Fast Facts

HealthPartners

SEPTEMBER 2018

News for Providers from HealthPartners Professional Services and Hospital Network Management

Administrative

IMPORTANT – New outreach locations or telemedicine services?

UPDATE YOUR PROVIDER AND LOCATION INFORMATION

Do you have new outreach locations or telemedicine services? If so, please contact your HealthPartners Service Specialist and provide details so the information can be added to our system.

Directory information can be reviewed and edited through our Provider Data Profiles tool. Log in at **healthpartners.com/provider log on** *(path: healthpartners.com/provider-public/)*. If you don't have access to the Provider Data Profiles application, contact your delegate. After you've logged in, your delegate's information appears in the help center section.

Information that should be reviewed includes:

- Office location(s) **where members can be seen for appointments**
- Provider name with credentials (MD, DO, etc.)
- Specialty(ies)
- Location(s) Name(s)
- Address(es)
- Phone number(s)
- Clinic hours
- Practitioner status for accepting new patients
- Clinic services available

If you have further questions regarding updating directory information, please call your HealthPartners Service Specialist.

INSIDE THIS ISSUE

New directory requirements - Cultural Competency Training and office accessibility

HealthPartners and all health plans are required to maintain accurate information in our provider directories. Managed Care Federal Regulation issued in 2016 also requires directories to include provider information regarding their Cultural Competency Training and whether their locations are accessible for members with disabilities.

Please take a moment to complete the Questionnaire included as part of this edition of Fast Facts on page 10.

Instructions are on the form for returning the information to HealthPartners.

Coding Corner

REMINDERS

New Patient vs. Established Patient Coding

- HealthPartners expects providers to follow American Medical Association (AMA) coding guidelines when billing for new patient services versus established patient services. The current year AMA CPT Professional Edition includes a definition of "new patient" and a definition of "established patient."

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 Medicare guidelines, the GA and GY modifiers should NOT be submitted.
- If a service is not covered per Medicare guidelines but ***is*** a covered benefit under a member's HealthPartners policy, 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 Non-coverage 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.

Connecting patients with free HealthPartners case management services

The HealthPartners Complex Case Management program provides case management services to patients with complex medical diagnoses who are experiencing frequent hospitalizations, emergency room use, increasing medical complexity and utilization, psychosocial issues and/or a decline in functional status.

Using fully integrated systems, processes and information platforms, these services have been shown to optimize health and care, reduce hospital admissions and readmissions, and maximize appropriate use of available resources—all while imparting an exceptional experience for patients and physicians.

HOW THE SERVICES WORK

Using personalized health coaching techniques and behavioral strategies including motivational interviewing, health coaching and shared decision making, HealthPartners registered nurse case managers provide tailored interventions designed to:

- Support medication adherence
- Ensure coordination of patient care and management of barriers
- Identify and close gaps in care
- Strengthen the patient's relationship with their provider and clinic
- Support the physician's plan of care and provide in-between visit support
- Support members through transitions in care (post hospital discharge, TCU to home, etc.)

A multi-disciplinary team of registered nurses, registered dietitians, pharmacists, behavior health specialists and social workers ensure that each patient receives the support and level of service appropriate to their circumstances. The team collaborates with the patient's physicians frequently throughout the duration of the patient's participation in the program, including care plan updates and reports of the patient's progress towards goals.

We've now made it easier for you to connect your patients with our services. We replaced the online PDF/print form with a new automated web-based form located on the Provider portal at **healthpartners.com**. You can find the new form—*Disease, Case & Lifestyle Management Services*—under "Forms for Providers" or you can check it out at **healthpartners.com/patientsupport**.

All you need to do is fill in the required information and click on "submit." We will take care of the rest.

We appreciate your partnership in meeting the needs of our members. If you have any questions, please contact the HealthPartners Connect team at **952-883-5469** or toll-free at **800-871-9243**.

New programs for eating disorders in children and teens at Melrose Center

Melrose Center is pleased to introduce three new programs for children and adolescents with eating disorders.

HOW TO REFER PATIENTS

All programs require participants to have an initial assessment and be a Melrose patient. To refer patients to Melrose Center, call our dedicated provider line at **952-993-5864** and speak directly to a Care Manager who can answer any questions you may have or help schedule your patient for an initial assessment. If your patient prefers, they can call **952-993-6200** to schedule an initial assessment. Financial counselors are also available for questions regarding insurance coverage.

