National Correct Coding Initiative (NCCI) edits

- HealthPartners follows NCCI coding guidelines for all products.
- Following those guidelines, non-site specific modifiers must be on the deny line only in order to override the edit.

GA and GY modifiers – Medicare products

- Per the HealthPartners GA and GY policy, submissions of these modifiers on a service will automatically result in a denial as member liability.
- If a service is covered per CMS policy or a member's supplemental benefits, the GA and GY modifiers should not be submitted.
- Providers are responsible for verifying coverage in advance. If you are unclear whether or not an item or service is covered by the member's plan, you should request a pre-service organization determination.
- To learn more, please access the **Use of GA, GY or GZ Modifier on Claim Submissions for Medicare Policy** and the **Advance Notice of Noncoverage for Medicare Members Policy**
  (Go to healthpartners.com/provider-public, then click on the Admin tools drop down menu and select Administrative policies).

Documentation

- If you believe HealthPartners will need additional documentation to override a coding edit, please submit it at the time of the original claim submission. This may help to avoid the necessity of a claim appeal.

Attention optometry and ophthalmology providers: eyewear claims

As a reminder, contracted provider groups are expected to submit claims directly to HealthPartners for covered services, including covered eyewear. Therefore, if your patient has coverage for eyewear and purchases eyewear from your clinic or facility, as a contracted provider, you should submit these claims to HealthPartners on behalf of your patients. Benefit examples include:

- Medicare-covered post-cataract eyewear for members on Medicare Cost and Medicare Advantage plans
- Pediatric eyewear
- General eyewear benefit included for Medicaid products

Submitting the claim on your patient's behalf ensures a smooth experience for your patient and your organization. Providers are expected to follow appropriate billing guidelines.

Medical Policy Updates –May 2018

MEDICAL AND DURABLE MEDICAL EQUIPMENT (DME) & MEDICAL DENTAL COVERAGE POLICY

Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at **healthpartners.com** *(path: healthpartners/Provider/Coverage Criteria).* Upon request, a paper version of revised and new policies can be mailed to clinic groups whose staff does not have Internet access. Providers may speak with a HealthPartners Medical Director if they have a question about a utilization management decision.

Coverage Policies	Comments / Changes
Physical and occupational therapy – rehabilitative	Effective immediately, policy revised. The criterion stating therapy must be specified in a plan of care that is reviewed and revised as medically necessary by the member's health care practitioner has been interpreted by some providers as conflicting with the rule allowing patients to see a physical therapist for 90 days without a doctor's referral. The statement has been removed to avoid confusion.
Cranial remolding helmet/band and protective helmet	Effective immediately, policy revised. Cranial remolding helmets/bands have been added to the DME Benefits Grid coverage policy as covered. Policy now addresses protective helmets only and has been retitled "Protective helmets."
Cranial remolding helmet/band and protective helmet – Minnesota Health Care Programs	Effective immediately, policy revised. Criteria for cranial remolding helmets/bands have been removed. These will be covered according to the MHCP Medical Supply Coverage Guide. A link to the guide appears on the DME Benefits Grid coverage policy. Policy now addresses protective helmets only and has been retitled "Protective helmets – Minnesota Health Care Programs."
DME Benefits Grid	Effective immediately, the following revisions were made: • Cranial remolding helmet/band has been added to the policy as covered. • Oscillatory positive expiratory pressure device, nonelectric, any type added as covered.
Transplants	Effective immediately: • Prior authorization requirement at the time of the evaluation and at the time of the listing added to match the already existing requirements on the prior authorization form. • Added under transplants eligible for coverage: allogeneic stem cell transplant for myelodysplastic syndrome with intermediate – very high IPSS-R scores and autologous stem cell transplant for AL amyloidosis.
Medical necessity	Effective 7/1/18: Policy has been revised to state prior authorization is needed for certain services that are on the prior authorization list. Language added to indicate medical necessity criteria applies to both medical and behavioral health. Luxury treatment programs added as a noncovered service.
Speech therapy – rehabilitative	Effective 3/1/18, policy revised for clarity. The statements that rehab ST beyond 2 years for certain conditions (cleft lip/palate, post cochlear implantation, post receipt of initial hearing aids) must follow the habilitative therapy prior authorization process were removed. There is no change in coverage of these services. Requests for rehabilitative speech therapy beyond two consecutive years may be subject to review.
Spinal cord stimulator	Effective 7/1/2018: • Policy name change to "Spinal cord and implanted peripheral nerve stimulation." • Prior authorization requirements added for the following noncovered stimulators: Ganglion root stimulator, peripheral nerve and peripheral field stimulation and occipital nerve stimulation.
Flutter device	Effective immediately: policy retired, information added to DME Benefits Grid as covered.

