Harvard Pilgrim Health Care | TUFTS Health Plan

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

Effective: July 1, 2024

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.

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 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 used. See MNG.
Bariatric Surgery	43644, 43645, 43770-43775, 43845-43848, 43860, 43865-43886-43888, 43999	MassHealth criteria used https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-bariatric-surgery/download
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) (cms.gov) and Article - Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908) (cms.gov)
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) (cms.gov) For hypoglycemia due to a diagnosis other than diabetes mellitus: https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-diabetes-management-devices-continuous-glucose-monitoring-systems-and-insulin-pumps-0/download
Custom Fabricated Oral Appliances for Obstructive Sleep Apnea (OSA)	E0486	CMS Criteria Used: LCD - Oral Appliances for Obstructive Sleep Apnea (L33611) (cms.gov)
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 MNG.

Service	Procedure Codes	Criteria Reference
Gender Affirming Services	11970, 11971, 14040, 14041, 14301, 14302, 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 used. See MNG.
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) (cms.gov) For all other indications, internal criteria used. See MNG..
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) (cms.gov) Speech generation devices: LCD - Speech Generating Devices (SGD) (L33739) (cms.gov) and MassHealth Guidelines for Medical Necessity Determination for Augmentative and Alternative Communication Devices, Including Speech-Generating Devices | Mass.gov

Service	Procedure Codes	Criteria Reference
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: https://www.mass.gov/doc/home-health-services-3/download
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 (cms.gov) And Hospice Manual for MassHealth Providers | Mass.gov
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 MNG.
Hyperbaric Oxygen Treatment	99183, G0277	CMS Criteria Used: NCD - Hyperbaric Oxygen Therapy (20.29) (cms.gov)
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) (cms.gov) Hysterectomy for all other indications: InterQual criteria is used. See MNG..
Implantable Neurostimulators	**Gastric Stimulation:** 43647, 43881, 64590 **Stereotactic Introduction, Subcortical Electrodes:** 617202, 61850, 61860, 61863, 61867, 61885, 61886	Gastric Stimulation: See InterQual criteria Stereotactic Introduction, Subcortical Electrodes: NCD - Electrical Nerve Stimulators (160.7) (cms.gov)

Service	Procedure Codes	Criteria Reference
	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	Spinal Cord Stimulator Insertion: NCD - Electrical Nerve Stimulators (160.7) (cms.gov) Sacral nerve Stimulator for Urinary Incontinence Temporary Trail and Permanent: NCD - Sacral Nerve Stimulation For Urinary Incontinence (230.18) (cms.gov) Sacral nerve Stimulator for Fecal Incontinence Temporary Trail and Permanent: Internal Criteria Used. See MNG. Vagus Nerve Stimulation: NCD - Vagus Nerve Stimulation (VNS) (160.18) (cms.gov)
Inpatient Acute Level of Care (Medical/Surgical)	See MNG for Services that Require Prior Authorization	InterQual® Criteria Used
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) (cms.gov) Internal Coverage criteria for microprocessors of the knee and ankle/ foot. See MNG
Manual Wheelchairs for Tufts Health Together, Tufts Health RI Together and Tufts Health One Care	K0003-K0007, E1161	CMS criteria used: LCD - Manual Wheelchair Bases (L33788) (cms.gov) and Article - Manual Wheelchair Bases - Policy Article (A52497) (cms.gov)
Mobile Outpatient Cardiac Telemetry (MOCT)	93228, 93229	InterQual® Criteria Used. See MNG.
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 (cms.gov)
Orthognathic Surgery for Severe Oral-	**Bone Augmentation, Mandible**: 21110-21123,	InterQual® Criteria Used. See MNG for modifications.

Service	Procedure Codes	Criteria Reference
Maxillofacial Functional Disorders	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	
Osteogenesis Stimulators, Noninvasive	**Osteogenesis Stimulator, Electrical Noninvasive, Not Spinal Application:** E0747, 20974 **Osteogenesis Stimulator, Electrical Noninvasive, Spinal Application:** E0748, 20974 **Osteogenesis Stimulator, Low Intensity Ultrasound, Noninvasive:** E0760, 20979	CMS criteria used: NCD - Osteogenic Stimulators (150.2) (cms.gov), LCD - Osteogenesis Stimulators (L33796) (cms.gov), and Article - Osteogenesis Stimulators - Policy Article (A52513) (cms.gov)
Out-of-Network Coverage at the In-Network Level of Benefits (All Plans)	See MNG for Services that Require Prior Authorization	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,	CMS Criteria used: LCD - Outpatient Physical and Occupational Therapy Services (L34049) (cms.gov) and Article - Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566) (cms.gov)