BINGE EATING SUPPORT FOR TEENS (BEST)

Binge Eating Disorder is the most common eating disorder in the U.S. **Research*** shows that binge eating behaviors can begin in early adolescence and may develop into binge eating disorder later in adolescence or adulthood. Primary care providers play a critical role in identifying binge eating behaviors in adolescents and encouraging treatment which can improve outcomes. **(path: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140795/)*

Melrose Center's Binge Eating Support for Teens (BEST) program is cutting edge and meets a great need since there is no other BED program for teens in existence. This eight-week outpatient group program addresses the unique psychosocial and educational needs of teens (age 14-18) that binge eat. Once a week sessions include a therapist-led lesson, a meal experience guided by an RD and a nutrition or life skill topic led by a RD, OT or PT. Parent/Guardian involvement is expected for three out of eight weeks.

Participants will build confidence by learning alternatives to binge eating and ways to manage challenging feelings, thoughts and emotions. They'll discover a healthy relationship with food and how to eat mindfully. This program utilizes evidence-based therapy approaches and well-established strategies adapted from the successful Melrose Center Binge Eating Disorder Program for adults.

COGNITIVE-BEHAVIOR THERAPY (CBT-AR) FOR AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

In 2013 the American Psychiatric Association established the diagnosis of ARFID. ARFID involves food avoidance or restriction that results in substantial weight loss or failure to achieve expected weight gain, malnutrition or significant interference in psychosocial functioning. ARFID differs from anorexia and bulimia. Rather than experiencing fear of weight gain or body image disturbance, individuals with ARFID show little interest in eating, avoid specific foods due to a feeding-related traumatic event such as gagging or choking, or avoid foods with specific sensory qualities such as texture or taste.

While ARFID is most often seen in children, it can affect individuals of all ages.

Melrose therapists are trained in a cognitive behavior therapy technique specifically for the treatment of ARFID, developed by leading researchers from Massachusetts General Hospital.

ADOLESCENT PARTIAL HOSPITALIZATION PROGRAM FOR AGES 13-17

This day treatment program is three days a week and is designed for adolescents to provide ongoing support in a structured environment.

Adolescents will participate in skills, strategy and nutrition groups, and other groups, including but not limited to music therapy, exercise education, mind/body awareness, and developing supportive relationships. Adolescents also participate in guided restaurant outings to practice the skills they learn. Parents/Guardians join their child one evening per week for Family Learning Series and learn more on how to support the adolescent's recovery at home.

Medical Policy updates – 9/1/18

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: 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
Reduction Mammaplasty	Effective immediately, policy revised. • Criterion #4 was changed from 'Reduction mammoplasty in patients less than 18 years old will be determined on a case by case basis' to 'Member must either be at least 18 years of age, or have completed breast growth, as evidenced by documentation of stable breast size over the preceding 12 months.' • The requirements in criterion #2 were changed from 'Documented history of recurrent dermatitis of the skin related to large breasts. An example is grooves on shoulders from a bra' to 'documented history of recurrent dermatitis of the skin related to large breasts. An example is intertrigo (a rash appearing between folds of skin); -or- documented history of grooves on shoulders from a bra.'
Equipment in skilled nursing / long term care facility	Effective immediately, policy retired.
Durable Medical Equipment & Prosthetics	Effective immediately, policy revised. Prior authorization is not required for DME and supplies that are included in a facility's per diem. New non-covered indications: Durable medical equipment (DME) and supplies covered under a facility's per diem are not eligible for separate reimbursement.
Artificial Pancreas System	Effective immediately, policy revised. Artificial pancreas is now covered for ages 7 years and older, when criteria are met.
Airway clearance system / chest compression generator system	Effective 11/1/18, policy revised. Added chest injury and spinal instability to list of non-covered indications. Language indicating that requests will be initially authorized for 3 months rental, with continued rental requiring separate prior authorization and documentation of medical necessity, was moved from the Administrative Process section to Indications that are covered #4. Added that coverage beyond three months requires that member is consistently using device. Added criteria for replacement.
Wearable cardioverter defibrillator and non-wearable external defibrillator – Commercial & Minnesota Health Care Plans	Effective immediately, policy title changed to Automatic external defibrillator. Wearable cardioverter defibrillator and accessories have been moved to the DME benefits grid as covered items. The coverage criteria for automatic external defibrillator remain on the policy, with no changes made to the criteria. Prior authorization is required for automatic external defibrillators.

