Fast Facts
News for Providers from HealthPartners Professional Services and Hospital Network Management

November 2015

ADMINISTRATIVE INFORMATION

HealthPartners Programs and Important Information

Information is available for your review regarding key HealthPartners programs, policies and procedures, important member information, and other pertinent information at healthpartners.com/provider.

Access Quality Improvement & Utilization Management (path: healthpartners.com/provider-public/quality-and-measurement) for information on:
- Quality Improvement and our Annual Evaluation on meeting our goals
- Utilization Management (UM)
- Program descriptions
- Clinical Guidelines and Guideline Updates

Access Administrative policies (path: healthpartners.com/provider-public/administrative-policies) for administrative policies including:
- Medical Record Standards
- Utilization Management Coverage Criteria Policies
- How to Contact a Medical Director regarding UM
- Member Rights & Responsibilities
- Member Complaint Processes and Procedures
- Access to UM Staff

Access Website privacy policy (path: healthpartners.com/provider-public/privacy) and Privacy Practices for Providers (path: https://secure5.compliance360.com/Common/ViewUploadedFile.aspx?PD=ueERP8hiqeu2ELAToeoOuXj87oDg5RXzgD2z1WHotryuyaVh%2fMGqVZ3mA79g%2fOfCoUlgo1PfsjPAshVHvwaqKeslMYV%2b8XBl3lXqgJ8%2bf7MnC%2fnEeNE4fOTZBgT7EyZRXoa8y8KNUeyg962%2b3X0r3zgVWszkBhhlWWsxGyaPfJz5oqueySLSxHj90XPtXBtZ0qWEn7KjQ2Mo56a9IehBzYzTlxoGKZx0orKAlJ8orYz%2f5aYynV5Fy9wcb3x2NAE0bNlzzvemhnygZ2Z0mGQ%3d%3d) for Confidentiality/Privacy policies.

Member Services for Providers

Remember that you can access detailed member information online including eligibility and benefits, remittances, referral information, claims status, forms and policies, and much more. To register for your secured Provider Portal account, go to healthpartners.com/provider and start taking advantage of these great services! Accessing this information through the Provider Portal will be the fastest way to get you what you need. Should you need any additional information, Member Services is available Monday-Friday from 7:00 am – 5:00 pm, Central Standard Time.
Physician Incentive Plans (PIP) Disclosure

The Centers for Medicare and Medicaid Services (CMS) requires health plans to request information from contracted providers regarding the existence of physician incentive plans. The information should also include any physician incentive plans that exist between your organization and downstream subcontractors.

Physician Incentive Plan Disclosure is required even if there are no incentive arrangements or the arrangements have a low level of risk either through referrals or low utilization.

If your information has changed since your organization last submitted this form, please submit the fax back form that’s attached to this edition of Fast Facts to HealthPartners and a Summary Data Form will be sent to you for completion.

Thank you in advance for your assistance in keeping physician incentive plan information up to date. For more information from CMS on Physician Incentive Plans, please visit CMS Relationships With Providers (path: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html). If you have questions or need more information, please contact your Service Specialist.

Disclosure of Ownership and Management Information, Business Transactions & Exclusions Statement for Providers

The Minnesota Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) require health plans, including HealthPartners, to collect information from their contracted providers regarding their ownership and management, significant business transactions, and the identity of any individuals or entities excluded from participating in government funded health care programs.

If you have not submitted this completed form to HealthPartners for 2015, please do so as soon as possible.

We are required to collect this information on an annual basis. If you’ve already submitted 2015 information but want to submit your 2016 information, the same form can be used.

The form can be found on our provider portal at healthpartners.com/providers-forms or click Disclosure of Ownership form (path: healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_043027.pdf).

Any payer will accept another payer’s form, so you only have to complete it once and submit it to each of the payers with whom you have contracts.

Forms for HealthPartners can be emailed to Narayanee.x.ananth@healthpartners.com; faxed to 952-853-8708; or mailed to HealthPartners, Compliance Business Analyst, Mail Stop 21108C, 8170 33rd Ave. S., Bloomington, MN 55440.

Fraud, Waste & Abuse

Every year fraud, waste and abuse costs Americans $80 billion and puts patients at risk for getting unnecessary or improper care. Understanding this issue and working together will help us ensure that our patients and members receive quality care while keeping health care costs affordable.

