Hip and knee joint replacement surgery policy change

EFFECTIVE 1/1/2023

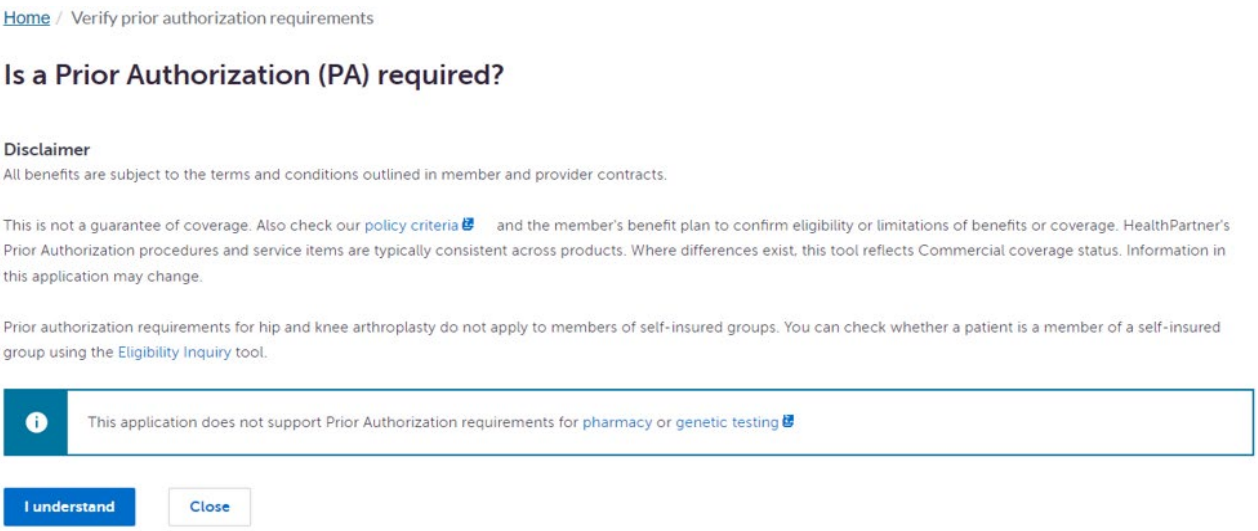
HealthPartners will require provider authorization for hip and knee joint replacement and revision. This policy is applicable to all members who have HealthPartners fully insured coverage, including fully insured commercial members, Minnesota Health Care Programs (Medicaid) members and Medicare Advantage Members. Prior authorization requirements for hip and knee arthroplasty do not apply to self-insured members.

IMPORTANT INFORMATION

- **Prior auth links:** **Prior Authorization Form – Knee** **Prior Authorization Form - Hip**
- Prior authorizations can be submitted online by logging into your HealthPartners Provider Portal account and creating a new **prior auth request**
- Here is a link to the coverage criteria for hip and knee replacement and revisions: **Hip/knee joint replacement policy**
- You can check which procedure codes require prior authorization at **healthpartners.com/verifyparequirements** or visit **healthpartners.com/provider-public/**; then click on *Verify PA requirements* in the **Shortcuts** box on the left-hand side of this landing page. This application can be used to determine if any procedure codes require prior authorization, not just hip and knee replacement and revision codes.

FREQUENTLY ASKED QUESTIONS

1. **How are surgeries scheduled prior to announcement of this policy handled?** All hip and knee replacement and revisions surgeries for fully insured members will require prior authorization effective 1/1/2023, even if the surgery was scheduled before this policy was announced. Prior authorizations for these procedures should still be submitted.
2. **Does the surgical practice or hospital submit the prior authorization form?** The surgical practice should submit the prior authorization form. The surgical practice has the clinical information necessary to complete the form.
3. **Are all fully insured members included?** Yes, commercial fully insured members from plans issued MN, ND, SD, IA and WI are included. Government-sponsored plans are also included.
4. **What happens if I submit a prior authorization form for a self-insured member?** You will receive a response from HealthPartners indicating this member does not require a prior authorization for this service.
5. **Why is HealthPartners choosing to prior authorize these procedures?** Hip and knee replacements and revisions are expensive procedures, cost in excess of $23,000, and we need to verify that members meet surgical criteria prior to incurring an expense of this magnitude.



SPOT THE SPAM: ASK WHO, WHAT AND WHY?

WHO

Who's the sender? Is the sender familiar? Does the sender's email address match the sender's name?

