 67904, 67906, 67908, **Blepharoplasty, Upper Eyelid:** 15822, 15823, **Blepharoplasty, Lower Eyelid:** 15820, 15821	CMS Criteria Used: LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528) and Article - Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908)
Continuous Glucose Monitoring and Diabetes Management Devices	A4239, A9274, A9276, A9277, A9278, E2103	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

Service	Procedure Codes	Criteria Reference
		Necessity Guidelines for Diabetes Management Devices- Continuous Glucose Monitoring and Insulin Pumps
Custom Fabricated Oral Appliances for Obstructive Sleep Apnea (OSA)	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
Endoscopic Sinus Surgeries	**Sinusotomy, Frontal, Endoscopic:** 31276 **Sinusotomy, Maxillary:** 31256, 31267 **Balloon Ostial Dilatation:** 31295 31296, 31297, 31298 **Ethmoidectomy, Endoscopic:** 31253, 31254, 31255, 31257, 31259	InterQual® Criteria Used. See Endoscopic Sinus Surgeries MNG for details on the Provider Resource Center
Gender Affirming 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-Cell Transplantation (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 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

Service	Procedure Codes	Criteria Reference
		Transplantation MNG for details on the Provider Resource Center.
High-Cost Durable Medical Equipment (DME), Adaptive Strollers and Speech Generating Devices	**Strollers**: E1231-E1238 **Speech generating devices:** E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599	CMS and MassHealth Criteria Used: Strollers: LCD - Manual Wheelchair Bases (L33788) and Article - Manual Wheelchair Bases - Policy Article (A52497) Speech generation devices: LCD - Speech Generating Devices (SGD) (L33739) and MassHealth Guidelines for Augmentative and Alternative Communication Devices, Including Speech-Generating Devices
Home Health Care Services for Tufts Health Together, Tufts Health RI Together, and One Care	G0151- G0153, G0155-G0158, G0162, G0299, G0300, G0493, G0494, G2168, G2169, T1002, T1003, T1502, T1503, 99501, 99211	MassHealth Criteria Used: MassHealth Guidelines for Medical Necessity Determination for Home Health Services
Hospice Services for Tufts Health Together, Tufts Health RI Together and Tufts Health One Care	T2042-T2046 **Revenue Codes:** 0650, 0651, 0652, 0659	CMS and MassHealth Criteria Used: Medicare Benefit Policy Manual Chapter 9 and Hospice Manual for MassHealth Providers
Human Leukocyte Antigen Genotyping for Tufts Health Direct, Tufts Health Together, Tufts Health RI Together, Tufts Health One Care	81370-81383	InterQual® Criteria Used. See Human Leukocyte Antigen Genotyping for Tufts Health Direct, Tufts Health Together, Tufts Health RI Together, Tufts Health One Care MNG for details on the Provider Resource Center
Hyperbaric Oxygen Treatment	99183, G0277	CMS Criteria Used: NCD - Hyperbaric Oxygen Therapy (20.29)
Hysterectomy, Certain Elective	**Hysterectomy, Abdominal, +/- BSO:** 58150, 58152 **Hysterectomy, Vaginal, +/- BSO:** 58260, 58262 58270, 58290, 58291 **Hysterectomy, Laparoscopically Assisted Vaginal (LAVH), +/- BSO:** 58263, 58290- 58292, 58294, 58550, 58552- 58554 **Hysterectomy, Open/Laparoscopic Supracervical (LSH), +/- BSO:** 58180- 58544 **Hysterectomy, Total Laparoscopic (TLH), +/- BSO:** 58570-58573	CMS Criteria and InterQual® used: Hysterectomy for injury of illness: Article - Sterilization (A59060) Hysterectomy for all other indications: InterQual criteria is used. See Hysterectomy, Certain Elective MNG for details on the Provider Resource Center

