Coming Soon – Provider Survey

In April HealthPartners will mail a short survey to a sample of primary care, specialty and behavioral health physicians. The survey assesses satisfaction in two key areas where we continue to focus improvement activities – Continuity/Coordination of Care across care settings and experience with the Utilization Management process for services requiring prior authorization.

If you receive a survey, we encourage you to complete it. Your feedback is important in helping us to identify potential areas of improvement.

Questions, please contact Kelsey Folin, Medical Policy Prior Authorization Program, at **952-883-5768**.

Coming soon – Clear Claim Connection (C3)

HealthPartners is preparing to upgrade its claims coding software early April 2018. Shortly after the upgrade, we will implement new software called Clear Claim Connection, or C3.

WHAT IS C3?

C3 is a web-based solution that enables HealthPartners to share claim auditing rules, payment policy, and clinical rationale inherent in code auditing. C3 is designed to make claims payment policies, related rules, clinical edit clarifications, and other source information easily accessible and available for viewing via the provider portal. This functionality provides the ability to test "what if" claim scenarios before actually submitting a claim for payment.

WHAT'S NEXT?

Additional information and instructions for accessing C3 via the provider portal will be included in the May Fast Facts edition and will also be posted on the provider portal closer to the June implementation date.

Medical Policy Updates – 03/01/2018

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: healthpartners/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
Prothrombin Time Monitoring - Home	Effective immediately, policy retired. Language regarding coverage of prothrombin time monitoring has been added to DME Benefits Grid policy.
Neuromuscular electrical stimulator (NMES)	Effective 5/1/18, policy revised to indicate that the device being provided must be the same device that was trialed in an appropriate clinical setting. Statement that H-wave is not covered for pain control has been removed and added to the TENS unit policy.
Rhinoplasty & septorhinoplasty	Effective 5/1/18, policy revised for clarity and has been restructured. Sections have been created for primary rhinoplasty, secondary rhinoplasty, septorhinoplasty and repair of weakened external valves. Documentation requirements have been expanded. Please see policy for details. Also, a list of procedures which are generally considered cosmetic has been added to the non-covered indications.

Coverage Policies	Comments / Changes
Bronchial Thermoplasty	Effective immediately, policy retired.
DME Benefits Grid	Effective immediately the following revisions were made: 1. More clearly states the benefit grid does not apply to MHCP products, but a link is provided to the MHCP medical supply coverage guide. 2. Removed limits from a number of items. Items are now either covered or non-covered. 3. The following items have moved from covered to non-covered status: • Aqua K pad • Enuresis alarms • Commode (coverage remains the same but sentence added that all other types of commodes not covered) • Danny sling • Paraffin bath • Sitz bath • Exercise equipment 4. The following items were removed from the grid: • Prosthetic stump coverings • Punctal plugs • Quick Serter • Standing frame • Trend event recorder 5. Postural drainage board, bronchial drainage table or tilt table were combined with bronchial drainage board. 6. New – replacement of external equipment for cochlear implants, artificial larynx, tracheo-esophageal voice prosthesis, tracheostomy-speaking valve and voice amplifier were added.

Coverage Policies	Comments / Changes
Physical & occupational therapy – habilitative	Effective 5/1/18, policy revised and restructured. Added the following: • Language indicating that once a member's habilitative physical or occupational therapy request is determined to be not medically necessary, member will not be eligible for further visits until clinical demonstrating medical necessity is submitted. • Language indicating that for members with plan benefit limits, visits will not be covered in excess of plan limits even if criteria are otherwise met. • Detailed requirements for treatment plan and goals. • Paragraph on continued therapy is more detailed and addresses demonstrating continued delay, revised treatment plan, progress toward goals and discharge planning. • Outline of maximum frequency/ number of therapy visits allowed based on age. • Therapy is not covered in the following circumstances: when it is for maintenance, does not require the skills of a licensed PT or OT, member is unable to participate, there is a lack of progress or treatment goals are met. • Requests for additional visits within the current authorization period will not be approved unless there is a change in condition. • Services that duplicate IEP (individual educational plan) or ISP (individual service plan) are not covered. • Habilitative therapy in the home is not covered. • Verbiage to call out hippotherapy and metronome therapy as experimental/ investigational treatment modalities.
Speech therapy – habilitative	Effective 5/1/18, policy revised and restructured. Added the following: • Language indicating that once a member's habilitative speech therapy request is determined to be not medically necessary, member will not be eligible for further visits until clinical demonstrating medical necessity is submitted. • Language indicating that for members with plan benefit limits, visits will not be covered in excess of plan limits even if criteria are otherwise met. • Detailed requirements for treatment plan and goals. • Paragraph on continued therapy is more detailed and addresses demonstrating continued delay, revised treatment plan, progress toward goals and discharge planning. • Outline of maximum frequency/number of therapy visits allowed based on age. • Therapy is not covered in the following circumstances: when it is for maintenance, does not require the skills of a licensed speech language pathologist, member is unable to participate, there is a lack of progress or treatment goals are met. • Requests for additional visits within the current authorization period will not be approved unless there is a change in condition. • Services that duplicate IEP (individual educational plan) or ISP (individual service plan) are not covered. • Habilitative therapy in the home is not covered. • Verbiage to call out aquatic (pool) therapy for treatment of speech disorders in children as an experimental/investigational treatment modality.