NOTE – Look closely at the spelling in the email address and domain, along with spelling in the email message. Scammers can be tricky and may know you're likely to receive emails from HealthPartners and may try to replicate our name and email messages. If a sender's name or email address don't match previous communications, use extra caution with the message.

WHAT

What's the email trying to get you to do: Does the email contain a link or attachment? Is the link URL (hover over the link with your mouse) different from the email topic or sender? Is what they're asking strange?

If the answer to all these questions is yes, use extra caution before taking any action with the email. Phishing emails can have a topic that doesn't make sense for the sender or creates a sense of urgency, anxiety, loss or is pushy. They also can leave out details or sounds too good to be true. Hovering your cursor over links may show a different website address than the topic or sender of the email. If the email appears phishy, do not interact with it.

WHY

Why are you receiving the email? Is it expected? Does it sound reasonable?
For example: Do you receive emails or notifications as authorized contact or delegate for your organization? Did you authorize an action on HealthPartners provider account?

You can protect your organization and the people you serve by spotting and not acting on phishing emails.

Medical Policy Updates – 11/1/2022

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
Category III CPT codes – Minnesota Health Care Programs	• Effective 9/13/2022, the following services now covered per updated DHS guidance: ○ **0404T** - Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency. • Prior authorization is not required.
Investigational services – list of non-covered services	• Effective immediately, the following has been added as a non-covered service: ○ **64590** - Implantable peripheral nerve stimulation for treatment of urinary incontinence (e.g., eCoin). **Note**: code provided is not specific to this device, but is considered investigational when used to report this service
Dental services - orthognathic surgery	• Effective immediately: Indications not covered section of this policy has been revised to reflect services not covered under the medical benefit. • Effective 1/1/2023: All guidance related to coverage of orthognathic surgery for treatment of temporomandibular disorder (TMD) will be located exclusively on the Temporomandibular disorder (TMD) treatments policy.

Coverage Policies	Comments / Changes
Temporomandibular disorder (TMD) treatments	• Effective 1/1/2023: Orthognathic surgery for surgical treatment of TMD will be considered when all criteria are met: ○ Physical symptoms including, but not limited to, pain, impaired mandibular range of motion, locking of the jaw; and ○ Observation of TMJ instability or dysfunction; and ○ Documentation of 3-6 months of conservative treatment when determined appropriate that includes but is not limited to, physical therapy, analgesics and oral appliances; and ○ Documentation of significant impairment of function and or internal derangement of the joint which is not amenable to improvement with non-surgical care; and ○ Documentation from a TMD Specialist, Orofacial Pain Specialist, or requesting surgeon clearly explains why a member's clinical condition cannot be treated with conventional surgical TMD procedures.
Breast surgery	Effective 1/1/2023, policy revised to indicate that requests for breast reconstruction due to Poland syndrome are reviewed on a case by case basis and require prior authorization.
Synagis (palivizumab) injections for respiratory syncytial virus (RSV) prophylaxis – Minnesota Health Care Programs	Effective immediately, policy revised to reflect changes to DHS coverage criteria for Synagis for the 2022-2023 RSV season. Members who meet criteria are now eligible for up to eight (8) monthly Synagis injections. This is an increase over the five (5) monthly doses that members were eligible for during the 2021-2022 RSV season. Requests for Synagis continue to require prior authorization.
Genetic testing - pharmacogenetics	Effective 1/1/2023, policy has been updated for alignment with practice guidelines and literature. • Coverage criteria for CYP2C19 variant analysis to determine drug metabolizer status has been expanded to include the following: ○ The member is being considered for or is currently undergoing treatment with clopidogrel (Plavix); **and** ○ The member meets **all** of the following: ▪ Will be undergoing percutaneous coronary intervention (PCI); ▪ Has acute coronary syndromes (ACS); ▪ Is at high risk for poor outcomes (e.g., urgent PCI for ACS event, elective PCI for unprotected left main disease or last patent coronary artery).
Genetic testing: aortopathies and connective tissue disorders	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature. **FBN1 sequencing for Marfan Syndrome** • FBN1 sequencing and/or deletion/duplication analysis is considered medically necessary when: • The member has some of the below symptoms of Marfan syndrome but does not meet the clinical diagnostic criteria for a diagnosis. ○ The clinical diagnostic criteria are as follows: ▪ Aortic root enlargement (Z-score >2.0 or greater) or dissection, and ▪ Ectopia lentis, or

