ICD-10 Planning

The deadline for ICD-10 implementation is approaching fast. ICD-10 is going to have a major impact on billing, reporting and many other related processes in your organization.

As recommended by the Centers for Medicare and Medicaid (CMS) and the American Health Information Management Association (AHIMA), your ICD-10 conversion project should have four overall phases identified. Whether you are part of a large provider organization or a small clinic, we suggest you start by organizing your plan around these four phases:

Phase 1 – Develop an implementation plan
Phase 2 – Implementation preparation
Phase 3 – “Go Live” preparation
Phase 4 – Post-implementation follow up

For more information regarding ICD-10 implementation, please visit the CMS website at: [CMS ICD 10 information](#). In addition, if you missed the ICD-10 Webinar hosted by the Minnesota ICD-10 Collaborative on November 10, 2011 that addressed the business and technical aspects of ICD-10, the information can be accessed from the HealthPartners website at: [healthpartners.com/provider](http://healthpartners.com/provider) or click here: [ICD-10 Resources](#).
Two Digit Medicaid Program Code

Eligibility

In support of the Minnesota Administrative Uniformity Committee’s (MN AUC) Best Practice Guidelines and our providers reporting needs, HealthPartners is now supplying the 2 digit Medicaid Program Code on eligibility transactions.

For further information regarding this two-digit code, please review the MN AUC Best Practice published on the MN AUC website. The document provides instructions on the location of the Minnesota Department of Human Services (DHS) two digit major program code in the eligibility transaction.

This data is also displayed on the HealthPartners Provider Portal eligibility results in the Member Detail section labeled; "Medicaid Program Code".

*Information presented is current at the time of eligibility verification and is subject to change.*

Remittance Advice

HealthPartners is also supplying two digit major program codes on the 835 v5010 remittance as well as the remittance advice on HealthPartners Provider Portal.

*Information presented on the remittance advice is current as of the time of adjudication and is subject to change.*

**HealthPartners Portal Remit:**

The Program Code on the remittance is labeled “Contract”.

**HealthPartners 835 v5010 EDI transaction:**

The program code will be supplied in the REF*CE segment. The code will be prefixed with 'PMAP ' and a space (e.g. 'PMAP DM'). Please see sample below:

```
CLP*GOUL000001*1*585*0**MC*2141053182*11*1
NM1*QC*1*xxxxx*xxxxxx****MI*xxxxxx
NM1*82*1******XX*1111111111
REF*1L*4183
REF*1W*00772213
REF*CE*PMAP BB
DTM*232*20100927
DTM*233*20100930
DTM*050*20110328
```

If you have questions regarding the data supplied in the EDI transactions, please consult with your software vendor or clearinghouse.

NDC Submission on Professional and Outpatient Facility Claims

We want to remind you that in support of the Federal Deficit Reduction Act of 2005, you should report the 11-digit National Drug Code (NDC), NDC Quantity and NDC Unit of Measure on all professional and outpatient facility drug claims. In addition, you should supply proper documentation when submitting unlisted, unclassified or miscellaneous drug codes.

The ability to adjudicate medical drug claims using NDC detail is designed to remain consistent with industry requirements, ensure accurate reimbursement and make certain the effective use of our members and your patients’ medical benefits (i.e. annual benefit limits and lifetime maximums).
You are strongly encouraged to consult with your vendor(s) to determine how to appropriately submit NDC codes through their billing system; however, here are some suggestions:

- You should submit a valid NDC number, NDC quantity of the drug dispensed, and the related NDC unit of measure when billing Healthcare Common Procedure Coding System (HCPCS) codes for drug products.
- The submitted NDC number should reflect the actual NDC number on the package or container from which the drug was administered.
- NDC number should be in the HIPAA compliant 11-digit format; without hyphens, spaces or special characters.
- The submitted NDC Quantity should indicate the exact amount dispensed, and the Unit of Measure should reflect the value assigned by the drug manufacturer and reported in the major drug compendiums (e.g. number of ML).
- When billing electronically with the claims transaction (837), the NDC number, NDC quantity of the drug dispensed, and the related NDC unit of measure should be submitted using the 2410 Loop - Drug Identification.

