MEMBER IDENTIFICATION PROCESS

- HealthPartners sends claims data to Matrix.
- Matrix identifies an initial set of members through their proprietary algorithm to create the outreach list.
- Matrix provides outreach lists to HealthPartners in March, June and September.
- HealthPartners reviews and edits the outreach list.
    - The following scenarios are removed from outreach list:
        - newly deceased or hospice or 'do not call' members
        - those with upcoming/scheduled visit (based on our EPIC data)
        - those active with our Disease and Case Management (based on CarePartner data)
- When approved by HealthPartners, Matrix will then send out the invitation letters.

MEMBER OUTREACH IDENTIFIERS

- Members who may not have had any clinic visits (last 12 months).
- Prescription data or other data available indicates a member may have unmet and undocumented care needs.
- Disease and Case Management/Behavioral Health referral.

HP ATTRIBUTED MEMBER/PATIENTS

- Outreach to HP-attributed patients is set for Q3 and Q4 only. This is to allow natural flow of visits to occur the first half of the year and for the HP care group to have first opportunity to get patients in for needed care without duplication.
    - For non-HP network providers outreach occurs Q2-Q4.

SERVICES NOT IN SCOPE

- Care or treatment
- Ongoing care or treatment
- Home care service

HEALTH PLAN PRODUCTS INCLUDED

- Medicare Advantage
- Medicaid (PMAP, MinnesotaCare)
- Minnesota Senior Health Options – will be HP referrals only as of 2019
- All commercial individual and fully insured small group
- Community-based members only

Medical Policy updates – 1/1/2025

MEDICAL, BEHAVIORAL HEALTH, 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
Genetic testing: dermatologic conditions	• Effective immediately, policy revised as follows: ○ Epidermolysis Bullosa is now a covered indication when the member demonstrates clinical features of the condition.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility (Commercial and MHCP policy versions)	• Effective immediately, policy revised as follows: ○ Under the Pan-cancer Hereditary Cancer Susceptibility Panels, Hereditary Breast Cancer Susceptibility Panels, Hereditary GI/Colon Cancer Susceptibility Panels, Hereditary Gastric Cancer Susceptibility Panels, Hereditary Pancreatic Cancer Susceptibility, Hereditary Polyposis Susceptibility Panels, Hereditary Prostate Cancer Susceptibility Panels, and Hereditary Neuroendocrine Cancer Susceptibility Panels criteria sections: ▪ Removed the following indication from the above criteria sets: The panel does not include genes without a known association with cancer by ClinGen. ○ Under the Hereditary GI/Colon Cancer Susceptibility Panels, CDKN2A Targeted Variant Analysis, and FH Targeted Variant Analysis criteria sections: ▪ Removed the following indication: The member is 18 years or older. ○ Under the Hereditary Prostate Cancer Susceptibility Panels criteria section: ▪ Added the following indication: • The member's probability of having a BRCA1 or BRCA2 pathogenic variant is greater than 2.5% based on prior probability models (examples: Tyrer-Cuzick, BRCApro, CanRisk). ○ Under the Hereditary Neuroendocrine Cancer Susceptibility Panels criteria section: ▪ Added the following indications: • The member has a diagnosis of at least one of the following: gastrinoma, duodenal or pancreatic neuroendocrine tumor, or a first-degree relative meeting any of the criteria in this criteria set but who is not available for testing. ○ Uder the PALB2 Sequencing and/or Deletion/Duplication Analysis criteria section: ▪ Added the following indication: The member has a personal history of metastatic prostate cancer. ▪ Lowered the required percentage for a member's probability of having a BRCA1 or BRCA2 pathogenic variant based on prior probability models (examples: Tyrer-Curzick, BRCApro, CanRisk). New requirement is greater than 2.5% instead of greater than 5%. ○ Under the SMAD4 and/or BMPR1A Sequencing and/or Deletion/Duplication Analysis criteria section: ▪ Revised the indication stating, "The member has juvenile polyps (any number) and a family history of JPS" by removing "juvenile polyps (any number)" so the new indication reads as, "The member has a family history of JPS." ○ Under the STK11 Sequencing and/or Deletion/Duplication Analysis criteria section: ▪ Removed the requirement a member meet two of the listed indications. The new requirement is a member is to meet one of the listed indications. ▪ One indication required a member to have a close relative with Peutz-Jeghers Syndrome (PJS). This indication has been revised to require the member to have a family history of PJS. ○ Under the VHL Sequencing and/or Deletion/Duplication Analysis criteria section: ▪ Removed "clear cell" from indications involving "clear cell renal cell carcinoma." Indications now read "renal cell carcinoma."