Coverage Policies	Comments / Changes
Genetic testing: aortopathies and connective tissue disorders - Continued	▪ A systemic score of >7 or greater, as demonstrated by the following clinical features and associated scores*: • Wrist and thumb sign (3) • Wrist or thumb sign (1) • Pectus carinatum deformity (2) • Pectus excavatum or chest asymmetry (1) • Hindfoot deformity (2) • Plain flat foot (pes planus) (1) • Pneumothorax (2) • Dural ectasia (2) • Protrusio acetabulae (2) • Reduced upper segment/lower segment AND increased arm span/height ratios (1) • Scoliosis or thoracolumbar kyphosis (1) • Reduced elbow extension (1) • 3 of 5 facial features (dolichocephaly, downward slanting palpebral fissures, enophthalmos, retrognathia, malar hypoplasia) (1) • Skin striae (1) • Myopia (1) • Mitral valve prolapse (1) **or** • The member has a close relative with a documented clinical diagnosis of Marfan syndrome and the member had symptoms of Marfan syndrome, but the member **does not** meet clinical criteria for diagnosis of an individual with a family history of Marfan syndrome, which are: o Clinical diagnostic criteria for an individual with a family history of Marfan syndrome: ▪ Ectopia lentis; or ▪ Multiple systemic features (see above criterion); or ▪ A dilated aortic root (if over 20 years, greater than two standard deviations; if younger than 20, greater than three standard deviations). **Loeys-Dietz Syndrome Multigene Panel** • Loeys-Dietz syndrome (LDS) multigene panel analysis are considered medically necessary when: • The member meets all the following: o Characteristic facial features, including widely spaced eyes and craniosynostosis; and o Bifid uvula or cleft palate; and o Tortuosity of the aorta and its branches; or • The member has a first degree relative with a clinical diagnosis of LDS; and • The panel includes, at a minimum, the following genes: TGFBR1 and TGFBR2.

Coverage Policies	Comments / Changes
Genetic testing: aortopathies and connective tissue disorders - Continued	**Familial Thoracic Aortic Aneurysm and Dissection (TAAD) Multigene Pane** • TAAD multigene panels are considered medically necessary when: • The member has aortic root enlargement (Z-score greater than 2.0) or has had a type A or type B aortic dissection; and • The member does not have any major criteria for diagnosis of another connective tissue disorder; or • The member has a family history of dilation or dissection of the aortic root, consistent with autosomal dominant inheritance; and ○ The panel includes, at a minimum, the following genes: ACTA2, FBN1, MYH11, SMAD3, TGFBR1, TGFBR2.

Genetic testing: epilepsy, neurodegenerative, and neuromuscular disorders	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature.
	Duchenne and Becker Muscular Dystrophy
	• An additional criterion for DMD Sequencing and/or Deletion/Duplication Analysis to establish or confirm a diagnosis of Becker Muscular Dystrophy is added to the current criteria as follows:
	  ○ The member has an elevated serum creatine kinase concentration, typically more than 5 times the normal levels.
	Hereditary Spastic Paraplegia Multigene Panel
	Criteria for multigene panel analysis to establish a genetic diagnosis of hereditary spastic paraplegia is revised as follows:
	• The member has any of the following:
	  ○ Lower-extremity spasticity especially in hamstrings, quadriceps, adductors, and gastrocnemius-soleus muscles; or
	  ○ Weakness especially in the iliopsoas, hamstring, and tibialis anterior; or
	  ○ Lower-extremity hyperreflexia and extensor plantar responses; or
	  ○ Mildly impaired vibration sensation in the distal lower extremities; and
	• A multigene panel must include the following genes, at a minimum: SPAST, ATL1, KIF1A, CYP7B1, SPG7, SPG11.

Genetic testing: prenatal diagnosis (via amniocentesis, CVS or PUBS) and pregnancy loss	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature. • Coverage criteria for **chromosomal microarray analysis and conventional karyotype analysis for prenatal diagnosis** have been revised. These tests are now considered medically necessary when the member has received counseling regarding the benefits and limitations of prenatal screening and diagnostic testing (including chromosomal microarray via amniocentesis, CVS or PUBS) for fetal chromosomal abnormalities. • Coverage criteria for **conventional chromosomal analysis for pregnancy loss** have been revised. These tests are now considered medically necessary in a member who has a history of two or more consecutive clinical pregnancy losses.