HealthPartners’ policy on Preventing, Detecting & Reporting Fraud, Waste & Abuse contains information on the laws and regulations designed to combat fraud, waste, and abuse, the definitions of fraud, waste, and abuse, and ways to report your suspicions. Examples of fraud, waste, and abuse include, but are not limited to:

- Identity theft
- Credit card theft
- Inappropriate billing
- Misrepresentation of services
- Drug diversion or misuse
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 Integrity and Compliance Hotline at 1-866-444-3493, or the HealthPartners Fraud and Abuse Hotline at 952-883-5099, or send an e-mail to reportfraud@healthpartners.com.

Please review the Preventing, Detecting & Reporting Fraud, Waste & Abuse policy at HealthPartners Provider Administrative Policies (path: healthpartners.com/provider-public/administrative-policies) and share it with others within your organization who may need to be aware of this information. Feel free to call Steve Bunde, Health Plan Compliance Officer at 952-883-6541 if you have any questions or concerns.

Changes to Peak Network for 2016

We’re making a network change that we want you to be aware of. Because prescription costs are often higher at Walgreens than at other pharmacies, Walgreens will no longer be an in-network pharmacy in the Peak network.

This change will be effective beginning January 1, 2016, and will potentially impact about 2,500 members who have had a prescription filled at Walgreens since 1/1/2015, and impacts the following PEAK groups: 0044, 0057, 0058.

Peak members who fall into the following categories will be notified via a letter as well as a phone call from our Pharmacy Navigators to explain the change and answer questions:

1. Antipsychotics
2. Anticonvulsants
3. Immunosuppressants
4. Antianxiety

Peak members who have filled a prescription at Walgreens in 2015 will receive a letter describing the change and the impact.

Medicare Part D Prescribers – Important Enrollment Information

The Centers for Medicare & Medicaid Services (CMS) has finalized changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. The change requires physicians and other eligible professionals who write prescriptions for Part D drugs to:

- be enrolled in Medicare in an approved status; or
- have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

CMS is strongly encouraging providers and other eligible professionals to submit enrollment applications or opt-out affidavits to their Medicare Administrative Contractor (MACs) no later than January 1, 2016. This will ensure sufficient time for processing to avoid their patients’ prescription drug claims from being denied beginning June 1, 2016. These dates have changed from the previous Fast Facts article to align with CMS’s revised timeframes.

Medicare enrollment can be checked at Medicare Individual Provider List | Data.CMS.Gov (path: data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx).

For more information regarding this change, including how to enroll in Medicare, please check the following:

- Prescriber Enrollment Information - Centers for Medicare & Medicaid Services (path: cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html)

Medical Policy Announcements

Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at healthpartners.com/provider (path: Provider/Admin Tools). 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.
# Medical and DME Coverage Policy Updates