Coverage Policies	Comments / Changes

Genetic testing: hereditary cancer susceptibility
 	
(Commercial policy)
	• Effective immediately, policy revised as follows:
	  ○ Under the BRCA1 and BRCA2 Sequencing and/or Deletion/Duplication Analysis criteria section:
	  ▪ Increased the age for when a member's breast cancer is diagnosed from age 50 or younger to 65 or younger.
	  ▪ Expanded a criterion in this section by adding prostate cancer that is intermediate risk with intraductal/cribriform histology as an acceptable indication.
	  ▪ Lowered the required percentage for a member's probability of having a BRCA1 or BRCA2 pathogenic variant based on prior probability models (examples: Tyrer-Curzick, BRCApro, CanRisk). New requirement is greater than 2.5% instead of greater than 5%.

Genetic testing: hereditary hearing loss	• Effective immediately, policy revised to read as follows:
	  ○ Prior authorization is not required for GJB2 and GJB6 Sequencing and/or Deletion Duplication Analysis or Multigene Panel Analysis for sensorineural hearing loss.
	  ○ Prior authorization is required for all other genetic testing related to hereditary hearing loss that is associated with a procedure code listed in "Box A."

Genetic testing: immune, autoimmune and rheumatoid disorders	• Effective immediately, policy revised as follows:
	  ○ Rheumatoid Arthritis TNFi Treatment Response Algorithmic Tests
	  ▪ Criteria section title changed.
	  ▪ Testing moved away from being considered investigative to medically necessary when the following criteria are met:
	  • The use of genetic rheumatoid arthritis algorithmic tests to determine appropriateness of TNFi treatment (PrismRA) is considered medically necessary when:
	  ○ The member is age 18 or older, and
	  ○ The member has a diagnosis of moderately to severely active rheumatoid arthritis (RA), and
	  ○ The member previously received first-line therapy for treatment of rheumatoid arthritis conventional synthetic disease-modifying anti-rheumatic drug (csDMARD), and
	  ○ The member is unresponsive/refractory or intolerant to the therapy despite a therapeutic dose, and
	  ○ One of the following:
	  ▪ The member has not yet initiated a biologic or targeted synthetic therapy (b/tDMARD) for RA (i.e., TNFi), or
	  ▪ The member has initiated a biologic or targeted synthetic therapy (b/tDMARD) for RA (i.e., TNFi) and is unresponsive/refractory or intolerant to a therapeutic dose, and
	  ○ The member has not had previous testing using molecular biomarkers for predictive therapy selection for rheumatoid arthritis.

Coverage Policies	Comments / Changes
	• The use of genetic rheumatoid arthritis algorithmic tests to determine appropriateness of TNFi treatment (PrismRA) is considered investigational for all other indications. ○ HLA Typing for Axial Spondyloarthritis ▪ Removed the following previously required indication from the criteria set: • HLA-B27 results are needed to establish a diagnosis of axial spondyloarthritis.
Genetic testing: non-invasive prenatal screening (NIPS)	• Effective immediately, policy revised as follows: ○ Policy title has been changed to Genetic testing: prenatal cell-free DNA testing.
Genetic testing: skeletal dysplasia and rare bone disorders	• Effective immediately, policy revised as follows: ○ Under the Osteogenesis Imperfecta multigene panel analysis criteria section: ▪ One indication previously stated, "The member has a family history of osteogenesis imperfecta, typically with autosomal dominant inheritance. Removed the "…typically with autosomal dominant inheritance" portion of this indication.
In-network benefit requests – UnityPoint Health benefits	• Effective 12/1/2024, policy retired.
Investigational services – list of non-covered services	• Effective immediately, policy revised. ○ The following services have been added to this policy as non-covered/investigational: ▪ External upper limb electrical stimulation/remote neuromodulation for prevention or treatment of migraines (e.g., Nerivio® [Theranica Bio-Electronics Ltd.]) ▪ Eye-tracking testing devices (e.g., EyeBOX - Oculogica) to aid in diagnosis of concussion ▪ Renal denervation, also known as transcatheter renal sympathetic nerve ablation, for treatment of refractory hypertension. Example devices include the Symplicity Spyral™ renal denervation system (Medtronic) and the Paradise® Ultrasound Renal Denervation System (ReCor Medical, Inc.) ▪ Transcatheter tricuspid valve repair, percutaneous approach (e.g., TriClip G4 System – Abbott Medical) ○ Additionally, Low level laser therapy (i.e., cold laser therapy) (0552T) was clarified to be investigational for any condition other than prevention or treatment of oral mucositis associated with cancer treatment.
Category III CPT codes policy	• Effective immediately, the following service has been added to this policy as eligible for coverage: ○ Low level laser therapy (i.e., cold laser therapy) for prevention or treatment of oral mucositis associated with cancer treatment (code 0552T).