Service	Procedure Codes	Criteria Reference
Intensity Modulated Radiation Therapy	77385, 77386, G6015, G6016	Internal criteria is used. See Intensity Modulated Radiation Therapy MNG on the Provider Resource Center.
Implantable Neurostimulators	**Gastric Stimulation:** 43647, 43881, 64590 **Stereotactic Introduction, Subcortical Electrodes:** 617202, 61850, 61860, 61863, 61867, 61885, 61886 **Spinal Cord Stimulator Insertion:** 63650, 63655, 63663, 63685 **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	Gastric Stimulation: InterQual criteria is used: See Implantable Neurostimulators MNG for details on the Provider Resource Center Stereotactic Introduction, Subcortical Electrodes: NCD - Electrical Nerve Stimulators (160.7) Spinal Cord Stimulator Insertion: NCD - Electrical Nerve Stimulators (160.7) 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)
Inpatient Acute and Post-Acute Levels of Care (Medical/Surgical)	See Inpatient Acute Level of Care MNG for details on the Provider Resource Center	CMS and InterQual® Criteria Used: 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 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 – L5782, 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 Elastography (MRE) for Chronic Liver Disease	76391	Internal criteria is used. See Magnetic Resonance Elastography (MRE) for Chronic Liver Disease on the Provider Resource Center
Manual Wheelchairs for Tufts Health Together, Tufts Health	K0003-K0007, E1161	CMS criteria used: LCD - Manual Wheelchair Bases (L33788) and Article - Manual Wheelchair Bases - Policy Article (A52497)

Service	Procedure Codes	Criteria Reference
RI Together and Tufts Health One Care		
Minimally Invasive Procedures for the Treatment of Benign Prostatic Hypertrophy	**Cryoablation, Prostate**: 55873 **Water vapor therapy:** 53854 **Urethral Lift:** 52540-52441 **Prostatectomy, Transurethral Ablation (TUNA):** 53850, 53852, 52450 **Water Vapor Therapy, Aquablation:** 0421T and C2596	CMS and InterQual criteria is used: 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 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 Medical Transportation: Ground/ Air	A0425 A0426, A0428, A0430, A0431, A0435 **PA is not required when submitted with one of the following modifiers:** DH, EH, GH, HD, HG, HH, HJ, JH, NR, PH, RH, RN	CMS Manual used: Medicare Benefit Policy Manual Chapter 10
Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders	**Bone Augmentation, Mandible**: 21110-21123, 21125, 21127, 21215, 21244, 21245 **Bone Augmentation, Maxilla:** 21208, 21210, 21230, **Osteotomy, Anterior Segment Mandible**: 21198, 21199 **Osteotomy, Anterior Segment, Maxilla:** 21188, 21206 **Osteotomy, LeFort I:** 21141-21143, 21145- 21147 **Osteotomy, Sagittal Split Mandible Ramus:** 21193-21196 **Osteotomy, Maxillary Buttress +/- Mid Palatal Osteotomy:** 21188, 21206, 21299 **Additional codes:** 21209, D7940, D7941, D7943-D7950, D7993-D7996	InterQual® Criteria Used. See Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders MNG for modifications on the Provider Resource Center
Osteogenesis Stimulators, Noninvasive	**Osteogenesis Stimulator, Electrical Noninvasive, Not Spinal Application:** E0747, 20974 **Osteogenesis Stimulator, Electrical Noninvasive,**	CMS criteria used: NCD - Osteogenic Stimulators (150.2), LCD - Osteogenesis Stimulators (L33796), and Article - Osteogenesis Stimulators - Policy Article (A52513)