<table>
<thead>
<tr>
<th>Medical Coverage Policies</th>
<th>Comments / Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Access Technologies/Telehealth Services - Medicare</td>
<td>Policy has been revised to remove the geographic limitation requirement for Medicare-covered telehealth services and add coverage for real-time interactive audio and video technologies.</td>
</tr>
<tr>
<td>Genetic Testing; Gene Expression Profiling Assays for Cancer Management</td>
<td>This is a new coverage policy. Prior authorization is required for most gene expression profiling assays. Single-gene and specified multiple-gene expression profiling assays are covered when coverage criteria are met. These gene expression profiling assays are covered only if test results will directly impact cancer management (including, but not limited to, cancer prevention, diagnosis, treatment, risk stratification, and prognosis). Prior authorization is not required for the remaining specific multiple-gene expression profiling assays listed in the policy, as these are considered experimental/investigational and are not covered. Repeat testing of any gene in a histologically-distinct tumor, using the same or a different gene expression profiling assay, is not covered and is considered not medically necessary.</td>
</tr>
<tr>
<td><strong>Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)</strong> (<a href="http://healthpartners.com/public/coverage-criteria/stereotactic-radiosurgery/">path</a>)</td>
<td>Policy revised adding criteria specific to SBRT, including coverage for prostate cancer, effective immediately. Prior authorization continues to be required.</td>
</tr>
<tr>
<td><strong>Breast Surgery</strong> (<a href="http://healthpartners.com/public/coverage-criteria/stereotactic-radiosurgery/">path</a>)</td>
<td>Policy revised to add coverage of acellular dermal matrix for reconstruction.</td>
</tr>
<tr>
<td><strong>CardioMEMS implantable monitor for management of congestive heart failure</strong> (<a href="http://healthpartners.com/public/coverage-criteria/cardioMEMS">path</a>)</td>
<td>New policy effective immediately for commercial and Medicaid products. This procedure is considered investigational based on a lack of scientific support of efficacy. Prior authorization is not required, but services will deny to either provider or member liability based on use of the GA modifier. Note: Medicare does reimburse for this service and Medicare claims will be allowed.</td>
</tr>
</tbody>
</table>
| **Investigational Services – List of non-covered services** ([path](http://healthpartners.com/public/coverage-criteria/investigational-services-noncovered-services/)) | This policy has been updated effective 9/9/15, adding the following investigational and non-covered services:  
- Upper airway stimulation/hypoglossal nerve stimulation therapy for obstructive sleep apnea (i.e., Inspire device)  
- Exoskeleton – ReWalk personal system for home use in spinal cord injury  
Please remember that the services included on this policy will deny to either provider or member liability based on use of the GA modifier. |
| **Eye Surgery - refractive** ([path](http://healthpartners.com/public/coverage-criteria/eye-surgery-refractive/)) | Policy revised effective immediately. Coverage is now allowed for photorefractive (PRK) surgery if criteria are met. Prior authorization is required. |
| **Cranial Reshaping Helmets and Helmets for use post cranial surgery** ([path](http://healthpartners.com/public/coverage-criteria/cranial-reshaping-helmet-band/)) | Policy revised to clarify current content and revise timeline from 12 to 18 months for infants to have cranial reshaping helmets. Guidelines were added for coverage post cranial surgeries, which require prior authorization. These changes are currently effective. |
### Pharmacy Policies

#### Specialty Drugs for Chronic Inflammatory Disorders:

- **Tocilizumab** (Actemra)
- **Belimumab** (Benlysta)
- **Certolizumab** (Cimzia)
- **Vedolizumab** (Entyvio)
- **Pegloticase** (Krystexxa)
- **Atabacept** (Orencia)
- **Infliximab** (Remicade)
- **Rituximab** (Rituxan)
- **Golimumab** (Simponi/Simponi ARIA)
- **Ustekinumab** (Stelara)
- **Natalizumab** (Tysabri)

Revised coverage criteria.

Additional requirements for first-line agent use prior to specialty drug approval. Provider attestation will be required for annual reauthorization and use of regimens outside of FDA-approved labeling. See [healthpartners.com](http://healthpartners.com) for updated criteria after November 1, 2015.

Self-administered drugs in this category will also have updated prior authorization criteria.

Claims received without prior authorization may be denied effective 1/1/16.

#### Somatostatin Analogues for Acromegaly:

- **Octreotide Acetate** (Sandostatin LAR)
- **Lanreotide** (Somatuline Depot)
- **Pasireotide** (Signifor LAR)
- **Pegvisomant** (Somavert)

New coverage criteria for use in acromegaly.

Claims received without prior authorization may be denied effective 1/1/16.

#### Compounded Medications

Reminder that compounded medications billed for more than $200 require prior authorization from Pharmacy Administration.

Claims received without prior authorization may be denied effective 3/1/15.

#### Recently FDA-Approved Medications Coverage Policy

Reminder that select new drugs require prior approval.

Prior authorization from Pharmacy Administration is required for newly approved, professionally-administered specialty medications.

Click [HERE*](http://healthpartners.com) for a complete and up-to-date list of drugs impacted by the policy or visit [healthpartners.com](http://healthpartners.com).

*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 1/1/12 as this policy was published in November 2011.

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### Drug Formulary Updates

#### Changes to our Commercial and State Programs Drug Formularies

- **Fluoxetine (Prozac) tablets** have been removed from formulary, effective January 1 2016. Fluoxetine capsules are preferred. This is the same active ingredient, and less costly by $750 per year. Additional communications are being sent to affected providers and members. Members are being asked to change therapy and to contact pharmacists or providers to help with changes. Requests will be approved (allowing patients to continue taking the tablets) if the tablet form is medically necessary.

- **Entresto (valsartan/sacubitril)** for heart failure has been added to the formulary.
Please see the online formulary for details at healthPartners.com/formularies.