As announced in previous Fast Facts editions, we may reject claims with missing or invalid NDC numbers, or missing NDC Quantity and NDC Units of measure. In addition, we will review claims for proper documentation and may reject claims with insufficient information. You may resubmit the rejected claims along with appropriate documentation. For instance:

- If a medical drug claim is submitted using an unlisted, unclassified or miscellaneous code and a unique HCPCS code exists for the drug, we may reject the claim.
- If a medical drug claim is submitted using an unlisted, unclassified or miscellaneous code and a unique HCPCS code does not exist for the medication, you need to provide supporting documentation to properly adjudicate the claim (see above for suggestions).

For additional information please click on the link below:

HealthPartners Administrative Policy

» Please contact your HealthPartners Service Specialist if you have additional questions or send an email to NDCTeam@HealthPartners.com.

Updated Prior Authorization Policy

The Prior Authorization Policy has been updated to include the process for obtaining a post-service review for services that require prior authorization. The post-service review can be requested if a prior authorization was not completed before the claim was submitted. You can view the updated policy at healthpartners.com/provider. You will need to log in and select administrative policies or click here: Administrative Policies.

Please review the changes and contact your HealthPartners Service Specialist if you have additional questions.

Fraud, Waste and Abuse: Responsibility to Report

HealthPartners is committed to preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA) and we ask that you assist us in this effort. Accordingly, we are providing you with HealthPartners policy on preventing, detecting, and reporting Fraud, Waste and Abuse.

The policy contains information on:

- Laws designed to combat health care fraud
- Reporting to, and cooperating with Federal and State authorities
- Obligations to report suspected health care fraud, and
• Protections for good faith reporters of suspected fraud, waste, or abuse

You can assist in reducing actual or suspected FWA by verifying patients’ identities and registering them under the correct accounts.

Everyone has the right and responsibility to report possible fraud, waste or abuse. To report suspected fraud, waste or abuse, you may call the HealthPartners Corporate Integrity Hotline at 866-444-3493, or the HealthPartners Fraud and Abuse Hotline at 952-883-5099, or send an e-mail to reportfraud@healthpartners.com.

Please review the policy at: Fraud, Waste and Abuse Policy and share it with others within your organization who may be need to be aware of this information. Feel free to call Steve Bunde, Senior Director, Integrity and Compliance at 952-883-6541 if you have any questions or concerns.

Claims Estimator

Copays? Coinsurance? Deductibles?

Find out with the Claim Estimator application in the Provider Portal.

HealthPartners Claim Estimator allows providers to enter services for a patient and receive an estimate based on that patient’s benefit package and provider contractual setup.

Among the features of the Claim Estimator:

• Professional Medical claim estimation for a CMS 1500 claim
• Summary of claim estimation results including member liability
• Capability to print estimate summary

Use of this online tool can assist you in predicting plan payment and patient responsibility. Additionally this information can be used to initiate a conversation regarding patient liability with the patient prior to rendering services.

» If you have further questions, please contact the EC support line: 952-883-7505 Opt 2 or at healthpartners.com/providerregistration.

Help your patients manage their healthcare costs

Effective March 1, 2012, CIGNA is launching an expanded Web tool that will help CIGNA members better estimate the cost of care for many different types of medical services. Cost estimates will be available for 200 of the most common procedures, which represent up to 80 percent of procedural claims – from office visits and lab tests to more complex services like MRIs, colonoscopies and outpatient surgeries.

How cost information is determined

The cost estimates are generated based on claims experience and reflect the negotiated price for services. The estimated costs will include all aspects of a procedure (for example, the cost for tonsil removal would include facility, physician and anesthesia costs). In addition:

• These cost estimates are also personalized to reflect the customer’s out-of-pocket costs, using the real-time status of any deductible, coinsurance and available funds.
• CIGNA’s cost estimates are proven to be accurate. CIGNA compared cost estimates to actual claims and they are within 10 percent of the claim costs more than 90 percent of the time.
• Cost information is only available to CIGNA members (via the secure CIGNA member website), and is not accessible by the general public
Why it’s important
CIGNA knows that when people make better choices about their health care, everyone benefits. Receiving the right care from the right health care professionals can improve patient health, save them money and strengthen the bottom line of the companies where they work. That’s why CIGNA designs tools to make cost and quality more transparent.