Coverage Policies	Comments / Changes
Investigational Services – list of noncovered services	Effective immediately, the following services have been added as there is insufficient reliable evidence in the form of high-quality peer-reviewed medical literature to establish the safety and efficacy of these treatments or their effect on health care outcomes: **0253T, 0474T** – Aqueous drainage device for use in Minimally Invasive Glaucoma Surgery (e.g., CyPass micro stent) **0449T, 0450T** – Aqueous drainage device for use in Minimally Invasive Glaucoma Surgery (e.g., XEN Gel stent) **0501T, 0504T** – Coronary fractional flow reserve, non-invasive, including analysis, interpretation, and report (e.g., HeartFlow FFRct Analysis) **0424T** – Phrenic nerve neurostimulation (e.g., Remede implantable system) for treatment of central sleep apnea; insertion or replacement of complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator) **L8699** – Prosthetic Implant, not otherwise specified, when used to describe a synthetic cartilage implant (SCI) for treatment of first MTP joint arthritis (e.g., Cartiva SCI)

Contact the Medical Policy Intake line at **952-883-5724** for specific patient inquiries.

BEHAVIORAL HEALTH

Coverage Policies	Comments / Changes
Chronic Pain - Multidisciplinary Intensive Day Treatment Programs	Effective 7/1/2018, policy revised to: • Add psychotherapy such as mindfulness-based stress reduction to the Indications that are covered section. • Add treatment of postural orthostatic tachycardia syndrome (POTS) to the Indications that are not covered section. • Add visceral pain to the list of conditions that are not eligible for coverage at a multidisciplinary pain program because there are other programs more appropriate for this condition. • Add to the definition of Chronic Pain. Chronic pain is pain that persists longer than three months.

Pharmacy Policy Updates – May 2018

HEALTHPARTNERS DRUG FORMULARY

Changes for Commercial and State Programs include several updates for opioid medications, starting July 2, 2018:

1. The first opioid prescription for members will be limited to a 7-day supply. Members starting therapy with opioid medications are also limited to a 14-day supply per episode. This limit is intended to allow one refill. Prior authorization is required for longer therapy.
2. The cumulative daily dose of opioids will be limited. This expands our current dose limit to include all opioid prescriptions. Current limits are for individual drugs and allow multiple prescriptions. This expansion "rolls up" the dose limit to include all opioid medications. Prior authorization is required when the cumulative opioid dose is equal or greater than 90 morphine-equivalents per day.

3. Long-acting opioids will require prior authorization for members with new prescriptions.
4. Codeine and tramadol is non-formulary for younger children <= age 11.
5. Codeine cough syrups are non-formulary for younger children <= age 17.

Please see the formulary for details and a complete list at **healthPartners.com/formularies**.

Quarterly formulary updates and additional information such as Prior Authorization and Exception Forms, Specialty Pharmacy information and Pharmacy and Therapeutics (P&T) Committee policies are available at **healthpartners.com/provider/admin tools/pharmacy policies**, including the **Drug Formularies** *(healthpartners.com/formulary).*
Pharmacy Customer Service is available to providers (physicians and pharmacies) 24 hours per day and 365 days per year.

- Fax - **952-853-8700** or **1-888-883-5434** Telephone - **952-883-5813** or **1-800-492-7259**
- HealthPartners Pharmacy Services, 8170 33rd Avenue South, PO Box 1309, Mpls, MN 55440

HealthPartners Customer Service is available from 8 AM - 6 PM Central Time, Monday through Friday, and 8 AM – 4 PM Saturday. After hours calls are answered by our Pharmacy Benefit Manager.

Reminder – Provider Survey

HealthPartners mailed a short survey to a sample of psychiatrists, primary care and specialty physicians, as well as their office managers. The survey assesses satisfaction in two key areas where we continue to focus improvement activities – Continuity/Coordination of Care across care settings and experience with the Utilization Management process for services requiring prior authorization.

There's still time to complete the survey if you've received it and haven't returned it yet. Your feedback is important in helping us to identify potential areas of improvement.

Questions, please contact Kelsey Folin, Medical Policy Prior Authorization Program, at **952-883-5768**.

View Member's ID card online

You can now view a member's ID card online in our Provider Portal eligibility application. The member ID card can provide additional information such as care type or further administrative information. Simply search for a member and find the "View member card" link in the results.

Coverages

If you do not see the date you are looking for, please widen your search by inserting the dates you are looking for into the date of service fields and resubmit your inquiry.

- Benefit records display benefits for a specified time period within a coverage policy.
- Coverage dates indicate the begin and end date of the member's coverage.

View member card – 3502

The view member card link opens the member's card image: