HPHCURRENT EVENTS

Medicare Advantage: Expansion and New Benefits for 2019

As open enrollment for Medicare Advantage begins this month, we want to update you on our expanded service area and new benefits for 2019.

Expanded service area

We're pleased to announce that we've expanded our service area for Stride℠ (HMO) Medicare Advantage plans from 20 to 26 counties for 2019:

- **Massachusetts:** Barnstable, Bristol, Essex, Middlesex (excluding 01824, 01826, and 01863), Norfolk, Plymouth, Suffolk, and Worcester
- **Maine:** Androscoggin, Cumberland, Franklin, Kennebec, Knox, Sagadahoc, Waldo, and York
- **New Hampshire:** Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan

New benefits & plan changes for 2019

As in 2018, members can choose from the following Stride plan options: Basic Rx (HMO), Value Rx (HMO), or Value Rx Plus (HMO). Plans continue to offer competitive member premiums, minimum PCP copays, and comprehensive benefits including: Part D prescription drug coverage; inpatient hospital coverage; routine care and wellness visits; preventive dental coverage; low-cost hearing exams and robust hearing aid coverage with copayments; and annual eye exams.

Among the updates for 2019 are:

- $0 premium Basic Rx plan available in all ME and NH counties and most MA counties
- $0 copayment for diabetic retinopathy screening
- OTC benefit changes for Value Rx and Value Rx Plus plans ($200 and $250 per year, respectively, increasing from $150 per year)
- A new Wallet Benefit, a spending allowance to help cover qualified healthcare expenses such as fitness, eye wear, acupuncture, massage therapy, and more. The Wallet Benefit amount varies by plan:
    - Basic Rx (HMO): $250 per year
    - Value Rx (HMO): $325 per year
    - Value Rx Plus (HMO): $400 per year

- New Gain Rx plan for Hillsborough, Merrimack, and Rockingham counties in New Hampshire. This plan is designed for beneficiaries who are eligible for Medicare and Medicaid. Gain Rx members who are eligible for both Medicare and full Medicaid coverage will have $0 premiums and no copayment or coinsurance for PCP office visits, specialist office visits, outpatient surgery, or inpatient hospital stays.
- Opioid edits at pharmacy point of service when two or more prescribers have written orders, or when Morphine Milligram Equivalent (MME) is 90mg or greater

If you have questions about our 2019 Stride℠ (HMO) Medicare Advantage plans or would like information to display in your office, please contact your Provider Relations representative. ◆

CAQH Solution Chosen to Improve Provider Directory Accuracy

As a member plan in HealthCare Administrative Solutions (HCAS), Harvard Pilgrim is participating in efforts to institute a centralized process for providers to review their demographic data and report changes to ensure provider directory accuracy. We are pleased to announce that an important milestone has been reached: HCAS has selected a vendor for this work — DirectAssure®, a CAQH Solution.

We anticipate that the DirectAssure® business solution will allow Harvard Pilgrim and other HCAS health plans to maintain more accurate provider directories while easing the burden on healthcare providers, who currently must update their demographic information individually with each plan. Because DirectAssure® works in concert with CAQH ProView, an online database that most providers already use to regularly review and attest to professional and practice information, this approach capitalizes on an existing workflow.

As you know, patients rely on directories for information that guides them in choosing a provider that's right for them and for assistance in contacting provider offices. Inaccurate provider directory information is not only a source of frustration for patients, but also a barrier to receiving good health care. Recognizing this, several government and regulatory agencies, including CMS, MassHealth, and the National Committee for Quality Assurance, have developed requirements that health plans maintain accurate provider directory data. By offering providers a more efficient means of updating directory information, this centralized approach will help improve the accuracy of directories.

Harvard Pilgrim will be working closely with our provider partners on this effort in the coming months — discussing implementation and timing, training needs, and answering your questions.

For more information, including a copy of the announcement press release and an FAQ, please refer to the following websites:

- http://www.hcasma.org/Directory.htm
- https://www.caqh.org/solutions/directassure

We'll also continue to share updates in future issues of the newsletter. ◆

Introducing Maine POS and HMO Open Access Plans

On Jan. 1, 2019, Harvard Pilgrim is introducing a new family of commercial POS and HMO products for fully insured large groups (100+ employees) in Maine, known as POS and HMO Open Access plans.

These plans provide a new option for the large group market that features the best aspects of Harvard Pilgrim's existing HMO and PPO products. They will offer members the ease and flexibility of a PPO, with no requirement for referrals, along with affordability.

Although referrals will not be needed for POS or HMO Open Access plans, members will still be required to select a Harvard Pilgrim primary care physician — to continue Harvard Pilgrim's focus on care coordination and care management and emphasize the doctor-patient relationship.

Recognizing members

We will offer four base plan designs: Open Access POS, Open Access POS HSA, Open Access HMO, and Open Access HMO HSA.