What if my patient has questions?
If your patients have questions, they can call CIGNA customer service at the number on the back of their member ID card.

Injectable/Immunization Fee Schedule Update
As outlined in your market basket fee schedule, the fees for injectables and immunizations are subject to quarterly updates. The next update will be effective February 15, 2012. A list of the updated fees will be available on the Provider Portal. Please find the Injectable Fee Schedule link under the HPI Administrative Program for Medical Providers/Fee Schedule Updates or click here Administrative Policies.

CLINICAL

Medical, Durable Medical Equipment (DME) and Medical Dental Coverage Policy Updates
Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at www.healthpartners.com/provider pathway: 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>Medical Coverage Policies</th>
<th>Comments / Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autologous Bone Marrow Grafting for Osteonecrosis</td>
<td>New policy, investigational, not covered. This service also appears on the Investigational Services: List of non-covered services policy as not covered, effective 1/15/12.</td>
</tr>
<tr>
<td>Balloon Sinuplasty</td>
<td>Policy updated to reflect 2011 code changes.</td>
</tr>
<tr>
<td>Bio-identical Hormone Replacement and Saliva Hormone Testing</td>
<td>Policy revised to make it gender neutral. There is insufficient literature to support efficacy for treatment for either gender. This testing &amp; treatment are considered experimental and not covered.</td>
</tr>
<tr>
<td>Endoscopic Gastroplasty / Fundoplication for Gastroesophageal Reflux Disease (GERD)</td>
<td>New policy, investigational, not covered. This service also appears on the Investigational Services: List of non-covered services policy as not covered, effective 1/15/12.</td>
</tr>
<tr>
<td>Epidural Steroid Injection</td>
<td>Policy language clarification. Added comment: All members must meet criteria for coverage regardless where the service is provided.</td>
</tr>
<tr>
<td>Eye Surgery - Refractive</td>
<td>Policy revised to remove intraocular lens coverage information, which has been moved to a new and separate policy.</td>
</tr>
<tr>
<td>Intraocular Lens (IOL) after Cataract Surgery</td>
<td>New policy to clarify coverage of IOLs after cataract surgery. Standard non accommodating lenses are covered. Accommodating lenses are a contract exclusion and not covered.</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Investigational Services - Category III T Codes</td>
<td>The new codes effective 1/1/12 have been added to the policy, requiring prior authorization effective 1/1/12.</td>
</tr>
<tr>
<td>Investigational Services: List of non-covered services</td>
<td>Three services have been added to the list as investigational, as of 1/15/12. The services added are GraftJacket tissue matrix, Endoscopic gastroplication procedures and autologous bone marrow grafting for osteonecrosis.</td>
</tr>
<tr>
<td>Laminectomy</td>
<td>New Policy. Laminectomy surgery prior authorization requires prior authorization effective 4-1-2012</td>
</tr>
<tr>
<td>Pudendal Nerve Injections</td>
<td>Policy retired. No prior authorization required.</td>
</tr>
<tr>
<td>Sacroiliac Injections</td>
<td>Coverage changed from approval of 3 injection sessions in 12 months to up to 3 injections per year, per site, each individual injection requires prior authorization.</td>
</tr>
<tr>
<td>Transmyocardial Revascularization</td>
<td>Policy retired. No prior authorization required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DME Coverage Policies</th>
<th>Comments / Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aids for Children &amp; Infants - WI</td>
<td>Revised policy. No prior authorization required.</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>No prior authorization is required for rental of hospital beds for the first 3 months; prior authorization will be required from the 4th month forward effective 2/1/12. Codes include, but are not limited to E0250, E0255, E0260, E0261, E0265, E0266, E0270, E0301, E0302, E0303, and E0304.</td>
</tr>
<tr>
<td>Manual wheel chairs</td>
<td>No prior authorization is required for rental of manual wheel chairs for the first 3 months; prior authorization will be required from the 4th month forward effective 2/1/12. Codes include, but are not limited to K0001, K0002, K0003, K0004, K0005, K0006, K0007, and K0009.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Dental Coverage Policies</th>
<th>Comments / Changes</th>
</tr>
</thead>
</table>

Contact the Medical Policy Intake line at 952-883-5724 for specific patient inquiries. For general policy and process questions contact Deb DooherAnderson at 952-883-5798
HealthPartners is expanding its waste management program for select oral oncology agents as of February 1, 2012. Nexavar, Sutent and Tarceva have been included in the program since implementation in early 2011. Afinitor, Sprycel, Targetin, Tasigna and Votrient will be added to the program. High costs and high discontinuation rates are often observed with these agents and this program helps reduce resulting drug waste.