Coverage Policies	Comments / Changes
Chimeric antigen receptor/genetically engineered T-cell receptor (CAR-T) therapy	A new policy will be effective 5/1/2018 that contains medical coverage criteria for Kymriah (tisagenlecleucel) and Yescarta (axicabtagene ciloleucel). These therapies are used for treatment in a specific subset of patients who have refractory/relapsed acute lymphocytic leukemia (ALL) or large B-cell subtypes of Non-Hodgkin lymphoma (NHL). Prior authorization is required for CAR-T therapy.
Genetic Testing: Pharmacogenetics	Revised policy effective 5/1/2018. Prior authorization is required for most services. New covered indications: BRCA1/2 genotyping related to olaparib or rucaparib therapy; DPYD and TYMS genotyping related to fluoropyrimidine therapy. COMT, KIF6, NUDT15, and serotonin receptor genotyping are not covered and are considered experimental/investigational. Pharmacogenetic testing related to medication therapy for depression, mood disorders, psychosis, anxiety, attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD), and substance use disorders is not covered and is considered experimental/investigational.
Genetic Testing: Neurological, Developmental, and Sensory Disorders and Congenital Anomalies	Revised policy effective 5/1/2018. Policy combines two existing policies: *Genetic Testing for Neurodevelopmental Disorders, Epilepsy and Seizure Disorders, and Multiple Congenital Anomalies* and *Genetic Testing for Neurodegenerative and Neuromuscular Disorders*, with additional new content describing coverage of genetic testing for congenital adrenal hyperplasia; gonadoptropin-releasing hormone (GnRH) deficiency; familial dysautonomia; and vision- and hearing-related disorders; and diagnostic genetic testing following concerning newborn screening results. Prior authorization is required for most services. Diagnostic and/or confirmatory genetic testing after newborn screening does not require prior authorization. Coverage of genetic testing may be available for members who are first- or second-degree blood relatives of affected/symptomatic individuals when coverage criteria are met. Pre-test genetic counseling is required for most services addressed by this coverage policy, including multiple-gene panels for any indication. Genetic testing associated with age-related macular degeneration (ARMD), familial hemiplegic migraine, and isolated speech impairment/speech delay is not covered and is considered experimental/investigational.

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

Pharmacy Policy Updates – March 2018

HEALTHPARTNERS DRUG FORMULARY

No new announcements. Formulary updates are made quarterly (Jan 1, April 1, July 1, Oct 1). Items below are reminders.

STATE PROGRAMS-ONLY

In addition to updates below, these changes will be made for Minnesota Health Care Programs.

- Advair, Dulera and Symbicort will be limited, after fluticasone/salmeterol (AirDuo generic). Fluticasone/salmeterol is approved for asthma, for those 12 years of age and older. It is less costly (less than $100 per month versus almost $400 for branded inhalers) and will be preferred. Exceptions will be made for younger children and for treating COPD. These limits will be effective April 1, 2018.

COMMERCIAL AND STATE PROGRAMS

- Many opioid dose limits are being decreased from a morphine-equivalent dose of 120mg per day to a morphine-equivalent dose of 90mg per day, effective January 1, 2018.
- Cosentyx is being added to formulary (from NF-PA to F-PA). First-line therapy must still be tried and failed, effective April 1, 2018.
- Taltz (NF-PA) is being restricted; reserved for patients who have tried and failed Cosentyx, effective April 1, 2018.
- Penicillamine capsules (Cupramine) are being restricted; tablets (Depen) will be the preferred formulation of penicillamine, effective July 1, 2018. Penicillamine capsules (Cupramine) are significantly higher in cost, approximately $30,000 a month for Wilson Disease and $60,000 for Cystinuria. Penicillamine tablets are around $7,000 for Wilson Disease and $14,000 for Cystinuria. Both formulations will require PA for use after trial and failure of other treatment options.
- Tiopronin (Thiola) is being added to formulary, effective July 1, 2018. It will require a PA for use in Cystinuria after trial and failure of other treatment options. A 30-day supply to treatment Cystinuria is approximately $7,000.

MEDICARE

Most of these changes were previously announced and implemented for Commercial and State Programs. Medicare changes are effective January 1, 2018.

- Lantus and Toujeo (insulin glargine) are being removed from the formulary and replaced with Basaglar (insulin glargine). Basaglar is very similar (considered a follow-on product by the FDA) and is less costly.
- Tiotropium (Spiriva) and Stiolto (tiotropium/olodaterol), inhalers for COPD, are being deleted and replaced with umeclidinium (Incruse) and Anoro (umeclidinium/vilanterol).
- Many opioid dose limits are being decreased from a morphine-equivalent dose of 120mg per day to a morphine-equivalent dose of 90mg per day.
- Solifenacin (Vesicare), for overactive bladder, is being deleted. Oxybutynin, tolterodine (Detrol and Detrol LA generic), trospium (Sanctura IR generic) and mirabegron (Myrbetriq) remain available on formulary.

Please see the formulary for details and a complete list at **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 (P&T) Committee policies are available at **healthpartners.com/provider/admin tools/pharmacy policies**, including the **Drug Formularies** *(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
Recently FDA-Approved Medications Coverage Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=AENTRY_046122)*	Revised coverage policy. Authorizations will be effective for six months. 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: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 effective 1/1/2012 as this policy was published in November 2011.

Patient Perspective

Matrix Outreach continues in 2018

HealthPartners is working with Matrix Home Health Care Specialists to provide an in-home comprehensive health risk assessment to some members. Selected members are invited to have a home-based health risk assessment performed by a nurse practitioner at no cost to the member. The goal of the program is to identify care gaps and get members connected or reconnected with their primary care clinics, as well as to document chronic conditions and make referrals into case and disease management as necessary.

If your team receives a call from a patient asking what Matrix is, please assure them HealthPartners is partnering with Matrix and encourage them to call the HealthPartners Member Services number on the back of their HealthPartners insurance card. Our Member Services call centers are familiar with this program.

The results of the assessment are shared with members, the primary care provider and internal HealthPartners programs as applicable.