Coverage Policies	Comments / Changes

Hip and knee joint replacement surgery	• New policy effective 1/1/2023. Prior authorization is required for hip and knee joint replacement surgery, including hemiarthroplasty, patellofemoral arthroplasty, revision of total hip or knee replacement, and prosthesis removal. HealthPartners will utilize MCG Care Guidelines coverage criteria as follows:
	  ○ For hip replacement, including hemiarthroplasty and revisions: MCG 26th Edition: ISC Hip Arthroplasty (S-560) and MCG 26th Edition: ISC Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty (S-600)
	  ○ For knee replacement and revisions: MCG 26th Edition: ISC Knee Arthroplasty, Total (S-700)
	  ○ For patellofemoral arthroplasty or prosthesis removal: GRG: Musculoskeletal Surgery or Procedure GRG (SG-MS) (General Recovery Care) = GRG
	• Please see published policy for details.
	• Prior authorization is also required for these services for members on Medicare plans beginning 1/1/23. MCG Care Guidelines will apply when a Local Coverage Determination does not exist.
	• Prior authorization requirements do not apply to members of self-insured groups.

Repetitive transcranial magnetic stimulation	Effective 1/1/2023: • Policy title will change to Transcranial magnetic stimulation. • At least two months must pass between initial and repeat courses of treatment. • More than one repeat course of TMS is considered investigational as there is insufficient reliable evidence supporting the efficacy of multiple courses of treatment. • Navigated transcranial magnetic stimulation (nTMS) is considered experimental/investigational for any indication due to a lack of sufficient evidence supporting efficacy. • Direct supervision by a physician will no longer be required.
Outdoor/wilderness therapy programs	Effective immediately: Policy has been retired. This service is a non-covered benefit/contract exclusion.
Genetic testing: hereditary cancer susceptibility	Effective 1/1/2023, policy has significant revisions as follows (Please refer to published policy for specific details.): Prior authorization is still required. • Criteria expanded for Hereditary Breast Cancer Susceptibility Panels, BRCA1/BRCA2 Sequencing/Deletion/Duplication Analysis, and PALB2 Sequencing/Deletion/Duplication Analysis sections in the policy. • Hereditary Colorectal Cancer Susceptibility Panels section title changed to Hereditary GI/Colon Cancer Panel Tests with removal of several covered clinical indications and addition of two colorectal cancer indications. Expanded list of minimum required genes to be included in requested panels. • Addition of two clinical indications for coverage under the Hereditary Pancreatic Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Addition of several clinical indications under the Hereditary Prostate Cancer Susceptibility Panels section.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility - Continued	• Addition of MEN1 and MEN2 under the Hereditary Neuroendocrine Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Removal of several clinical indications under the APC Sequencing and/or Deletion/Duplication Analysis section. Addition of known familial mutation in APC and Multifocal/bilateral congenital hypertrophy of the retinal pigment epithelium (CHRPE). • Under CDH1 sequencing and/or deletion/duplication analysis for Hereditary Diffuse Gastric Cancer, addition of a personal history of cancer and a CDH1 pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis has not yet been performed. • Revision and addition of one clinical indication under the SMAD4/BMPR1A Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under TP53 targeted variant analysis. • Addition of clinical indication under MEN1 sequencing and/or deletion/duplication analysis. • Addition/removal of clinical indications under the TP53 Sequencing and/or Deletion/Duplication Analysis section. • Addition of "all polyps at least 5mm" under MUTYH sequencing and/or deletion/duplication analysis. • Addition of clinical indication under STK11 targeted variant analysis for Peutz-Jeghers syndrome. • Addition/removal of clinical indications under the VHL Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under PTEN Targeted Variant Analysis. • Addition of several clinical indications under PTEN sequencing and/or deletion/duplication analysis. • Clinical indication added for personal history of colorectal and/or endometrial cancer with PREMM5 score of 2.5% or greater under MLH1, MSH2, MSH6, PMS2, or EPCAM Sequencing and/or Deletion/Duplication Analysis. • For Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer testing, PTEN Targeted Variant Analysis, CDH1 Targeted Variant Analysis, SMAD4/BMPR1A Targeted Variant Analysis, TP53 Targeted Variant Analysis, MUTYH Targeted Variant Analysis, and STK11 Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a blood relative with a known pathogenic or likely pathogenic variant of the target gene. • For FLCN Targeted Variant Analysis, FH Targeted Variant Analysis, and VHL Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a first- or second-degree relative with a known pathogenic or likely pathogenic variant of the target gene.