Service	Procedure Codes	Criteria Reference
	97032-97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97530, 97533, 97535, 97542, 97750, 97755, 97760, 97761, 97763	
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) (cms.gov) and Article - Oxygen and Oxygen Equipment - Policy Article (A52514) (cms.gov)
Percutaneous Posterior Tibial Nerve Stimulation (PTNS)	64566	CMS criteria used: LCD - Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) (cms.gov)
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) (cms.gov) and Article - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article (A52467) (cms.gov)
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) (cms.gov) and Article - Power Mobility Devices - Policy Article (A52498) (cms.gov)
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, E2300, E2301, E2610	CMS criteria is used: LCD - Power Mobility Devices (L33789) (cms.gov), NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) (cms.gov), LCD - Wheelchair Options/Accessories (L33792) (cms.gov), and NCD - Mobility Assistive Equipment (MAE) (280.3) (cms.gov)
Procedures for the Treatment of Symptomatic Varicose Veins	**Ablation, Endovenous, Varicose Vein:** 36475, 36476, 36478, 36479 **Ambulatory Phlebectomy, Varicose Vein:** 37765, 37766 **Ligation/Excision, Varicose Vein, +/- Stripping:** 37700, 37718, 37722, 37780, 37785 **Ligation, Subfascial, Endoscopic, Perforating Vein:** 37500, 37735, 37760	CMS criteria is used: LCD - Treatment of Varicose Veins of the Lower Extremities (L34536) (cms.gov), LCD - Varicose Veins of the Lower Extremity, Treatment of (L33575) (cms.gov), Article - Billing and Coding: Treatment of Varicose Veins of the Lower Extremities (A56914) (cms.gov) , and Article - Billing and Coding: Treatment of Varicose Veins of the Lower Extremity (A52870) (cms.gov)

Service	Procedure Codes	Criteria Reference
	Sclerotherapy, Varicose Vein: 36465, 366466, 36470, 36471, S2202, 36482, 36483	
Procedures for the Treatment of Benign Prostatic Hypertrophy (BPH)	**Cryoablation, Prostate**: 55873 **Water vapor therapy:** 53854 **Urethral Lift:** 52540-52441 **Prostatectomy, Transurethral Ablation (TUNA):** 53850, 53852, 52450	CMS, InterQual, and internal criteria is used. Cryoablation of the prostate initial treatment: NCD - Cryosurgery of Prostate (230.9) (cms.gov) All other procedures see InterQual criteria. See MNG.
Proton Beam Therapy (PBT)	77520, 77522, 77523, 77525	CMS criteria is used: LCD - Proton Beam Therapy (L35075) (cms.gov)
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 **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	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) (cms.gov) MassHealth criteria is used for Redundant Skin MassHealth Guidelines for Medical Necessity Determination 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 MNG.
Solid Organ Transplant: Heart	33940, 33944, 33945	CMS and MassHealth criteria used: NCD - Heart Transplants (260.9) (cms.gov) and https://www.mass.gov/doc/guidelines-

Service	Procedure Codes	Criteria Reference
		for-medical-necessity-determination-for-organ-transplant-procedures/download
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) (cms.gov) and https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-organ-transplant-procedures/download
Solid Organ Transplant: Kidney	50300, 50320, 50323, 50325, 50327- 50329, 50340, 50360, 50365, 50370, 50380, 50547	MassHealth criteria is used: https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-organ-transplant-procedures/download
Solid Organ Transplant: Liver	47135, 47140-47147	CMS and MassHealth criteria is used: NCD - Adult Liver Transplantation (260.1) (cms.gov) and https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-organ-transplant-procedures/download
Solid Organ Transplant: Lung	32850- 32856, 33930, 33933, 33935	MassHealth criteria is used: https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-organ-transplant-procedures/download
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) (cms.gov) and https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-organ-transplant-procedures/download
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) (cms.gov)
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) (cms.gov) Internal Criteria is used for Hypoglossal Nerve Stimulation. See MNG.
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 MNG.

