NEW medical coverage policy: Vitamin D blood testing

**EFFECTIVE SEPTEMBER 1, 2019,** vitamin D blood testing using 25(OH) D or 1,25-OH(2) D will only be covered for members with:

- certain diagnoses in higher risk patients where monitoring informs decisions for managing treatment or disease progression; and
- known/suspected excessive vitamin D blood levels.

Prior to ordering vitamin D serum testing, all participating network providers are required to complete the following steps to adhere to the medical coverage criteria policy.

**STEP 1:** Inform your patients when testing is being done for a diagnosis not in this policy.

**STEP 2:** Obtain a signed patient waiver acknowledging their specific diagnosis is not listed and therefore, they will be responsible for the cost of the testing.

Prior to September 1, 2019, it is recommended that providers review any applicable standing orders around vitamin D testing that would conflict with the coverage criteria policy.

This policy will be administered through our claims system. Any diagnoses that are not listed in the policy will be denied to patient liability.

**WHY CHOOSE WISELY**

- Health Plan members spent more than $1.0M in out-of-pocket cost sharing related to vitamin D blood testing. Forty two percent of these members had diagnoses that did not have evidence of need for vitamin D serum testing.
- Vitamin D screening is in the “Top Five” list of Choosing Wisely® recommendations that VBD Health Low-Value Care Task Force has identified to employers and other purchasers as “ready to take action on” as a low-value service. ([Path: vbidhealth.com](https://vbidhealth.com))
- An ABIM Foundation survey found only minimal progress in physician awareness from the “information only” Choosing Wisely campaign. ([Health Affairs, 2017](https://www.healthaffairs.org))

**MOVING THE NEEDLE: WHAT YOU CAN DO**

When focused on Choosing Wisely recommendations, care systems have reported specific interventions aimed at stewardship that have significantly decreased low-value vitamin D blood testing. ([American Journal of Medicine, 2018; Kaiser Permanente Center for Health Research, 2017](https://www.ajm.org))
RESOURCES

Medical Policy
You will find the full Vitamin D medical policy on our website. (Path: healthpartners.com/public/coverage-criteria/policy.html?contentid=ENTRY_210082)

FREQUENTLY ASKED QUESTIONS

When is 25-hydroxyvitamin D blood testing covered?
Vitamin D testing may be considered medically necessary and, therefore, covered only in patients with clinical diagnoses of one or more underlying diseases or conditions specifically associated with vitamin D deficiency or decreased bone density.

When is 25-hydroxyvitamin D blood testing not covered?
Vitamin D testing is considered not medically necessary and is not covered in the following situations:
- Routine testing or general population screening
- When ordered in response to a diagnosis NOT listed in the medical coverage criteria policy.

What products does this affect?
This policy affects most, but not all, HealthPartners plans. These coverage criteria may not apply to Medicare products if Medicare requires different coverage. Please contact Member Services at 952-883-7979 or 1-800-233-9645 for a copy of a Medicare coverage policy or criteria.

Who does this policy apply to?
This policy applies to health plan members 18 years of age or greater.

How will my patient know when a vitamin D testing is covered or not?
- Tell your patient you are ordering a vitamin D test for their diagnosis that is not listed in the coverage criteria policy so they are aware it is their responsibility for the cost of the test.
- If you order testing for one of the diagnoses listed in the criteria policy, you may advise their test will be covered per regular benefits for their plan.

How will you determine coverage?
The member will be responsible for the cost of the test when claims are received with a diagnosis not listed in the coverage indications.

What if my patient has further questions about their responsibility for the cost of the test?
If your patient has further questions:
- Inform them of their “specific diagnosis” you are using to submit testing charges to the health plan.
- Direct them to call the member services number printed on their insurance card.

How have you communicated this change to patients/members?
Updates using our existing member communication platforms are planned.

Care System Action Plan

- Screening guideline: Convene cross-disciplinary committee to review current guideline protocol for appropriate vitamin D high-risk screening
- Point-of-care alert: Clinician acknowledgement of current guideline “hard stop”
- Lab order preference list: Modify to eliminate shortcuts
- Leadership education: Care system leadership educational meetings
- Communication: Weekly email and educational reminders
- Performance feedback: Visits to primary clinic sites to review monthly performance rates “number of low-value or potentially appropriate vitamin D per unique patient visits” (American Journal of Medicine, 2018)
Medical Policy updates – 7/1/2019

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.