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility Minnesota Health Care Programs (MHCP) policy	Effective 1/1/2023, the MHCP policy has significant revisions as follows (Please refer to published policy for specific details.): Prior authorization is still required. • Criteria expanded for Pan-Cancer Hereditary Cancer Susceptibility Panels, Hereditary Breast Cancer Susceptibility Panels, Hereditary Pancreatic Cancer Susceptibility Panels, Hereditary Prostate Cancer Susceptibility Panels, and PALB2 Sequencing/Deletion/ Duplication Analysis sections in the policy. • Hereditary Colorectal Cancer Susceptibility Panels section title changed to Hereditary GI/Colon Cancer Panel Tests with removal of several covered clinical indications and addition of two colorectal cancer indications. Expanded list of minimum required genes to be included in requested panels. • Addition of two clinical indications for coverage under the Hereditary Pancreatic Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Addition of several clinical indications under the Hereditary Prostate Cancer Susceptibility Panels section. • Addition of MEN1 and MEN2 under the Hereditary Neuroendocrine Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Removal of several clinical indications under the APC Sequencing and/or Deletion/Duplication Analysis section. Addition of known familial mutation in APC and Multifocal/bilateral congenital hypertrophy of the retinal pigment epithelium (CHRPE). • Under CDH1 sequencing and/or deletion/duplication analysis for Hereditary Diffuse Gastric Cancer, addition of a personal history of cancer and a CDH1 pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis has not yet been performed. • Revision and addition of one clinical indication under the SMAD4/BMPR1A Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under TP53 targeted variant analysis. • Addition of clinical indication under MEN1 sequencing and/or deletion/duplication analysis. • Addition/removal of clinical indications under the TP53 Sequencing and/or Deletion/Duplication Analysis section. • Addition of “all polyps at least 5mm” under MUTYH sequencing and/or deletion/duplication analysis. • Addition of clinical indication under STK11 targeted variant analysis for Peutz-Jeghers syndrome. • Addition/removal of clinical indications under the VHL Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under PTEN Targeted Variant Analysis. • Addition of several clinical indications under PTEN sequencing and/or deletion/duplication analysis.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility *Minnesota Health Care Programs (MHCP) policy - Continued*	• Clinical indication added for personal history of colorectal and/or endometrial cancer with PREMM5 score of 2.5% or greater under MLH1, MSH2, MSH6, PMS2, or EPCAM Sequencing and/or Deletion/Duplication Analysis. • For Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer testing, PTEN Targeted Variant Analysis, CDH1 Targeted Variant Analysis, SMAD4/BMPR1A Targeted Variant Analysis, TP53 Targeted Variant Analysis, MUTYH Targeted Variant Analysis, and STK11 Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a blood relative with a known pathogenic or likely pathogenic variant of the target gene. • For FLCN Targeted Variant Analysis, FH Targeted Variant Analysis, and VHL Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a first- or second-degree relative with a known pathogenic or likely pathogenic variant of the target gene.
Genetic testing: immune, autoimmune, and rheumatoid disorders	Effective 1/1/2023, policy revised as follows: • New section added: Genetic Algorithmic Rheumatoid Arthritis Tests for Tumor Necrosis Factor Inhibitor (TNFi) Treatment. These tests are considered investigational and not covered.
Genetic testing: oncology – circulating tumor DNA and circulating tumor cells (liquid biopsy)	Effective 1/1/2023, policy revised as follows: • Metastatic colorectal cancer will be included as an additional covered diagnosis under Comprehensive molecular profiling panel tests via circulating tumor DNA (liquid biopsy). Prior authorization is still required. • For Lung Cancer Focused Panel Tests via Circulating Tumor DNA (ctDNA) and EGFR Variant Analysis via ctDNA sections: Removed clinical indication “The member does not have a biopsy-amenable lesion” from the criteria sets. Replaced with two indications requiring completion of a biopsy with either insufficient material for molecular analysis, or the tissue was not able to be assessed due to availability of testing methodologies. Prior authorization is required. • Removed NRAS Variant Analysis via circulating tumor DNA via ctDNA section from the policy as NRAS Variant Analysis, as a standalone test, is no longer an orderable test. Previously this testing was considered investigational. • Prior Authorization will be required for Colorectal cancer focused panel tests via circulating tumor DNA (ctDNA). Criteria will include coverage when the member has metastatic colorectal cancer, and the panel includes KRAS, NRAS and BRAF analysis. • EGFR variant analysis testing will no longer allow testing for a member who does not have a biopsy amenable lesion. Additional covered indications will include: Biopsy was performed but material was insufficient for molecular analysis, or Biopsy was performed but molecular analysis was not able to be completely assessed on tissue due to availability of testing methodologies. Prior authorization is required.