Walgreens Specialty Pharmacy (WSP) will administer the program. All HealthPartners members filling a script at WSP for an eligible drug will be offered the program. No prescribing changes are required for this program. Physicians should continue to write prescriptions for up to a one-month supply. All program activities will be facilitated by HealthPartners and WSP.

The program provides a trial amount (half a month) of drug therapy for patients newly prescribed these agents during the first month of therapy. Members will only be responsible for a proportional amount of monthly out of pocket costs for each fill. WSP will follow-up with members near the end of the trial period to assess tolerance to the regimen. If the member is tolerating the drug regimen, additional drug will be provided based on the amount ordered on the original prescription. If the member is not doing well on the drug, WSP will facilitate communication with the member’s physician. WSP will fax a report chronicling the member’s experience to the prescribing physician in either scenario.

Pharmacy Updates

Medicare Drug Formulary, Changes for January 2012

There are several changes to the Medicare Drug Formulary. Most of these follow changes that were made to the Commercial Drug Formularies earlier in year 2011. Changes include:

- Insulin. Novo Nordisk insulins (Novolog and Novolin) have been deleted, and replaced with Lilly (Humalog and Humulin). Members currently using Novolog and Novolin were notified, and have until April 1, 2012, to make changes.
- ARB Medications. Telmisartan (Micardis and Micardis HCT) has been deleted. The preferred ARB medication is losartan (generic Cozaar) and losartan/ HCTZ (generic Hyzaar). Irbesartan (Avapro and Avalide) and valsartan (Diovan and Diovan HCT) are also available with step-therapy from a generic ACE inhibitor or ARB. Members currently using Micardis and Micardis HCT were notified, and have until April 1, 2012, to make changes.
- Acetaminophen combinations. Combination products with more than 325 mg of acetaminophen (such as Vicodin) have been deleted, per FDA plans to remove these from the market due to safety concerns. Members currently using higher strengths were notified, and have until April 1, 2012, to make changes. Alternatives are available with the same ingredients but less acetaminophen.
- Diabetes medication quantity limits. Quantity limits to prevent high doses are being added per CMS guidelines. Limits include metformin IR 2,550mg per day, metformin ER 2,000mg per day, and glipizide 20mg per day. Members currently using higher doses were notified, and have until April 1, 2012, to make changes.
- Over-Active Bladder (OAB) medications: trospium XR (Sanctura XR) has been deleted. Preferred OAB medications are oxybutynin, tolterodine (Detrol and Detrol LA) and solifenacin (VESIcare).

Transition plans:

- Changes are effective January 1, 2012, for all new members starting these medications.
- All current members have been grandfathered, allowing them to receive at least one prescription in the first 3 months of 2012.
- Member letters are being sent for top changes. Remaining letters will be sent as members refill prescriptions in the first three months of 2012.
Minnesota Health Care Programs Drug Formulary, Changes for January 2012

Several changes to the HealthPartners Minnesota Health Care Programs (Medicaid and Minnesota Care) Drug Formulary have been made to help new members transition as smoothly as possible, including:

- Novolog and Novolin insulins have been added to this formulary. Both Lilly (Humalog and Humulin) and Novo Nordisk (Novolog and Novolin) are covered for MinnesotaCare and Medicaid members. Costs are similar for these insulins for this group. Lilly insulin (Humalog and Humulin) is preferred for Commercial and Medicare members.

- Atomoxetine (Strattera) and lisdexamfetamine (Vyvanse) have been added to match the PreferredRx formulary, and guanfacine ER (Intuniv) has been added with an age edit to match the PreferredRx formulary.

- Duloxetine (Cymbalta), pregabalin (Lyrica), and milnacipran (Savella) have been added with step therapy that matches the PreferredRx formulary.

Transition plans:

- Prior authorization and step-therapy medications will process as formulary medications for two months, and then members can continue to receive these medications. HealthPartners will continue to review utilization for opportunities.