<table>
<thead>
<tr>
<th>Coverage Policies</th>
<th>Comments / Changes</th>
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<tbody>
<tr>
<td>Infertility care – Wisconsin</td>
<td>Effective immediately, policy is retired.</td>
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<td>Termination of pregnancy</td>
<td>Effective immediately, policy is retired.</td>
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<tr>
<td>Sympathectomy (thoracic) for the treatment of primary hyperhidrosis</td>
<td>Effective immediately, the policy title has been changed to Primary hyperhidrosis treatments. The administrative process section denotes which treatments require prior authorization. The medical necessity criteria for sympathectomy have been reorganized, but the content has not changed.</td>
</tr>
<tr>
<td>Oral appliances for sleep disorders</td>
<td>Effective immediately, policy revised. Policy was clarified to indicate that besides the Apnea-Hypopnea Index (AHI), Respiratory Disturbance Index (RDI) and Respiratory Event Index (REI) are also acceptable measurements of obstructive sleep apnea severity.</td>
</tr>
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<td>Medical cannabis</td>
<td>Effective immediately, policy is retired.</td>
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| Transcutaneous electrical nerve stimulator (TENS) unit | Effective immediately, policy revised. Policy updated to state the following:
1) A TENS device is covered as a rental item capping at 6 months, or when purchase price met, whichever occurs first. Once purchase price met, the item will be owned by member.
2) Electrodes are covered without prior authorization.
No changes were made to the diagnoses covered or not covered. TENS devices do not require prior authorization. |
| Artificial pancreas system | Effective immediately, policy is retired. |
| Vitamin D testing | A new medical coverage policy, Vitamin D testing, will become effective on 9/1/19.
Diseases and conditions associated with vitamin D deficiency will be listed on the policy as covered indications. Testing for vitamin D levels as screening in the general population is not considered medically necessary and therefore will not be covered.
The policy applies to members age 18 and over.
Vitamin D testing does not require prior authorization. |
| Vision therapy/orthoptics | Effective 9/1/19, the policy has been clarified to read “Vision therapy/orthoptic office visits exceeding 12 lifetime visits are considered not medically necessary.”
Also clarified that prior authorization is not applicable for vision therapy for diagnoses other than convergence insufficiency, as it is considered experimental/investigational. The provider and facility will be liable for payment unless the provider notifies the member that a specific service has been determined by HealthPartners to be experimental/investigational; and the member signs a waiver agreeing to pay for the specific non-covered service being rendered; and the claim has been billed with a GA modifier indicating such. If the member has signed a waiver agreeing to pay for the specific service, then the member will be liable for payment. |

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

Fast Facts  July 2019
BEHAVIORAL HEALTH

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<td>Chemical health services</td>
<td>Effective 9/1/2019, policy revised. Detailed information added regarding the level of care for substance use disorder residential treatment. Including specific hours of clinical service required at each level of care.</td>
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Pharmacy Policy updates – 7/1/2019

HEALTHPARTNERS DRUG FORMULARY – RECENT UPDATES

Changes take effect July 1 for MN Health Care Programs (MHCP) Drug List

Starting next month, HealthPartners will adopt the Minnesota Department of Human Services’ (DHS) Preferred Drug List (PDL) for members in Prepaid Medical Assistance Program, MinnesotaCare, Minnesota Senior Care Plus, Special Needs Basic Care, and MSHO. The State’s PDL does not apply to Medicare Part D drug coverage. All of the MHCP health plans are implementing this change. Letters are being mailed to health plan members impacted by the change, and they are asked to contact pharmacists and providers for new prescriptions.

How this will affect clinicians and patients

- Some drugs that are prescribed today were removed or moved to non-preferred (NP) status.
- A patient who is taking a non-preferred drug will need prior authorization. Patients will be required to try and fail two preferred drugs or have a clinical reason for not being able to try the preferred drug.

Providers are asked to:

- Respond to requests for preferred products in a timely manner.
- Contact HealthPartners if this non-preferred medication is medically necessary for a patient. Our standard process can be used by submitting a prior authorization to Pharmacy Administration (fax to 1-888-883-5434).

Additional information about this change is available on the MN DHS website.

Additional information about this change is available on the MN DHS website.

(\textit{path:} mn.gov/dhs/assets/pdl-faq-providers_tcm1053-378520.pdf)

OTHER PHARMACY FORMULARY UPDATES

- Bromfenac (Prolensa) eye drops has been removed from the formulary.
- Immune globulin must be billed as a medical claim.
- Levodopa (Inbrija) inhalation has been added to formulary with prior authorization. Inbrija is considered a specialty medication.
- Mesalamine (Pentasa) has been removed from the formulary. Current members will be grandfathered (allowed to continue), but some may see increased co-pays.
- Nepafenac (Nevanac) eye drops have been removed from the formulary.
- Lanadelumab (Takhyro) subcutaneous injection for prevention of hereditary angioedema attacks will now be required for prophylaxis prior to the use of Cinryze.
- Generic deferasirox will be required for treatment of iron overload conditions prior to the use of Jadenu.
- Crizotinib (Xalkori) and lorlatinib Lorbrena will be reserved for patients who have tried and failed other first line ALK-inhibitors (e.g., alectinib). Exceptions will be made for Xalkori when ROS-1 or MET exon 14 skipping mutations are present.
• Cabozantinib (Cabometyx) will be reserved for patients who have tried and failed sunitinib (Sutent) or pazopanib (Votrient). Exceptions will be made for patients with poor or intermediate risk or non-clear cell histology.
• Apomorphine (Apokyn) will be reserved for patients diagnosed with Parkinson’s experiencing off periods who have tried and failed treatment with Inbrija.
• The following medications will be added to the Trial Drug Program Effective 10/1/19. The first 6 fills of a trial drug will be limited to less than a month supply (usually 14-15 days). The Trial Drug Program is for medications that may not be well tolerated due to side effects, or with potential for discontinuation.
  o Oncology: Copiktra (duvelisib), Daurismo (glasdegib), Iclusig (ponatinib), Lorbrena (lorlatinib), Talzenna (talazoparib), Vitrakvi (larotrectinib), Vizimpro (dacomitinib) and Yonsa (abiraterone)

All members and their providers receive additional communications.