Coverage Policies	Comments / Changes

Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies	Effective 1/1/2023, policy revised as follows:
	Prior authorization is still required.
	• Revisions made to Comprehensive Molecular Profiling Panels for Hematologic Malignancies and Myeloid Malignancy Panels section:
	  ○ A member having a suspected or confirmed diagnosis of acute myeloid leukemia is no longer a covered indication. Instead, a member is to have blood work (CBC) and bone marrow evaluation which are consistent with acute myeloid leukemia.
	  ○ A member with a myelodysplastic syndrome newly diagnosed is no longer a covered indication.
	  ○ A member suspected to have a myeloproliferative neoplasm with clinical suspicion for a myeloid neoplasm remaining high is no longer a covered indication.
	  ○ For a suspected myeloproliferative neoplasm, a comprehensive panel is to be ordered, if applicable, as part of an initial evaluation, or ordered after a negative JAK2/CALR/MPL analysis.
	• Adding new section to policy with prior authorization required: Tumor Agnostic Molecular Profiling Panel Tests with Immunohistochemical (IHC) and Cytogenetic Analyses. Testing indicated for a member with recurrent, relapsed, refractory, metastatic, or advanced (stages III or IV) cancer who is seeking further cancer treatment and, either has not had tumor molecular profiling, or has had previous tumor molecular profiling with a new primary cancer diagnosis requiring the testing.
	• Indeterminate thyroid nodules requiring biopsy added as a covered indication under BRAF variant analysis testing.
	• Revisions made to FLT3 Variant Analysis section:
	  ○ Removed previous negative testing for BCR-ABL1 from the list of indications.
	  ○ Added diagnosis of myelodysplastic syndrome to the list of indications for this testing.
	• Revisions made to Tumor Specific KRAS Targeted Mutation Analysis Tests section:
	  ○ Metachronous colorectal cancer revised to unresectable metachronous colorectal cancer.
	  ○ Removed diagnosis of uterine sarcoma from indications.
	• Removed anaplastic oligoastrocytoma from the list of indications under the MGMT Methylation Analysis Tests section.
	• Removed “locally advanced or metastatic pancreatic adenocarcinoma” and “unresectable or metastatic Ewing’s sarcoma” from the list of indications under the Microsatellite Instability Analysis (MSI) section.
	• Removed uterine carcinosarcoma from the list of indications under the Tumor Specific PIK3CA Targeted Mutation Analysis section.

Coverage Policies	Comments / Changes

Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies
 	
Minnesota Health Care Programs (MHCP) policy
	Effective 1/1/2023, the MHCP policy is revised as follows:
	Prior authorization is still required.
	• Revisions made to Comprehensive Molecular Profiling Panels for Hematologic Malignancies and Myeloid Malignancy Panels section:
	  ○ A member having a suspected or confirmed diagnosis of acute myeloid leukemia is no longer a covered indication. Instead, a member is to have blood work (CBC) and bone marrow evaluation which are consistent with acute myeloid leukemia.
	  ○ A member with a myelodysplastic syndrome newly diagnosed is no longer a covered indication.
	  ○ A member suspected to have a myeloproliferative neoplasm with clinical suspicion for a myeloid neoplasm remaining high is no longer a covered indication.
	  ○ For a suspected myeloproliferative neoplasm, a comprehensive panel is to be ordered, if applicable, as part of an initial evaluation, or ordered after a negative JAK2/CALR/MPL analysis.
	• Adding new section to policy with prior authorization required: Tumor Agnostic Molecular Profiling Panel Tests with Immunohistochemical (IHC) and Cytogenetic Analyses. Testing indicated for a member with recurrent, relapsed, refractory, metastatic, or advanced (stages III or IV) cancer who is seeking further cancer treatment and either has not had tumor molecular profiling, or has had previous tumor molecular profiling with a new primary cancer diagnosis requiring the testing.
	• Indeterminate thyroid nodules requiring biopsy added as a covered indication under BRAF variant analysis testing.
	• Revisions made to FLT3 Variant Analysis section:
	  ○ Removed previous negative testing for BCR-ABL1 from the list of indications.
	  ○ Added diagnosis of myelodysplastic syndrome to the list of indications for this testing.
	• Revisions made to Tumor Specific KRAS Targeted Mutation Analysis Tests section:
	  ○ Metachronous colorectal cancer revised to unresectable metachronous colorectal cancer.
	  ○ Removed diagnosis of uterine sarcoma from indications.
	• Removed anaplastic oligoastrocytoma from the list of indications under the MGMT Methylation Analysis Tests section.
	• Removed “locally advanced or metastatic pancreatic adenocarcinoma” and “unresectable or metastatic Ewing’s sarcoma” from the list of indications under the Microsatellite Instability Analysis (MSI) section.
	• Removed uterine carcinosarcoma from the list of indications under the Tumor Specific PIK3CA Targeted Mutation Analysis section.