Service	Procedure Codes	Criteria Reference
	Spinal Application: E0748, 20974 **Osteogenesis Stimulator, Low Intensity Ultrasound, Noninvasive:** E0760, 20979	
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)
Outpatient Physical Therapy, Occupational Therapy and Speech Therapy	**PT eval:** 97161-97165 **OT eval:** 97165-97168 **ST**: 92507, 92508, 92521, 92522- 92524, 92526, 92610 **Additional codes:** 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032-97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97530, 97533, 97535, 97542, 97750, 97755, 97760, 97761, 97763	CMS Criteria used: LCD - Outpatient Physical and Occupational Therapy Services (L34049) and Article - Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566)
Oxygen and Respiratory Therapy Equipment	**Home Oxygen Therapy, Portable System:** E0430, E0431, E0433, E0434, E0435, E0443, E0444, E1391, K0738 **Home Oxygen Therapy, Stationary System:** E0424, E0425, E0439- E0442, E1390, E1391	CMS Criteria is used: LCD - Oxygen and Oxygen Equipment (L33797) and Article - Oxygen and Oxygen Equipment - Policy Article (A52514)
Percutaneous Posterior Tibial Nerve Stimulation (PTNS)	64566	CMS criteria used: LCD - Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) and Article - Billing and Coding: Posterior Tibial Nerve Stimulation for Voiding Dysfunction (A57453)
Positive Airway Pressure (PAP) Devices for Tufts Health RI Together and Tufts Health One Care	E0470, E0471, E0601	CMS criteria is used: LCD - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718) and Article - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article (A52467)
Power Operated Vehicles (POVs) for Tufts Health Together, Tufts Health RI Together and Tufts Health One Care	K0800, K0801, K0802, K0806, K0807, K0808	CMS criteria used: LCD - Power Mobility Devices (L33789 and Article - Power Mobility Devices - Policy Article (A52498)
Power Wheelchairs for Tufts Health Together, Tufts Health RI Together and Tufts Health One Care	K0010- K0014, K0813- K0864, K0868-K0886, K0890-K0891, K0898, K0899, E1002-E1012, E2298, E2301, E2610	CMS criteria is used: LCD - Power Mobility Devices (L33789), NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16), LCD - Wheelchair

Service	Procedure Codes	Criteria Reference
		Options/Accessories (L33792), and NCD - Mobility Assistive Equipment (MAE) (280.3)
Procedures for the Treatment of Symptomatic Varicose Veins	**Endovenous Ablation, Lower Extremity Superficial Truncal or Perforator Vein:** 36473, 36474**,** 36475, 36476, 36478, 36479 **Phlebectomy, Lower Extremity Superficial Tributary Varicose Vein:** 37765, 37766 **Ligation and Division +/- 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	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)
Proton Beam Therapy (PBT)	77520, 77522, 77523, 77525	CMS criteria is used: LCD - Proton Beam Therapy (L35075) and Article - Billing and Coding: Proton Beam Therapy (A56827)
Reconstructive and Cosmetic Surgery	**General Cosmetic and Reconstructive Surgery:** 15836, 15839, 15877- 15879 (ICD-10 codes B20, E88.1) **Rhinoplasty:** 30400, 30410, 30420, 30430, 30435, 30450 **Gynecomastia:** 19300 **Breast Implant Removal:** 19328, 19330, 19370, 19371 **Breast Reconstruction/ Reduction:** 19316, 19318, 19340, 19342, 19355, 19357, 19361, 19364, 19367, 19369 **Panniculectomy:** 15830, 15838, 15839 **Redundant Skin:** 15831-15835, 15837, 15838, 15839 **Scar revision:** 0479T, 0480T, 11042, 11043, 11400, 11401-11404, 11406, 11420- 11424, 11426, 11440-11444, 11446, 13100-13102, 13120-1322, 13131-13132, 13151, 13152 (ICD-10 codes L90.5, L91.0) **Hemangioma/ Port Wine Treatment:** 17106-17108	CMS, MassHealth, InterQual, and Internal Criteria is used. CMS criteria used for: General Cosmetic and Reconstructive Surgery, Rhinoplasty, Gynecomastia, Breast Implant Removal, Breast Reduction, Panniculectomy LCD - Cosmetic and Reconstructive Surgery (L39051) and Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774) MassHealth criteria is used for Redundant Skin MassHealth Guidelines for Excision of Excessive Skin and Subcutaneous Tissue | Mass.gov InterQual criteria is used for Scar Revision Internal criteria is used for: Hemangioma, Port Wine Stain Treatment, Hair Removal, Labiaplasty, and Liposuction for Lipedema. See Reconstructive and Cosmetic Surgery MNG for details on the Provider Resource Center