Service	Procedure Codes	Criteria Reference
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 MNG.
Upper Limb Prosthesis	L6000-L6020, L6026, L6050-L6714, L6721-L6810, L6880-L&405, L7499, L7510, L7520	Internal Criteria is used. See MNG.
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) (cms.gov) InterQual is used for all other vertebroplasty or kyphoplasty indications. See MNG.
Video Capsule Endoscopy	91110, 91111, 91299	MassHealth criteria is used: MassHealth Guidelines for Medical Necessity Determination for Capsule Endoscopy | Mass.gov

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 MNG.
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 MNG.

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:

Service	Procedure Codes	Medicaid Reference
		https://www.mass.gov/regulations/130-CMR-63000-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) https://www.mass.gov/doc/651-cmr-3-home-care-program/download Adult Foster Care and Group Adult Foster Care: https://www.mass.gov/doc/130-cmr-408-adult-foster-care/download Adult Day Health: https://www.mass.gov/regulations/130-CMR-40400-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) https://www.mass.gov/regulations/130-CMR-63000-home-and-community-based-services-waiver-services Day habilitation: https://www.mass.gov/regulations/101-CMR-34800-rates-for-day-habilitation-services Home Health: https://www.mass.gov/files/documents/2019/06/17/pb-hha-54.pdf Personal Care Attendant: https://www.mass.gov/regulations/130-CMR-42200-personal-care-attendant-services Billing and administration: https://www.mass.gov/regulations/130-CMR-450000-administrative-and-billing-regulations
Respite	H0045, T1005, S5150, S5151	MassHealth criteria is used. https://www.mass.gov/doc/home-and-community-based-services-waivers-regulations/download

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.

Service	Procedure Codes	Criteria Reference
Abecma	Q2055, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Amtagvi	J3490	Internal criteria is used: See MNG
Adstiladrin	J9029	MassHealth criteria represented on an internal MNG: See MNG.
Breyanzi	Q2054, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used:

Service	Procedure Codes	Criteria Reference
		NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Carvykti	Q2056, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Casgevy	J3490	MassHealth criteria represented on an internal MNG. See MNG.
CGM: Freestyle and Dexcom Products	A4238, E2102	CMS Criteria and MassHealth Criteria Used: Diabetes mellitus: LCD - Glucose Monitors (L33822) (cms.gov) For hypoglycemia due to a diagnosis other than diabetes mellitus: https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-diabetes-management-devices-continuous-glucose-monitoring-systems-and-insulin-pumps-0/download
Hemgenix	J1411	MassHealth criteria represented on an internal MNG. See MNG.
Kymriah	Q2042, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Lyfgenia	J3394	MassHealth criteria represented on an internal MNG. See MNG.
Roctavian	J1412	MassHealth criteria used: https://mhdl.pharmacy.services.conduent.com/MHDL/pubsearch.do?index=R
Tecartus	Q2053, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Vyjuvek	J3401	MassHealth criteria represented on an internal MNG. See MNG.
Yescarta	Q2041, 0537T, 0538T, 0539T, 0540T	CMS Criteria Used: NCD - Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) (cms.gov)
Zynteglo	J3393	MassHealth criteria represented on an internal MNG. See MNG.

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)
High Tech Imaging and Cardiac Program	See PA code matrix	Managed by Evolent Welcome to RadMD.com | RADMD

Service	Procedure Codes	Criteria Reference
	hti-cardiac-code-matrix-mng.pdf (point32health.org)	
Whole Genome Sequencing	81425- 81427	Managed by Carelon Current Genetic Testing Guidelines | Carelon Clinical Guidelines and Pathways (carelonmedicalbenefitsmanagement.com)

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

The following tables list services and items requiring notification:

- Table 6 includes DME, prosthetic items, and associated procedure codes that require notification through the Precertification Operations Department.
- Table 7 includes procedure codes that require notification through the Behavioral Health Department.