Coverage Policies	Comments / Changes
Airway clearance system/ high frequency chest wall compression system – Minnesota Health Care Programs	• Effective immediately, the following item has been added to the indications that are not covered: ○ Lung expansion airway clearance devices
Prosthesis – lower limb	• Effective January 1, 2025, this policy has been separated into two policies. "Prosthesis – lower limb – Minnesota," which applies to fully insured products and self-insured public bodies in Minnesota and "Prosthesis- lower limb - Iowa, North Dakota, South Dakota, and Wisconsin," which applies to products in the applicable states.
Prosthesis – upper limb	• Effective January 1, 2025, this policy has been separated into two policies. "Prosthesis – upper limb – Minnesota," which applies to fully insured products and self-insured public bodies in Minnesota and "Prosthesis- upper limb - Iowa, North Dakota, South Dakota, and Wisconsin," which applies to products in the applicable states.
Nutritional support	• Effective January 1, 2025, this policy has been separated into two policies. "Nutritional support – Minnesota," which applies to fully insured products and self-insured public bodies in Minnesota and "Nutritional support – Iowa, North Dakota, South Dakota and Wisconsin," which applies to products in the applicable states.
Varicose vein procedures of the lower extremities	• Effective March 1, 2025, policy revised. ○ Recurring edema (swelling) has been removed from the criteria related to pain when requesting minimally invasive endovenous thermal ablation, endovenous chemical ablation, and requests for additional treatment sessions. ○ Requests for additional treatment sessions will require the results of an updated duplex ultrasound scanning performed after initial treatment and within six months prior to the requested additional session.
Hip and knee joint replacement surgery	• Effective immediately, MCG Health guidelines criteria 28th edition, will be utilized for hip and/or knee joint replacement surgical procedures.
Residential – psychiatric residential treatment facility – Minnesota Health Care Programs Residential – psychiatric residential treatment facility – Minnesota	• Effective immediately the following MCG Health guidelines criteria 28th edition will be utilized for psychiatric residential treatment facilities. ○ Inpatient Behavioral Health Level of Care, Adult ○ Inpatient Behavioral Health Level of Care, Child or Adolescent
Autism – applied behavioral analysis for treatment of autism spectrum disorders	• Effective immediately, MCG Health guidelines criteria 28th edition, Applied Behavioral Analysis will be utilized for applied behavioral analysis for treatment of autism spectrum disorders.

Coverage Policies	Comments / Changes
Inpatient care	• Effective 03/01/2025 the following MCG Health guidelines criteria 28th edition will be utilized for inpatient care. ○ Inpatient Behavioral Health Level of Care, Adult ○ Inpatient Behavioral Health Level of Care, Child or Adolescent ○ Eating Disorders, Inpatient Behavioral Health Level of Care, Adult ○ Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent ○ Substance-Related Disorders, Inpatient Behavioral Health Level of Care, Adult ○ Substance-Related Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent ○ Inpatient and Surgical Care ○ General Recovery Care
Gender-affirming care, surgical	• Effective 1/1/2025, policy revised. ○ Prior authorization is no longer required for mastectomy, breast reduction, or breast augmentation when related to gender-affirming care. ○ We are removing the requirement for a diagnosis of gender dysphoria. ○ We are removing the requirement that the member must demonstrate the capacity to consent for the procedure from the policy. ○ We are removing the requirement for a letter of recommendation from a mental health provider which includes an assessment of the member's readiness for surgery. ○ Policy has been renamed from "Surgical treatment of gender dysphoria" to "Gender-affirming care, surgical." ○ Policy will adopt the terminology "gender-affirming care" or "treatment of gender incongruence" instead of "treatment for gender dysphoria."
Gender-affirming care, non-surgical	• Effective 1/1/2025, policy revised. ○ "Counseling services" are being added to the policy as a covered non-surgical service. These services were already covered but are being added to the policy for clarity. ○ Policy has been renamed from "Non-surgical treatment for gender dysphoria" to "Gender-affirming care, non-surgical." ○ Policy will adopt the terminology "gender-affirming care" or "treatment of gender incongruence" instead of "treatment for gender dysphoria."
Gender-affirming surgery – Minnesota Health Care Programs	• Effective 1/1/2025, policy revised. ○ Prior authorization is no longer required for mastectomy, breast reduction, or breast augmentation when related to gender-affirming care.