Service	Procedure Codes	Criteria Reference
	Hair Removal: 17380, 17999 (ICD-10 codes F64-F64.9, Z87,890) **Labiaplasty:** 56620 (ICD-10 codes N90.60, N90.61, N90.69) **Liposuction for Lipedema:** 15878, 15879	
Solid Organ Transplant: Heart	33940, 33944, 33945	CMS and MassHealth criteria used: NCD - Heart Transplants (260.9) and MassHealth Guidelines for Organ Transplant Procedures
Solid Organ Transplant: Intestinal (Small Bowel, Simultaneous Small Bowel-Liver) and Multivisceral	44132, 44133, 44135, 44136, 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 Transplant: Kidney	50300, 50320, 50323, 50325, 50327- 50329, 50340, 50360, 50365, 50370, 50380, 50547	MassHealth criteria is used: MassHealth Guidelines for Organ Transplant Procedures
Solid Organ Transplant: Liver	47135, 47140-47147	CMS and MassHealth criteria is used: NCD - Adult Liver Transplantation (260.1) and MassHealth Guidelines for Organ Transplant Procedures
Solid Organ Transplant: Lung	32850- 32856, 33930, 33933, 33935	MassHealth criteria is used: MassHealth 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 - Pancreas Transplants (260.3) and MassHealth Guidelines for Organ Transplant Procedures
Stereotactic Radiosurgery and Stereotactic Body Radiotherapy	61796, 61797, 61798, 63620, 63621, 77371-77373, 77432, 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 for the Treatment Obstructive Sleep Apnea	**Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement, and Hyoid Suspension:** 21193-21196, 21198, 21206 **Uvuloplatopharyngoplasty (UPPP):** 41245 **Hypoglossal Nerve Stimulation:** 64568, 64582-64584	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 Nerve Stimulation. See Surgical Procedures for the Treatment Obstructive Sleep Apnea MNG for details on the Provider Resource Center
Surgical Treatments for Lymphedema and Lipedema	15832, 15833, 15836, 15839, 15877- 15879, 38999 ICD-10 codes: I89.0, E65, E88.2, Q82.0	Internal Criteria is used. See Surgical Treatments for Lymphedema and Lipedema MNG for details on the Provider Resource Center
Temporomandibular Joint (TMJ) Disorder 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
Upper Limb Prosthesis	L6000-L6020, L6026, L6028-L6033, L6037, L6050- L6714, L6721-L6810, L6880-L7406, L7499, L7510, L7520	Internal Criteria is used. See Upper Limb Prothesis MNG for details on the Provider Resource Center
Vertebroplasty and 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 Endoscopy	91110, 91111, 91299	MassHealth criteria is used: MassHealth 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 Neuropsychological Testing and Assessment	96130, 96131, 96132 96133, 96136, 96137 96138, 9613, 96146	Medicare Behavioral Health InterQual® Criteria Used. See Psychological and Neuropsychological Testing and Assessment MNG for InterQual details on the Provider Resource Center
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 OneCare, Tufts Medicare Preferred and Tufts Health Plan Senior 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 Adaptations	S5165	MassHealth Criteria Used: 130 CMR 630.00: Home- and Community-Based Services Waiver Services
Long-Term Services & Supports (LTSS) for One Care	99509, G0156, H0043, H2014, S5100, S5101, S5102, S5120, S5121, S5130, S5131, S5135, S5136, S5140, S5165, S5170, S5175, S9977, T1999, T1019	MassHealth Criteria Used: **Home Care (including Grocery and delivery services, Home delivered meals)** 651 CMR 3.00: Home Care Program **Adult Foster Care and Group Adult Foster Care**: 130 CMR 408.000: Adult Foster Care **Adult Day Health:** 130 CMR 404.00: Adult Day 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 **Day Habilitation:** 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 Regulations
Respite	H0045, T1005, S5150, S5151	MassHealth criteria is used. 130 CMR 630.00: Home- and Community-Based Services Waiver 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 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	Criteria Reference
Abecma	Q2055	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Amtagvi	J3490	MassHealth criteria represented on an internal MNG. See Amtagvi MNG on the Provider Resource Center.
Adstiladrin	J9029	MassHealth criteria represented on an internal MNG. See Adstiladrin MNG on the Provider Resource Center.
Aucatzyl	C9301	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	MassHealth criteria represented on an internal MNG. 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
Hemgenix	J1411	MassHealth criteria represented on an internal MNG. See Hemgenix MNG on the Provider Resource Center.
Kymriah	Q2042	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Lyfgenia	J3394	MassHealth criteria represented on an internal MNG. See Lyfgenia MNG on the Provider Resource Center.
Omisigre	J3590	MassHealth criteria represented on an internal MNG. See Omisigre MNG on the Provider Resource Center.
Roctavian	J1412	MassHealth criteria represented on an internal MNG. See Roctavian MNG on the Provider Resource Center.
Tecartus	Q2053	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)