TABLE 6

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
None		

TABLE 7

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. for Services that Require notification	InterQual® and American Society of Addictive Medicine (ASAM)
Behavioral Health Level of Care for Non 24 Hour/ Intermediate/Diversionary Services	See MNG. for Services that Require notification	InterQual® and American Society of Addictive Medicine (ASAM)
Community Support Programs including Specialized Community Support Programs	H2015, H2016-HH, H2016-HK, H2016-HE	Internal criteria used. See MNG..
Peer Recovery Coach	H2016-HM	MassHealth criteria used: https://www.mass.gov/doc/managed-care-entity-bulletin-82-updates-to-the-masshealth-peer-recovery-coach-benefit-0/download

Prior Authorization Required	Yes ☐ No ☒

TABLE 8

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	Absorbant-Products-One-Care-mng.pdf (point32health.org)
Balloon Dilation of the Eustachian Tube	69705, 69706	BDET-mng.pdf (point32health.org)
Behavioral Health: Acupuncture Detoxification Level of Care	H0014	BH Acupuncture Detox (point32health.org)
Behavioral Health: Opioid Treatment Services (Methadone Maintenance) Level of Care	H0020, H004 with TF modifier, H0005 with HQ modifier, T1006 with HR modifier	BH-Opioid-Treatment-mng.pdf (point32health.org)
Breast Pumps	E0602-E0604	Breast-Pumps-mng.pdf (point32health.org)
Cardiac Event Monitors	33285, 33286, 93224-93227, 93241-93248, 93268, 93270- 93272, 93285, 93290-93292, 93294-93298, C1764	Cardiac Event Monitors (point32health.org)
Cardiovascular Disease Risk Test	N/A	CVD Risk Test (point32health.org)
Clinical Trials: Routine Costs	Modifiers: Q1, Q0 ICD-10: Z00.6	Clinical-Trials-mng.pdf (point32health.org)
COVID-19 Antibody (Serological) Testing	86328, 86408- 86409, 86413, 86769, 0024U	Covid 19 Antibody Testing (point32health.org)
COVID-19 Monoclonal Antibody Therapy	N/A	Monoclonal-Antibody-Treatment-for-Covid-mng.pdf (point32health.org)
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	Enteral Nutrition MAT RIT One Care (point32health.org)
Fecal Microbial Transplant (FMT) for Clostridium Difficile Infection	G0455, 44705 ICD-10: A04.71, A04.72	Fecal Microbial Transplant for CDI (point32health.org)
Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	96549, 96547, 96548	Hyperthermic Intraperitoneal Chemo (HIPEC) (point32health.org)
Iluvien	J7313 IDC-10 codes see MNG	Iluvien-COM-QHP-RIT-MAT-MDMNG.pdf (point32health.org)
Intraoperative Neurophysiological Monitoring	95940, 95942, G0453	Intraoperative Neurophysiological Monitoring (point32health.org)
Mohs' Micrographic Surgery (MMS)	17311-17315	Mohs Micrographic Surgery (point32health.org)

Service	Procedure Codes	Coverage Guideline
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	Watchman device (point32health.org)
Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia (POEM)	43497	POEM-mng.pdf (point32health.org)
Program of Assertive Community Treatment (PACT) Services	H0040	PACT (point32health.org)
Recovery Support Navigator	H2015-HF	Recovery Support Navigator (point32health.org)
Remote Patient Monitoring	99091, 99453, 99454, 99457, 99458 ICD-10 codes	Remote-Patient-Monitoring-mng.pdf (point32health.org)
Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	92132, 92133, 92134 ICD-10 codes	Scanning-Computerized-Ophthamic-Diagnostic-Imaging-mng.pdf (point32health.org)
Subcutaneous Implantable Cardioverter Defibrillator (S-ICD)	33270-33273	S-ICD (point32health.org)
Temporary Total Artificial Heart System Bridge to Transplant	33927- 33929, Q0480	Temporary Total Artificial Heart (point32health.org)
Transcatheter Mitral Valve Repair (TMVR)	33418, 33419, 0345T	TMVR_ (point32health.org)
Tumor Treating Fields (TTF)	E0766, A4555	Tumor-Treating-Fields-mng.pdf (point32health.org)
Upper Gastrointestinal Endoscopy (Esophagogastroduodenoscopy, EGD)	43200, 43202, 43231, 43233, 43235, 43237, 43238, 43239, 432422, 43259 ICD-10 codes	EGD-mng.pdf (point32health.org)
Urine Drug Testing	80305- 80307, G0480-G0483	Urine Drug Testing (point32health.org)
UVB Home Units for Skin Disease	E0691-E0694	UVB-Home-Units-mng.pdf (point32health.org)
Vitamin B12 Screening and Testing	82607, 84999 ICD-10 codes	Vitamin B12 Screening and Testing (point32health.org)
Vitamin D Screening and Testing	82306, 82652 ICD-10 codes	Vitamin-D-Screening-and-Testing-mng.pdf (point32health.org)

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