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

BEHAVIORAL HEALTH

Coverage Policies	Comments / Changes
Repetitive transcranial magnetic stimulation	Effective 1/1/2023: • Policy title will change to Transcranial magnetic stimulation. • At least two months must pass between initial and repeat courses of treatment. • More than one repeat course of TMS is considered investigational as there is insufficient reliable evidence supporting the efficacy of multiple courses of treatment. • Navigated transcranial magnetic stimulation (nTMS) is considered experimental/investigational for any indication due to a lack of sufficient evidence supporting efficacy. • Direct supervision by a physician will no longer be required.
Outdoor/wilderness therapy programs	Effective immediately: Policy has been retired. This service is a non-covered benefit/contract exclusion.

Drug Formulary updates

COMMERCIAL DRUG FORMULARY

Updates include:

- Budesonide (Pulmicort Flexhaler) will require prior authorization (PA), updating from formulary to formulary with PA. Pulmicort is reserved for patients who are pregnant or are trying to become pregnant.
- Insulin detemir (Levemir) is updating from a formulary medication with prior authorization to non-formulary with PA. Levemir is reserved for patients with an inadequate response to preferred alternatives.
- Aspirin 325mg is updating from a formulary ACA medication to a not-covered OTC status due to guideline updates.
- Weight Loss medication coverage is being updated. Semaglutide (Wegovy) and liraglutide (Saxenda) are being added to formulary with PA; and PA criteria for naltrexone/bupropion (Contrave) and phentermine/topiramate (Qsymia) are being updated. Wegovy and Saxenda will be allowed as first-line options.
    - PA Coverage Criteria: These weight loss medications are reserved for:
        - Patients with a body mass index (BMI) greater than 30 kg/m2, or greater than 27 kg/m2 with risk factors; and
        - Provider attestation of participation in a weight loss program addressing diet and exercise for at least two months prior to initiation of therapy (programs can include clinic-based or third-party programs); and
        - Two or more clinic appointments discussing weight loss and lifestyle changes (with provider, diabetes educator or dietician) in the previous six months prior to initiation of therapy.
    - Coverage duration: Initial approvals are for six months. Coverage will be extended for one year for patients with a positive response and continuing participation in a weight loss program addressing diet and exercise.
    - Pharmacy coverage follows benefit plan documents for coverage of weight loss medications.
- Lipase/protease/amylase (Zenpep) is being added to formulary.
- Ofatumumab (Kesimpta) will require prior authorization per FDA indication(s).

Please see the formulary for details, at **healthpartners.com/formularies**. Updates will be posted by October 1.

MINNESOTA HEALTHCARE PROGRAMS (MHCP) DRUG FORMULARY

Updates are available in our online drug formulary. These policy updates apply only to State Programs, and do not apply to members with Commercial or Part D plans.

MEDICARE DRUG FORMULARY

Updates for January 1, 2023 include:

- Brand Advair Diskus will be added to formulary at Tier 2. Generic fluticasone-salmeterol and Wixela, which are currently at Tier 3, will be removed from formulary.
- Several formulary removals.
  - Restasis has been removed, and the generic equivalent is on-formulary.
  - Asmanex and Pulmicort have been removed. Preferred alternatives include fluticasone (Flovent Diskus and HFA), beclomethasone (Qvar), and fluticasone (Arnuity).
- Tier increases, including fluconazole tablet and levothyroxine.
- Tier decreases, lowering copays to members, including potassium chloride and estradiol cream.
- Synthroid is being added to formulary
- Quantity limits, per standard dosing.

Click here for a complete list of our 2023 Medicare Drug Formulary

OPIOID PRESCRIBING

Providers are reminded about opioid prescribing guidelines. CDC guidelines are being updated.

The CDC Guidelines address patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas are:

1. **Determining when to initiate or continue opioids for chronic pain**

- Selection of non-pharmacologic therapy (interventions such as exercise, multidisciplinary rehabilitation, mind-body interventions).
- Selection of nonopioid pharmacologic therapy (including acetaminophen, non-steroidal anti-inflammatory drugs [NSAIDs], and selected antidepressants and anticonvulsants), or opioid therapy.
- Establishment of treatment goals.
- Discussion of risks and benefits of therapy with patients.

2. **Opioid selection, dosage, duration, follow-up and discontinuation**

- Selection of immediate-release or extended-release and long-acting opioids.
- Dosage considerations. Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reducing or tapering opioids, prescribing of naloxone, or other measures to reduce risk of overdose. MME conversion factors are being updated.

