HealthPartners

Fast Facts

MARCH 2021

News for Providers from HealthPartners
Provider Relations & Network Management

Administrative

Make sure patients can find you

Patients are often seeking to connect with providers. For many, seeing a provider who shares their race, ethnicity or gender is important. This is true for many specialties, but we hear it particularly from those seeking behavioral health providers.

To ensure patients can easily find clinicians in your practice who meet their needs, please update your practice's information in our Provider Data Profile application.

Follow these quick and easy steps:

- Log in at healthpartners.com/provider using your username and password
- Click on **Provider Data Profiles**
- Make updates by clicking on **Edit Practitioner**, including race, country of origin and personal profile

If you need access to the Provider Data Profile application, contact your delegate (located in the help center after you log onto the portal).

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Administrative Manual policy updates

Coverage Policies	Comments / Changes
Advance Notice of Non-Coverage for Medicare Members	Clarified use of pre-service organization determinations.
GA, GY, GZ Modifier on claims submissions for Medicare plans	Clarified claims denied to provider liability.

Medical Policy updates – 3/1/2021

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
Electric tumor treatment fields (ETTF) to treat glioblastoma (Optune™) - Minnesota Health Care Programs	Effective 12/28/2020, policy revised. Electrical stimulation for cancer treatment is covered for glioblastoma only. Code is covered according to Medicare policy and guidelines.
Site of service – attended polysomnography for evaluation of obstructive sleep apnea (OSA)	Effective 2/1/21, policy revised. • Clarified that in-facility titration of an upper airway/hypoglossal nerve stimulation device is generally covered subject to member plan documents. • Clarified that parasomnias do not need to be refractory to therapy. • Clarified under repeat testing, that members with known OSA who require repeat testing to start or resume OSA treatment, are still required to meet site-of-service criteria. • Added pulmonary hypertension as an example of a cardiorespiratory condition that may degrade accuracy of home sleep apnea testing (HSAT). • Added examples of environmental factors that may preclude use of HSAT. • Revised definition of HSAT to identify minimum parameters measured by this test.

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

Pharmacy updates

As part of the national Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also known as the SUPPORT Act, HealthPartners supports these programs to reduce abuse and misuse of prescription drugs for our State Program members.

Coverage Policies	Comments / Changes
Opioid Naïve days' supply limitation	Edits are in place for all opioid prescriptions. These edits include: • 7-day limits for new opioid prescriptions, and 14-day limits per episode. Prior authorization is required for more than 14 days.
Maximum doses of opioids	Edits are in place to limit opioid claims if cumulative doses meet or exceed 90 MME/day. All opioids have prior authorization and/or quantity limits. A new quantity limit has been added for tramadol 50mg of #8 per day. Prior authorization is required for higher doses.
Safety edits to limit duplicate fills and early refills	Edits are in place for all opioid prescriptions: • Limiting early refills. • Limiting concurrent use of long-acting opioids. Prior authorization is required for all long-acting opioids.
Concurrent opioids with benzodiazepines	Edits are in place to limit overlapping prescriptions for opioids and benzodiazepines. Prior authorization is required for concurrent prescriptions.
Concurrent opioids and antipsychotic medications	This is a review program, identifying patients with opioids and antipsychotic medications from two or more prescribers.
Antipsychotic medications in children	This is a review program, identifying children less than 18 years of age who are receiving antipsychotic medications as well as their prescribers. Antipsychotic medications carry higher metabolic risks and safety concerns for children.
Naloxone for higher-risk members	An alert is sent to pharmacies for members at risk for overdose encouraging naloxone. This is a new program, effective March 1, 2021.
Concurrent opioids with buprenorphine	Edits are in place to limit overlapping prescriptions for opioids and buprenorphine (Suboxone). This is a new program, effective March 1, 2021.
A program to identify potential fraud or abuse of controlled substances by individuals, health care providers and pharmacies	This program includes screening and audits of prescribers, pharmacies and members.

Please see the HealthPartners Formulary for details and a complete list of updates healthpartners.com/formularies. For additional information, please contact **peter.s.marshall@healthpartners.com**.

Quarterly formulary updates and additional information such as Prior Authorization and Exception Forms, Specialty Pharmacy information, and Pharmacy and Therapeutics Committee policies are available at: **healthpartners.com/provider/admin tools/pharmacy policies**, including the **Drug Formularies**.

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.

Government programs

Advance notice of noncoverage for Medicare members

PRE-SERVICE ORGANIZATION DETERMINATIONS

If there is uncertainty about whether or not something provided or referred for is covered for HealthPartners Medicare Advantage and Medicare Cost members, HealthPartners requires providers to request a Pre-service Organization Determination. Please refer to the current administrative policy: **Advanced Notice of Non-Coverage for Medicare Members**.

The process for requesting a Pre-Service Organization Determination is similar to requesting a prior authorization. Please follow the process outlined in the Prior Authorization for Medicare Products policy, Section III, 7 through 9.

Click here to review this policy: **Prior Authorization Review Process for Medicare and Medicaid**

HealthPartners must issue a coverage decision before the service can be provided. Failure to comply with this policy and process may result in denial of claims.

Use of GA and GY Modifiers on claim submissions for Medicare Advantage and Medicare Cost plans

USE A GA MODIFIER WHEN:

- You have determined that an item or service will not be covered, have notified the member of this information, and have obtained the appropriate written member consent prior to rendering the noncovered item or service.
- HealthPartners made a pre-service organization determination to deny coverage and sent the member a Notice of Denial of Medical Coverage prior to the noncovered item or service being rendered and you have obtained the appropriate written member consent prior to rendering the noncovered item or service.

Scenario	Result
• Covered service, GA modifier used inappropriately	Denied to provider liability
• Noncovered service, no GA modifier used	Denied to provider liability
• Noncovered service, GA modifier used appropriately	Denied to member liability

USE A GY MODIFIER WHEN:

- An item or service is never covered by Medicare and HealthPartners, and is a clear benefit exclusion in the member's health plan documents.
  - The use of this modifier indicates to the plan that you have verbally communicated this information to the member and have clearly documented the communication in the patient's medical record.

• Covered service, GY modifier used inappropriately	Denied to provider liability
• Never covered service, no GY modifier used	Denied to provider liability
• Never covered service, GY modifier used appropriately	Denied to member liability

Please refer to the following administrative policies for more details:

- **Use of GA, GY or GZ Modifiers on Claim Submissions for Medicare Plans**
- **Advance Notice of Noncoverage for Medicare Members**

If you bill HealthPartners for covered services using these modifiers inappropriately, the claim will be denied to provider liability.

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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