Positive changes (additions) are generally effective July 1, and negative changes (deletions) are generally effective August 1. Current members are grandfathered through September 30.

Please see the formulary for details and a complete list at HealthPartners Drug Formularies.

Click HERE for quarterly formulary updates and additional information such as Prior Authorization and Exception Forms, Specialty Pharmacy information, and Pharmacy and Therapeutics (P&T) Committee policies, including the Drug Formularies (Path for quarterly formulary updates: healthpartners.com/provider-public/pharmacy-services/policies-and-forms/; Path for Drug Formularies: healthpartners.com/provider/admin tools/pharmacy policies and 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**

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<td>Recent Food and Drug Administration (FDA) approved medications coverage policy</td>
<td>Prior authorization is required for recently approved drugs listed on this policy.</td>
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<tr>
<td>CLICK HERE to view this policy</td>
<td>Drugs recently added to this policy include:</td>
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<tr>
<td>COVERAGE POLICY can also be found in the medical coverage policy search page, searchable by drug name or billing codes. (path: healthpartners.com/public/coverage-criteria/)</td>
<td>• Zolgensma – site of care and preferred provider restrictions apply.</td>
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|                                                                                     | 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.
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| Oncology drug coverage policy | Prior authorization is required for oncology drugs listed on this policy.  
Drugs recently added to this policy include:  
- Isotodax  
Additional criteria may apply – see the coverage policy for more information. |
| **CLICK HERE** to view this policy  
**COVERAGE POLICY** can also be found in the medical coverage policy search page, searchable by drug name or billing codes. |  
| Emapalumab-izsg (Gamifant) | Prior authorization is required.  
New medical policy restricting use to patients diagnosed with primary hemophagocytic lymphohistiocytosis (HLH) meeting clinical criteria.  
See the coverage policy for full clinical criteria and prior authorization restrictions. |
| Medical policy will be live on the web by 7/1/19.  
**COVERAGE POLICY** can be found in the medical coverage policy search page, searchable by drug name or billing codes. |  
| Tagraxofusp-erzs (Elzonris) | Prior authorization is required.  
New medical policy restricting use to patients ≥ 2 years of age diagnosed with blastic plasmacytoid dendritic cell neoplasm meeting clinical criteria.  
See the coverage policy for full clinical criteria and prior authorization restrictions. |
| Medical policy will be live on the web by 7/1/19.  
**COVERAGE POLICY** can be found in the medical coverage policy search page, searchable by drug name or billing codes. |  
| Esketamine (Spravato) | Prior authorization is required. Coverage is restricted to patients meeting these criteria:  
- Treatment resistant depression – inadequate response to three or more classes of therapies  
- Prescribed by a Behavioral Health provider  
- Baseline measurement of depression provided  
Additional criteria may apply – see the coverage policy for more information. |
| Medical policy will be live on the web by 7/1/19.  
**COVERAGE POLICY** can be found in the medical coverage policy search page, searchable by drug name or billing codes. |  
| Brexanolone (Zulresso) | No prior authorization is required.  
New medical policy restricting use to in-patient setting.  
- Zulresso will not be covered in the ambulatory setting as the medication requires a 48-hour continuous infusion with monitoring.  
- No prior authorization is required. However, utilization is subject to review to ensure appropriate use.  
Additional criteria may apply – see the coverage policy for more information. |
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<td>New medical policy restricting use to patients diagnosed with acquired thrombotic</td>
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<td>the web by 7/1/19.</td>
<td>thrombotic thrombocytopenic purpura (aTTP) meeting clinical criteria.</td>
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<td>Elapegademase-lvr (Revcovi)</td>
<td>Prior authorization is required.</td>
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<td>Medical policy will be live on</td>
<td>New medical policy restricting use to patients diagnosed with severe</td>
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<td>combined immunodeficiency disease.</td>
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*(path: healthpartners.com/public/coverage-criteria/)

**Reminder**

**Provider survey**

HealthPartners mailed a short survey to a sample of psychiatrists, primary care and specialty care physicians, as well as their office managers. 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.

There’s still time to complete the survey if you’ve received it and haven’t returned it yet. Your feedback is important in helping us to identify potential areas of improvement.


**Patient Perspective**

**August is National Immunization Awareness Month**

National Immunization Awareness Month is held in August each year to raise awareness of the importance of immunizations to prevent diseases. Parents rely on their clinician to give them information about the vaccinations their child needs. Studies show:

- A strong recommendation from a clinician is the single most important factor in determining whether or not someone gets vaccinated.
- People want clear and consistent information about vaccines.