- Non-formulary medications will process for two months. These prescriptions will trigger transition letters, notifying members of preferred medications. These prescriptions will not be covered starting on March 1. Members will need to switch to formulary products, or work with providers to request formulary exceptions.

- Non-preferred glucose test strips such as One Touch will process for three months. These prescriptions will trigger transition letters, notifying members of preferred strips and including a mail-in program for a free meter replacement.

Commercial Drug Formulary, Changes for January 2012

- Ortho Evra and NuvaRing have been added to GenericsPlusRx. Both remain on formulary for PreferredRx and Medicaid.

- Atomoxetine (Strattera) and lisdexamfetamine (Vyvanse) have been added to GenericsPlusRx to match the PreferredRx formulary, and guanfacine ER (Intuniv) has added to GenericsPlusRx with an age edit to match the PreferredRx formulary.

- Ticagrelor (Brilinta) was reviewed and “not added.” Brilinta is used for acute coronary syndromes. It does not appear more effective than standard therapy such as clopidogrel (Plavix) in US patients, and safety concerns include a Black Box warning about aspirin dosing.

Preferred Drug List (Drug Formulary)

Drug Formularies are available at healthpartners.com/formulary. Click here to access the Medicare 2012 Drug Formulary. See these sites to verify formulary status. Drug Formularies are also available for handheld devices through Epocrates.

Quarterly Formulary Updates and additional information such as Prior Authorization and Exception Forms, Specialty Pharmacy information, pharmacy newsletters, and Pharmacy and Therapeutics (P&T) Committee policies are available here.

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. After hours calls are answered by our Pharmacy Benefit Manager.

Fast Facts January 2012
Biometric Screening

Some employers are incorporating biometric screening into some of their employees’ health and wellness programs (H&W). Depending on what H&W program your patient has selected, they may need to complete a form that includes testing that has been done in your office: cholesterol levels, blood pressure rates, Body Mass Index (BMI) or blood glucose levels. This form is protected under Protected Health Information (PHI) and is only used by the patient within the H&W program that they have chosen.

By further raising health awareness, the biometric snapshot supports your patient and your efforts in effectively managing their care, understanding their results, and the steps they can take to improve their health.

As part of the employer benefits program, employees who demonstrate engagement in the chosen health and wellness program have the opportunity to lower their own benefit costs.

Please contact your HealthPartners Service Specialist or Contract Manager if you have additional questions.

ICSI Guidelines – New and Revised Guidelines

December 2011

Institute for Clinical Systems Improvement (ICSI) health care guidelines represent the most appropriate medical practice for a range of common preventive services, chronic diseases and acute conditions.

A health care protocol is a step-by-step statement of a procedure routinely used in the care of individual patients to assure that the intended effect is reliably achieved.

Order sets are a standard set of orders for in-patient care for particular conditions.

Health Care Guidelines that have been recently developed or updated:

• Lipid Management in Adults
• Diagnosis and Treatment of Chest Pain and Acute Coronary Syndrome (ACS)
• Assessment and Management of Chronic Pain

Health Care Protocols/Order Sets/Supplements that have been recently developed or updated:

• Prevention of Ventilator-Associated Pneumonia Protocol

Our goal in communicating these updates is to promote the use of guidelines/protocols/order sets that are based on the best available evidence. Please review the above lists and determine if it is appropriate to implement some or all of them within the clinical practice of your medical group. Complete copies of all ICSI Guidelines, Protocols and Order Sets are available on the ICSI web site at icsi.org or call ICSI at (952) 814-7060 to obtain a hard copy.

Contact: Bev Norling, Quality Consultant, Quality Measurement and Improvement Department at (952) 883-6184 or quality@healthpartners.com

GOVERNMENT PROGRAMS

REMINDER: New Department of Human Services (DHS) Policy Requirement For Induction of Labor Prior to 39 Weeks Effective
January 1, 2012

As you may recall, in the November 2011 edition of Fast Facts, an article was included regarding a new program being implemented by the Department of Human Services (DHS) to reduce the number of elective inductions of labor prior to 39 weeks’ gestation.
This program promotes hospitals having a policy and procedure in place to prohibit the use of elective inductions prior to 39 weeks.