You can recognize members of these plans by their Harvard Pilgrim member ID cards.

Provider directory and plan information

Open Access POS and Open Access POS HSA members will use the "POS/POS Open Access" provider directory, and Open Access HMO and Open Access HMO HSA members will use the "HMO/HMO Open Access" directory. For more information about participating providers, please refer to Harvard Pilgrim's online provider directory or in *HPHConnect*.

For more information, please refer to the Open Access POS and Open Access HMO product pages in Harvard Pilgrim's commercial *Provider Manual*.◆

SaveOn Program Now Called Reduce My Costs

Harvard Pilgrim has changed the name of our SaveOn program to Reduce My Costs as part of an effort to make the health care experience easier for our members, employers, and providers by using product and program names that clearly reflect what they do. It's still the same program — offering qualifying members opportunities to save money on certain services.

Through Reduce My Costs, members receive cost information and financial incentives to encourage them to make informed health care decisions. By calling the Reduce My Costs phone line, participating members can speak with a nurse to receive information about the relative cost for certain elective outpatient procedures and diagnostic tests, including but not limited to: bone density studies, colonoscopy, laboratory services, radiology and imaging services (MRIs, CT scans, mammogram, etc.), and other non-emergency outpatient tests and procedures. This information can help members lower their out-of-pocket costs for particular services.

Harvard Pilgrim offers Reduce My Costs to Massachusetts, Maine, and New Hampshire employer groups, with availability and program cost varying based on factors such as group size and fully insured or self-insured status.

For more information, please refer to the Reduce My Cost information on our website.◆

CLINICIAN CORNER

Updates to Antiemetic Therapy Medical Review Criteria

Harvard Pilgrim is updating our commercial prior authorization medical review criteria for antiemetic therapy medications, which are indicated for the treatment of nausea and vomiting, commonly in oncology patients.

For dates of service beginning Dec. 1, 2018, the injectable forms of the drugs Cinvanti, Sustol, and Varubi will be covered with prior authorization, when all specific criteria outlined on the policy are met. This coverage is reflected via the addition of the following codes:

- C9463 – Injection, aprepitant, 1 mg (Cinvanti)
- J1627 – Injection, granisetron, extended-release, 0.1 mg (Sustol)
- C9464 – Injection, rolapitant, 0.5 mg (Varubi)

Additionally, Harvard Pilgrim is removing Anzemet (J1260 – Injection, dolasetron mesylate, 10 mg) from the policy because the medication is no longer available on the market. The following codes for the medications Aloxi and Emend will remain on the policy, and will continue to be covered with prior authorization:

- J2469 – Injection, palonosetron HCl, 25 mcg (Aloxi)
- J1453 – Injection, fosaprepitant, 1 mg (Emend)

To request authorization for any of these medications, please contact CVS Health–NovoLogix via phone (844-387-1435) or fax (844-851-0882). For more information, including criteria and prior authorization request forms, please refer to the Medical Drug Prior Authorization page in the Provider section of Harvard Pilgrim's website. ◆

Updates to Molecular Genetic Testing Clinical Guidelines

Harvard Pilgrim would like to make providers aware of some updates to the coverage criteria in several of the clinical guidelines maintained by AIM Specialty Health, which oversees our prior authorization program for molecular genetic tests. These changes apply for our commercial and Medicare Advantage products. For complete information, refer to Harvard Pilgrim's Molecular Diagnostic Management Medical Review Criteria and AIM's updated clinical guidelines.

Hereditary Cancer Susceptibility

Genetic testing of BRCA1/2, ATM, and PALB2 are now considered medically necessary and covered with prior authorization for the treatment of individuals with localized stage III (National Comprehensive Cancer Network [NCCN] high-risk and very high-risk group), regional or metastatic prostate cancer.

Pharmacogenetic and Thrombophilia

In addition to the existing covered indications on the policy, testing for common variants in Factor V Leiden (F5) and prothrombin (F2) is now covered for individuals with an unprovoked venous thromboembolism (VTE) when test results will impact long-term medication management and at least one of the following applies:

- There is concern for homozygous F2 or F5 or compound heterozygous F2/F5
- The annual risk of recurrent VTE is estimated to be between 5% and 10%

Reproductive Carrier Screening and Prenatal Diagnosis

- For a prenatal cell-free DNA screening to be covered for a single-gestation pregnancy, the 10-week gestation age limit has been removed.
- Cases with a known co-twin demise (vanishing twin syndrome) are no longer excluded from coverage of prenatal cell-free DNA screening.
- Criteria for carrier screening was expanded to include coverage for additional rare genetic variants for conditions common in certain ethnicities. Carrier screening for additional conditions may be considered medically necessary if the patient is at increased risk to be a carrier based on their ethnicity, including but not limited to:
    - Tay-Sachs carrier screening for individuals with French Canadian ancestry
    - Maple syrup urine disease screening for individuals with Mennonite ancestry

Single-Gene and Multifactorial Conditions

While the required criteria for coverage of genetic testing with a single-gene panel remains unchanged, the criteria that must be met in order for genetic testing with a multi-gene panel to be covered no longer includes the requirement that the patient has been evaluated by a board-certified medical geneticist, genetic counselor, or other specialist with specific expertise in the genes and conditions being tested for.