Coverage Policies	Comments / Changes
Discography/intra-discal steroid injections	Effective 9/1/18, lumbar discography is considered experimental/investigational and therefore not a covered service. Cervical and thoracic discography, functional anesthetic discography, and intra-discal steroid injections are also considered experimental/investigational and continue to be non-covered services.
DME Benefit Grid	Wearable cardioverter defibrillator, and replacement garments and electrodes added to the grid as covered. Replacement battery for wearable cardioverter defibrillator added as covered.
Genetic Testing: Connective Tissue, Skeletal and Integumentary Disorders	Effective 11/1/18. Policy revisions to describe additional covered and non-covered indications for testing. Prior authorization is required for most services. When coverage criteria are met, covered services now include genetic testing for ankylosing spondylitis, nonradiographic axial spondyloarthritis, tuberous sclerosis complex, primary lymphedema, hypophosphatasia, and hereditary hypophosphatemic rickets as well as whole exome sequencing. Coverage of multiple-gene panels for Ehlers-Danlos syndrome (EDS) is restricted to orders placed by genetics specialists. Single-gene testing for EDS, vascular type, is unchanged.

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

Pharmacy Policy updates – 9/1/18

HEALTHPARTNERS DRUG FORMULARY

Formulary updates are made quarterly. Recent updates for Commercial and State Programs include:

1. ADHD stimulant medications. Quantity limits have been updated, up to the FDA-approved maximum dose, up to #3 short-acting pills per day and #2 long-acting pills per day.
2. Insulin detemir (Levemir) has been updated from “on-formulary with step-therapy” to “on-formulary with prior authorization.” Criteria remain similar: reserved for patients with an inadequate response to insulin glargine, or with medical contra-indications to its use.
3. Olopatadine (Pazeo) remains non-formulary and prior authorization has been added. Pazeo is reserved for patients with an inadequate response to generic olopatadine 0.1% (Patanol generic).
4. Semaglutide (Ozempic) has been added to formulary.
5. Guselkumab (Tremfya) will require the use of secukinumab (Cosentyx) prior to approval. Change will be effective 10/1/18.
6. The following medications will be added to the Trial Drug Program effective 9/1/2018. The first 6 fills of a trial drug will be limited to less than a month supply, usually 14-15 days’ supply. The trial drug program is for medications that may not be well tolerated due to side effects, or with potential for discontinuation.
    - Oncology: Cometriq (cabozantinib), Lynparza (olaparib), Nerlynx (neratinib), Odomzo (sonidegib), Rubraca (rucaparib), Zejula (niraparib)
    - Parkinson’s: Nuplazid (pimavanserin)

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** *(path: 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.

PHARMACY MEDICAL POLICIES

Coverage Policies	Comments / Changes
Botulinum Toxin Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=AENTRY_045822)*	Prior authorization from Pharmacy Administration is required for some uses of botulinum toxins. Claims received without prior authorization for these uses may be denied.
Oncology Drug Coverage Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=ENTRY_190828)*	Prior authorization from Pharmacy Administration is required for select oncology medications. Claims for drugs on this policy received without prior authorization may be denied.
Recently FDA-Approved Medications Coverage Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=AENTRY_046122)*	Prior authorization from Pharmacy Administration is required for newly approved, professionally-administered specialty medications. Click **HERE*** for a complete and up-to-date list of drugs impacted by the policy or visit **healthpartners.com**. **path: http://www.healthpartners.com/ucm/groups/public/@hp/@public/@cc/documents/documents/dev_058782.pdf)* As drugs are approved for use, Pharmacy Administration will identify impacted drugs. Effective dates of the prior authorization requirement for each drug will be clearly stated. This list of impacted drugs is subject to updates without further notice. Claims received without prior authorization may be denied as this policy was published in November 2011.

2018 Clinical Indicators preliminary results

The preliminary 2018 HealthPartners Clinical Indicators results will be posted to the secured provider portal in mid-September for a comment period before final publication. The Clinical Indicators Report features comparative provider performance on clinical measures and consumer satisfaction results. The primary purpose is to provide valid and reliable information for providers to use in their efforts to improve patient care and outcomes. HealthPartners uses this information to support internal quality improvement initiatives, which includes provider incentive and tiering programs.

To view the document, click **HERE** *(path: https://healthpartners.com/provider-secure/quality-and-measurement/provider-measurement-results/)* and log in to the provider portal. Under the Quality drop down menu, choose Quality and measurement, Performance Measurements and Preliminary 2017/2018 Clinical Indicators Results.

The comment period ends October 30, 2017. The final 2017 Clinical Indicators Report and its Technical Supplement will be available online at **healthpartners.com/quality** after November 7, 2018. A reminder will appear in the November Fast Facts.