Opioid	Conversion Factor
Codeine	0.15
Fentanyl Transdermal (mcg/ hour)	2.4
Hydrocodone	1
Hydromorphone	5
Methadone	4.7
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Tramadol	0.2

- Duration of treatment.
- Considerations for follow-up and discontinuation of opioid therapy.

3. **Assessing risk and addressing harms of opioid use**

- Evaluation of risk factors for opioid-related harms and ways to mitigate risk to patient.
- Review of prescription drug monitoring program (PDMP) data.
- Use of urine drug testing.
- Considerations for co-prescribing benzodiazepines.
- Arrangement of treatment for opioid use disorder.

Link to CDC's opioid guideline overview

HealthPartners utilizes the following Pharmacy Opioid Safety programs for Medicare	
Opioid Cumulative Dosing Program (OCDP)	This program will block an incoming claim that puts a member's daily Morphine Milligram Equivalent (MME) greater than or equal to a soft-stop (pharmacy over-rideable) threshold of 90 MME across a single or multiple opioid-containing claims and/or hard-stop threshold for incoming claims with a cumulative MME greater than or equal to 200 MME.
Duplicative Long-Acting Opioid Therapy Program	This program will identify and deny concurrent use of long-acting opioids when there is any overlap in days' supply. A concurrent or duplicative long-acting opioid drug is defined as another long-acting opioid product with a different active ingredient.
Opioid Naïve Day Supply Limitation	This program will limit initial opioid prescription fills for the treatment of acute pain to no more than a seven days' supply for a member with no opioid history within a defined lookback period. The lookback period is 60 days.
Opioid-Benzodiazepine Concurrent Use Program	This program will identify and deny concurrent use of benzodiazepines and opioids when there is any overlap in days' supply. The program works bi-directionally (i.e., triggered by an incoming claim for an opioid with concurrent use of benzodiazepine or vice versa).
Opioid-Buprenorphine Concurrent Use Limitation	This program will identify and deny concurrent use of opioids when there is any overlap in days' supply with a pre-existing claim for buprenorphine for medication-assisted treatment (MAT). The edit works uni-directionally. This means it will only soft-stop analgesic opioids when members are currently taking buprenorphine for MAT. This edit will never stop a claim for buprenorphine for MAT.

Pharmacy Medical Policy updates

COMMERCIAL UPDATES:

Coverage Policies	Comments / Changes
Medical injectable site of care (MISOC) program	These medications have been added to the medical injectable site of care (MISOC) program: Amvuttra, Enjaymo, Evkeeza, Imfinzi, Nexviazyme, Opdualag, Oxlumo, Saphnelo, Tecentriq, Tezspire, Vyvgart Please note: Imfinzi, Opdualag, Tecentriq will not be required for home infusion. This program prefers more affordable sites of care for medication administration (home infusion, clinics, preferred outpatient hospital sites).
Infliximab	Adding Renflexis as an additional preferred agent. Preferred products are Inflectra and Renflexis.
IV Iron Replacement Therapy (Feraheme, Ferrlecit, Infed, Injectafer, Monoferric, Triferic, Venofer)	Adding a new medical policy requiring the use of preferred agents (Ferrlecit, Infed, Venofer, and Feraheme) unless there is a medical contraindication, prior ineffective response, or intolerance to all of the preferred agents.
Oncology - pegfilgrastim (Neulasta, Fulphila, Nyvepria, Udenyca, and Ziextenzo)	Update to prefer Neulasta and Udenyca on the medical benefit. Please note: biosimilars are preferred on the pharmacy benefit.

Pharmacy medical policies can be found in the medical coverage policy search page, searchable by drug name or billing codes. Policies will be searchable on or before the effective date at **healthpartners.com/public/coverage-criteria**.

MEDICARE PART B STEP THERAPY PROGRAM

Starting 1/1/2023, step therapy of preferred products will be required for members on Medicare Advantage plans that are newly starting select medical injectable therapies through Medicare Part B. Members stable on a non-preferred medication will have continued coverage of the non-preferred drug. The list of impacted medications are outlined below.

Non-Preferred Medication	Step Through Agent/ Preferred Medication
Remicade (and non-preferred biosimilars)	Inflectra or Renflexis
Herceptin (and non-preferred biosimilars)	Kanjinti or Ogivri
Rituxan (and non-preferred biosimilars)	Ruxience or Truxima
Avastin (and non-preferred biosimilars)	Mvasi or Zirabev
Fulphila, Ziextenzo, Nyvepria (and non-preferred biosimilars)	Neulasta or Udenyca