Coverage Policies	Comments / Changes
Gender-affirming care, non-surgical – Minnesota Health Care Programs	• Effective 1/1/2025, policy revised. ○ "Counseling services" are being added to the policy as a covered non-surgical service. These services were already covered but are being added to the policy for clarity. ○ Policy has been renamed from "Non-surgical treatment for gender dysphoria – Minnesota Health Care Programs" to "Gender-affirming care, non-surgical – Minnesota Health Care Programs." ○ Policy will adopt the terminology "gender-affirming care" or "treatment of gender incongruence" instead of "treatment for gender dysphoria."
Durable medical equipment (DME), orthoses and prostheses	• Effective immediately, policy revised. ○ Title revised to include "orthoses" as policy contains content applicable to orthoses. ○ Updated "orthotics" to "orthoses" and "prosthetics" to "prostheses" throughout policy. ○ Removed the statement "Prior authorization of the rental item will be required only for those items that currently require prior authorization." Prior authorization requirements are noted on individual DME policies. ○ Updated definition of DME. Please refer to published policy for details.
Coverage criteria and Prior Authorization changes through Cohere Health	We will be postponing the new prior authorization requirements and Coverage Criteria for HealthPartners Level Funded Self-Insured Commercial plans for a specific list of cardiovascular and musculoskeletal services through Cohere Health that was previously announced in the December 2024 Special Edition Fast Facts. More information will be communicated when we have a new effective date.

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

Drug Formulary updates

MEDICARE DRUG FORMULARY

Updates for January 1, 2025, include:

- Insulin supplies (e.g., alcohol pads, insulin pen needles/syringes) will require an insulin claim in the previous 120 days for coverage.
- Several formulary removals.
  - Restasis has been removed. Restasis Multidose is preferred.
  - Brimonidine-timolol 0.2%-0.5% eye drops have been removed. Preferred alternatives include brimonidine 0.2% and timolol maleate 0.5% eye drops.
- Tier increases, including pramipexole tablet, ciprofloxacin-dexamethasone ear drops and varenicline tablets.
- Tier decreases, lowering copays to members, including lamotrigine tablets
- Januvia is being added to formulary
- Quantity limits, per standard dosing

Updates are available in our online drug formulary.

Pharmacy Medical Policy updates

COMMERCIAL UPDATES

Coverage Policies	Comments / Changes
Amyloid monoclonal antibodies	Adding donanemab (Kisunla). Amyloid monoclonal antibodies are considered investigational, and are therefore not covered.
Biologics for chronic inflammatory diseases	Updating policy, adding new indications for guselkumab (Tremfya) and risankizumab (Skyrizi).
Brineura	Updating policy, adding a new indication.
Complement inhibitors	Adding crovalimab (PiaSky) to this policy, and updating the policy to include additional language confirming diagnosis.
Krystexxa	Updating renewal criteria, clarifying requirement for prior conventional therapies.
Medical Injectable Site of Care	Adding crovalimab (PiaSky).
Neonatal Fc Receptor Antagonists (Vyvgart, Rystiggo)	Updating policy, adding a new indication for Vyvgart Hytrulo.
Oncology - atezolizumab (Tecentriq)	Updating policy, adding Tecentriq Hybreza (SQ).
PD1 and PDL1 policy	Updating policy, adding tislelizumab-jsgr (Tevimbra).
Tecelra	Adding a new policy for afamitresgene (Tecelra).

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

Coverage Policies	Comments / Changes
Medicare PA	Prior authorization has been added for these medications. • Casgevy, Lyfgenia.

Medicare Policies can be found here: **healthpartners.com/content/dam/plan/coverage-criteria/medical/medicare-pa-list.pdf**. Policies will be searchable on or before the effective date.

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 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.

For additional information, please contact **healthpartnersclinicalpharmacy@healthpartners.com**.