3D mammogram coverage

STATE OF MINNESOTA EMPLOYEES

Effective July 1, 2018, the State of Minnesota employee benefits plan discontinued covering screening 3D mammograms under the preventive benefit. This decision applies to group numbers:

- 3080 – State of Minnesota
- 3081 – State of Minnesota – Direct Billed
- 4101 – PEIP January Renewals
- 4107 – PEIP July Renewals

The State of Minnesota's rationale for this decision is that the US Preventive Service Task Force (USPSTF) has not given screening 3D mammograms a Grade A or B recommendation at this time.

The State will cover all 3D mammograms under the member's Lab/Pathology/X-ray benefit subject to deductible and coinsurance. The State will cover conventional digital or film screening mammograms under the preventive benefit.

All other HealthPartners plans continue to cover 3D mammograms for routine screening under the member's preventive benefit which typically provides 100% coverage.

Government Programs

Claims Edits Aligning with National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

Just a reminder, as of 1/1/2018, HealthPartners is applying claim edits to align with NCDs and LCDs to all of our Medicare products. We have always expected providers to follow Medicare criteria unless otherwise indicated, however edits have been set up to apply to claims accordingly.

Fall Prevention Awareness Day

Fall Prevention Awareness Day is on September 22 and one way to help our patients avoid falls is through our work on the Medicare **Annual Wellness Visits**.

One of the important topics covered in that visit is asking about falls.

The Centers for Medicare and Medicaid Services (CMS) has prioritized this area for the simple reason – falls in the elderly have significant consequences. Medicare health plans are required to survey members asking if they have talked to their doctors about falls and how to prevent them. As clinicians, we should all be ready to initiate conversations/questions with our patients. There are some pretty simple interventions that we can do to help lessen the risk.

1) Medication review – you or medication therapy management (MTM) to focus on reducing or removing those medications that affect alertness and balance. For seniors, fewer medications and lower doses are always a reasonable approach.
2) Encouraging your patients to remain as active as possible – not only with walking but also through exercise programs offered by community resources and fitness centers. Balance and strengthening as well as walking can make a difference. For more targeted approaches, a physical therapy referral can always be helpful.
3) Encourage your patients to have regular eye appointments and remind them of the importance of proper fitting shoes.

Thank you for your involvement in our Annual Wellness Visit work, which will continue to help both our senior patients and our care groups continue to perform successfully in this new Medicare environment.

If you have questions regarding the content of this newsletter, please contact the person indicated in the article or call your HealthPartners Service Specialist. If you don't have his/her phone number, please call **952-883-5589** or toll-free at **888-638-6648**.

This newsletter is available online at **healthpartners.com/fastfacts**.

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Provider Directory and Subdirectory Questionnaire

Purpose:

Section 438.10 of the Managed Care Federal Regulation issued on May 6, 2016, requires providers who provide health care services to Minnesota Health Care Programs (MHCP) members enrolled in a Managed Care Organization (MCO) must confirm compliance with the requirement of cultural competency training and accessibility for people with disabilities.

Instructions:

Please complete this form for each office location and fax the form back to 952-853-8708.

If you have any questions regarding this form, please contact us at HealthPartners at 844-732-3537.

Sole Practitioner Name (First, Middle Initial, Last)_____

Clinic/Facility Name_____

Office Location Address_____

City _____State_____Zip Code_____

NPI Number_____

Clinic/Facility/Sole Practitioner Website URL_____

Clinic/Facility/Sole Practitioner Phone Number (including area code)_____

Is your office accepting new patients? Yes ☐ No☐

Cultural Competency:

Cultural and linguistic competence is the ability of managed care organizations and the providers within their network, to provide care to recipients with diverse values, beliefs and behaviors, and to tailor the delivery of care to meet recipients' social, cultural, and linguistic needs. The ultimate goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion, or socioeconomic status.

Has staff in your office completed cultural competency training in the past 12 months?

Yes ☐ If yes, please provide month/year_____No☐

Accessibility:

The following provider types do not need to complete the accessibility portion of this questionnaire: Home Health, Home and Community Based Services (HCBS), Nursing Homes, Personal Care Assistance (PCA), and Transportation.

The Americans with Disabilities Act (ADA) requires public accommodations to take steps to ensure that persons with disabilities have equal access to their goods and services. For example, the ADA requires public accommodations to make reasonable changes in their policies, practices, and procedures; to provide communication aids and services; and to remove physical barriers to access when it is readily achievable to do so. https://www.ada.gov/

Is your office, including parking, entry ways, and other relevant space, accessible for people with disabilities? Yes ☐ No☐

Are your office exam rooms accessible for people with disabilities? Yes ☐ No☐

Does your office have equipment accessible for people with disabilities? Yes ☐ No☐

Please provide a contact name and phone number in case there are questions regarding your responses to this questionnaire:

Signature	Date
Print Name	Phone Number