DHS has recently compiled the list of approved hospitals and the list will be available through the DHS MN-ITS system soon.

Attending providers who bill for labor and delivery services should check with the hospitals they deliver at to determine if the hospital is a DHS-approved hospital.

If the hospital is approved, attending providers do not need to submit further information with their claims submission.

If the hospital is not approved, attending providers are required to submit an attachment to any claim submitted for labor and delivery services. The attachment form can be found on the DHS website at the link below.

For more information regarding this program, please click here: Evidence-based Childbirth Program DHS or visit dhs.state.mn.us/partners and providers/keyword search = induction.

Training Requirement for Providers

HealthPartners Minnesota Senior Health Options (MSHO)
Model of Care 2012

The MSHO Model of Care defines the management, procedures and operational systems that provide the access, coordination and structure needed to provide services and care to the MSHO population.

The Model of Care is a Centers for Medicare and Medicaid Services (CMS) requirement for Special Needs Plans and annual provider training is required.

The Model of Care contains the following components:

1. Description of the HealthPartners MSHO Population
2. Measurable Goals
3. Staff Structure and Care Management Roles
4. Interdisciplinary Care Team
5. Provider Network of Specialized Expertise and Use of Clinical Practice Guidelines
6. Model of Care Training for Personnel and Provider Network
7. Health Risk Assessment
8. Individual Care Plan
9. Communication Network
10. Care Management for the Most Vulnerable Subpopulations
11. Performance Health Outcome Measurement

The HealthPartners 2012 MSHO Model of Care Training PowerPoint and 2012 MSHO Model of Care Summary document can be accessed on the Provider Portal at healthpartners.com/provider and search “What’s New” or click here: MSHO Model of Care.
Metro Area Health Plan Changes January 1st

A large number of people covered by Medicaid and MinnesotaCare in the seven metropolitan counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington) changed health plans on January 1, 2012 as a result of the competitive bidding process with the health plans for these programs.

HealthPartners was selected to continue to provide services in all metro counties. With this change, HealthPartners has approximately 13,000 new members effective January 1, 2012.

We want to remind you that it continues to be important for providers to confirm eligibility prior to providing services. It’s expected there will continue to be shifts in membership during the first quarter of 2012 for all health plans serving these members.

If you are working with patients that have questions, please encourage them to call HealthPartners Member Services at 952-967-7998 or toll free at 1-866-885-8880. Please also review the Frequently Asked Questions document regarding the January enrollment transition that DHS has posted. This can be found on the DHS web site dhs.state.mn.us/MHCPmemberservices

EVENTS

HealthPartners Institute for Medical Education – Center for Continuing Professional Development

2012 Event Calendar

Fundamental Critical Care Support – February 23-24 and July 19-20
Dermatology for Primary Care: Beyond the Basics – February 24
26th Annual Family Medicine Today – March 8-9
30th Annual OB/GYN Update – April 12-13
The Mind of a Child: Psychiatric Challenges for Today’s Youth – April 19
Psychiatry Update: Selected Topics for the Non-Psychiatrist – April 20
Pediatric Fundamental Critical Care Support – May 3-4 and November 8-9
30th Annual Strategies in Primary Care Medicine – September 20-21
Midwestern Region Burn Conference – October 10-13
Optimizing Mechanical Ventilation – October 26-28
12th Annual Women’s Health – November TBA
Emergency Medicine and Trauma Update: Beyond the Golden Hour – November TBA
Cardiovascular Conference – December 13-14

For further information, visit IME’s website at healthpartnersIME.com or contact (952) 883-6225.

» If you have questions regarding the content of this newsletter, please contact the person indicated in the article or call your HealthPartners Service Specialist. If you don’t have his/her phone number, please call 952-883-5589 or toll-free at 888-638-6648.

» This newsletter is available on-line at healthpartners.com/provider (pathway: Log in to the Provider Portal).

» Fast Facts Editor:
   Brenda Thommen, Hospital & Regional Network Management 952-883-5662 or brenda.k.thommen@healthpartners.com.

» Fast Facts CoEditor:
   Susie Beauvais, Professional Services Network Management 952-883-5660 or susan.m.beauvais@healthpartners.com.

Fast Facts January 2012