Service	Procedure Codes	Criteria Reference
Tecelra	Q2057	See Tecelra MNG on the Provider Resource Center.
Vyjuvek	J3401	MassHealth criteria represented on an internal MNG. See Vyjuvek MNG on the Provider Resource Center.
Yescarta	Q2041	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24)
Zynteglo	J3393	MassHealth criteria represented on an internal MNG. 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
Genetic and Molecular Diagnostic Testing for Tufts Health Direct, Tufts Health Together, Tufts Health RI Together, Tufts Health One Care	See Carelon for coding	Managed by Carelon Current Genetic Testing Guidelines | Carelon Clinical Guidelines and Pathways (carelonmedicalbenefitsmanagement.com)
Outpatient Diagnostic Imaging/ Advanced Imaging	See Evolent for coding	Managed by Evolent Welcome to RadMD.com | RADMD
Whole Genome Sequencing	81425- 81427	Managed by Carelon 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 Services	See MNG for details	See 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 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 Inpatient and 24-Hour Level of Care Determinations	See MNG	InterQual® and American Society of Addictive Medicine (ASAM) criteria is used. See Behavioral Health Inpatient and 24-Hour Level of Care Determinations MNG for details on the Provider Resource Center
Behavioral Health Level of Care for Non 24 Hour/ Intermediate/Diversionary Services	See MNG	InterQual® and American Society of Addictive Medicine (ASAM) criteria is used. See Behavioral Health Level of Care for Non 24 Hour/ Intermediate/Diversionary Services MNG for details on the Provider Resource Center
Community Support Programs including Specialized Community Support Programs	H2015, H2016-HH, H2016-HK, H2016-HE	MassHealth criteria represented on an internal MNG. See Community Support Programs including Specialized Community Support 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 ☐ No ☒

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 Eustachian Tube	69705, 69706	See Balloon Dilation of the Eustachian Tube MNG on the Provider Resource Center