Genetic testing with a multi-gene panel is medically necessary when all the single-gene testing criteria listed on the policy are met, as well as both of the following:

- The test is as targeted as possible for the clinical situation (i.e. does not include genes or mutations that are not clinically reasonable for the specific scenario)
- Clinical presentation warrants testing of multiple genes

Somatic Tumor Testing

- The criteria were expanded to include coverage of somatic genetic testing for uveal melanoma when the patient meets the testing criteria outlined in the relevant NCCN Clinical Practice Guidelines in Oncology.
- Gene expression or molecular profiling assays for confirmed prostate tumors are considered experimental and investigational and not covered.
- The criteria for coverage of MammaPrint to assess the risk for recurrence in a woman has been revised to include:
    - Breast tumor is stage 1 or stage 2

- Patient is at high clinical risk for recurrence based on the MINDACT categorization ◆

Synagis for Upcoming RSV Season

With 2018-2019 respiratory syncytial virus (RSV) season approaching, Harvard Pilgrim would like to remind providers of our policy regarding Synagis (palivizumab), an injection of antibodies used to protect high-risk infants from severe RSV disease.

Synagis requires prior authorization and should be reserved for infants with a history of pre-term birth, and children with chronic lung disease or congenital heart disease. For members who qualify to receive five doses, the first dose is typically administered at the beginning of November and the last dose at the beginning of March to provide protection into April.

Harvard Pilgrim's preferred specialty vendor, CVS Specialty, will handle dispensing of this medication. To order Synagis, clinicians should complete the appropriate form, found on the Pharmacy prior authorization page on Harvard Pilgrim's website. Massachusetts and New Hampshire providers will also need to fax a copy of the prescription to CVS Specialty at 800-323-2445, since their state-specific standard forms don't include a prescription section. However, the form for providers in all other states allows for the capability of including prescription information.

For more information, please visit the Pharmacy section of Harvard Pilgrim's provider website or call Clinical Pharmacy Services at 617-509-1786. ◆

OFFICE ASSISTANT

Hospital-Based Clinic and Treatment Room Commercial Payment Policy Updates

In a hospital-based clinic setting, Harvard Pilgrim reimburses the physician for the evaluation and management (E&M) services, and any facility charges should be billed under a clinic revenue code in the 051X or 052X series. Payment for clinic services is based on the contracted professional fee rate for the facility; for providers reimbursed for clinic services at a global rate, facility charges are not separately reimbursable. This is reflected in our current commercial Hospital-Based Clinic and Treatment Room payment policies.

Consistent with these policies, effective for dates of service beginning Jan. 1. 2019, Harvard Pilgrim will no longer reimburse E&M codes (CPT 99201-99499, 92002-92004, 92012-92014) when they are billed with any of the following revenue codes:

- 028X (Oncology) — used to report the treatment of tumors and related diseases, such as chemotherapy
- 0760, 0761, 0769 (Treatment Room) — used to report a procedure or treatment
- 0770, 0771 (Preventive Care Services) — used to report preventive screening services, such as screening for glaucoma or screening for a pelvic exam

This change is in keeping with appropriate billing and reimbursement practices indicated by the Uniform Billing Editor, and will help avoid payment retractions that occur when Harvard Pilgrim is billed for the same service for the same patient by both the physician and facility.

For more information, please refer to Harvard Pilgrim's updated commercial Hospital-Based Clinic Payment Policy and Treatment Room Payment Policy. ◆

2019 CPT and HCPCS codes

Harvard Pilgrim will accept new 2019 CPT and HCPCS codes for dates of service beginning Jan. 1, 2019, and will update fee schedules and policies as appropriate. Claims that include deleted CPT and HCPCS codes for dates of service after Dec. 31, 2018 will be denied. Harvard Pilgrim's commercial Non-Covered Services Payment Policy will be updated in the first quarter of 2019 to reflect the 2019 code changes.◆

Update to Filing Limit for Replacement Claims

Harvard Pilgrim has updated our commercial Replacement Claim Billing Policy to extend the timeframe for providers to submit a replacement claim. For claims received after Sept. 1, 2018, providers must submit a replacement claim within 90 days of the first date of the Explanation of Payment (EOP) of the original claim. Previously, the filing limit was 90 days from the date of service.

As a reminder, replacement claims are only accepted for individual claims and may be submitted electronically or on paper. For complete information, please refer to the updated Replacement Claim Billing Policy.◆

Network Matters **is a monthly newsletter for the Harvard Pilgrim provider network**

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