Service	Procedure Codes	Coverage Guideline
Behavioral Health: Acupuncture Detoxification Level of Care	H0014	See Behavioral Health: Acupuncture Detoxification Level of Care MNG on the Provider Resource Center
Behavioral Health: Opioid Treatment Services (Methadone Maintenance) Level of Care	H0020, H004 with TF modifier, H0005 with HQ modifier, T1006 with HR modifier	See Behavioral Health: Opioid Treatment Services (Methadone Maintenance) Level of Care MNG on the Provider Resource Center
Breast Pumps	E0602-E0604	See Breast Pumps MNG on the Provider Resource Center
Cardiac Event Monitors	33285, 33286, 93224-93227, 93241-93248, 93268, 93270- 93272, 93285, 93290-93292, 93294-93298, C1764	See Cardiac Event Monitors MNG on the Provider Resource Center
Cardiovascular Disease Risk Test	N/A	See Cardiovascular Disease Risk Test MNG on the Provider Resource Center
Clinical Trials: Routine Costs	Modifiers: Q1, Q0 ICD-10: Z00.6	See Clinical Trials: Routine Costs MNG on the Provider Resource Center
COVID-19 Antibody (Serological) Testing	86328, 86408- 86409, 86413, 86769, 0024U	See COVID-19 Antibody (Serological) Testing MNG on the Provider Resource Center
COVID-19 Monoclonal Antibody Therapy	N/A	See COVID-19 Monoclonal Antibody Therapy MNG on the Provider Resource Center
Enteral Nutrition, Digestive Enzyme Cartridges and Special Medical Formulas for Tufts Health Together and Tufts Health One Care	B4105, B4149, B4150, B4152- B4155, B4157-B4162	See Enteral Nutrition, Digestive Enzyme Cartridges and Special Medical Formulas for Tufts Health Together and Tufts Health One Care MNG on the Provider Resource Center
Fecal Microbial Transplant (FMT) for Clostridium Difficile Infection	G0455, 44705 ICD-10: A04.71, A04.72	See Fecal Microbial Transplant (FMT) for Clostridium Difficile Infection MNG on the Provider Resource Center
Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	96549, 96547, 96548	See Hyperthermic Intraperitoneal Chemotherapy (HIPEC)MNG on the Provider Resource Center
Iluvien	J7313 IDC-10 codes see MNG	See Iluvien MNG on the Provider Resource Center.
Intraoperative Neurophysiological Monitoring	95940, 95942, G0453	See Intraoperative Neurophysiological Monitoring MNG on the Provider Resource Center
Mohs' Micrographic Surgery (MMS)	17311-17315	See Mohs' Micrographic Surgery (MMS) MNG on the Provider Resource Center
Percutaneous Left Atrial Appendage Closure to Reduce Stroke Risk in Patients with Atrial Fibrillation (Watchman Device)	33340 ICD-10 codes: I48.0, I48.11, I28.19, I48.20, I48.21	See Percutaneous Left Atrial Appendage Closure to Reduce Stroke Risk in Patients with Atrial Fibrillation (Watchman Device)MNG on the Provider Resource Center

Service	Procedure Codes	Coverage Guideline
Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia (POEM)	43497	See Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia (POEM) MNG on the Provider Resource Center
Program of Assertive Community Treatment (PACT) Services	H0040	See Program of Assertive Community Treatment (PACT) Services MNG on the Provider Resource Center
Recovery Support Navigator	H2015-HF	See Recovery Support Navigator MNG on the Provider Resource Center
Remote Patient Monitoring Tufts Health Together, Tufts Health One Care, and Tufts Health Senior Care Options	99091, 99453, 99454, 99457, 99458 ICD-10 codes	See Remote Patient Monitoring Tufts Health Together, Tufts Health One Care, and Tufts Health Senior Care Options MNG on the Provider Resource Center.
Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	92132, 92133, 92134 ICD-10 codes	See Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) MNG on the Provider Resource Center
Subcutaneous Implantable Cardioverter Defibrillator (S-ICD)	33270-33273	See Subcutaneous Implantable Cardioverter Defibrillator (S-ICD) MNG on the Provider Resource Center
Temporary Total Artificial Heart System Bridge to Transplant	33927- 33929, Q0480	See Temporary Total Artificial Heart System Bridge to Transplant MNG on the Provider Resource Center
Transcatheter Mitral Valve Repair (TMVR)	33418, 33419, 0345T	See Transcatheter Mitral Valve Repair (TMVR) MNG on the Provider Resource Center
Tumor Treating Fields (TTF)	E0766, A4555	See Tumor Treating Fields (TTF) MNG on the Provider Resource Center
Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD)	43200, 43202, 43231, 43233, 43235, 43237, 43238, 43239, 432422, 43259 ICD-10 codes	See Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD) MNG on the Provider Resource Center
Urine Drug Testing	80305- 80307, G0480-G0483	See Urine Drug Testing MNG on the Provider Resource Center
UVB Home Units for Skin Disease	E0691-E0694	See UVB Home Units for Skin Disease MNG on the Provider Resource Center
Vitamin B12 Screening and Testing	82607, 84999 ICD-10 codes	See Vitamin B12 Screening and Testing MNG on the Provider Resource Center
Vitamin D Screening and Testing	82306, 82652 ICD-10 codes	See Vitamin D Screening and 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
    - 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, Aquablation, and Omisigre
    - Updated Bariatric Surgery from MassHealth criteria to InterQual criteria, updated Varicose Veins coding groupings
    - 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
    - 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
    - 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