**Preferred Drug List (Drug Formulary)**

Drug Formularies are available at healthPartners.com/formulary.

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 at HealthPartners.com/Providers/Pharmacy Services.

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.

**2015 Clinical Indicators Report**

The 2015 HealthPartners Clinical Indicators Report and Technical Supplement will be available online after November 4, 2015. The Clinical Indicators Report features comparative provider performance on clinical measures and consumer satisfaction results. The primary purpose is to provide valid and reliable information for providers to use in their efforts to improve patient care and outcomes. HealthPartners uses this information to support internal quality improvement initiatives, which may include provider incentive and tiering programs. The 2015 Clinical Indicators Technical Supplement includes measurement detail, optimal component rates and trended plan rates over time.

To view the report click HERE or go to healthpartners.com/quality and click on Clinical Indicators Results.

**Medicare Ineligible Code Changes**

Effective 1/1/2016 for Medicare products professional services, HealthPartners will follow Medicare’s reimbursement policy for invalid, bundled, and bundled/excluded codes identified by status indicator codes B, I and P. After January 1, 2016, any charges billed with these codes will be denied to provider liability. If you have any questions, please contact your contract manager or service specialist.

**Provider Data Profiles**

Did you know that regulators are developing new rules related to provider information? The regulators are listening to the consumers who want the most up-to-date information to make informed decisions about their health care insurance choices and the providers they use. You can make sure they get the most current information about your locations and practitioners by updating your information online using our Provider Data Profiles application.

The Provider Data Profiles application gives HealthPartners contracted providers the ability to view, verify and correct clinic or hospital demographic information displaying on the HealthPartners website and paper directories. Additionally, future enhancements to state and federal exchanges may require provider directories are displayed there as well.

Here is just a sampling of what can be done online using the Provider Data Profiles Application tool:

- Update your address or office hours for your location
- Verify if a practitioner is linked to a location
- Update practitioners to identify those that are not accepting new patients
- Terminate practitioners or locations
- Add a clinic description or practitioner personal profile

Additional features coming later this year include the ability to add practitioners to locations and generate a Minnesota Uniform Practitioners Change form when terminating or adding a location to a practitioner record.
To access your clinic’s provider data profiles, log in at HealthPartners.com/provider.

Contact your clinic’s HealthPartners Provider Portal site delegate if you do not see the Provider Data Profiles link in your application list.

Questions? Contact Provider Relations (path: healthpartners.com/provider-public/forms/provider-relations.html)

GOVERNMENT PROGRAMS

2016 Hearing Aid Information

NEW 2016 rates for hearing aid codes

**Following is information pertaining to hearing aid rates and billing practices that are applied to Commercial and Medicare lines of business.**

By now you should have received your 2016 market basket with the new fee schedule. Within the market basket, you may notice new fees for hearing aid codes. These fees will become effective 1/1/2016.

This information can also be viewed on our Provider Portal (path: healthpartners.com/provider-secure/provider-information/fee-schedule/).

HealthPartners created a reimbursement rate for a basic hearing aid(s). If your patient is seeking an upgraded hearing aid, please review the following information.

What is considered a basic hearing aid?

A basic hearing aid is defined as a hearing device that consists of a microphone, amplifier, volume control, battery and receiver, which is up to date using the latest technology.

An example of a basic hearing aid:

- 1 year manufacturer’s warranty
- 3 follow-up visits included in purchase price
- Hearing improvement for:
  - One-on-one conversations
  - Quiet environments with minimal background noise
  - Hearing on the telephone

If a member is requesting a hearing aid that is above and beyond the functionality of a basic hearing aid, this is considered an upgraded hearing aid. Some members may have coverage for upgraded hearing aids, however if the member does not have coverage for an upgraded hearing aid, the cost above the basic hearing aid is the member’s responsibility.

An example of an upgraded hearing aid could include:

- 2+ year manufacturer’s warranty
- 2+ year professional services
- One-time loss and damage protection
- Hearing improvement for:
  - Group settings
  - Environments with moderate background noise
  - Automatic functionality (Bluetooth/remote control)
- Any additional features that are not included with a basic hearing aid
Submitting claims with DME or hearing aid upgrades

When billing for an upgrade on DME or a hearing aid, please follow the Minnesota Administrative Uniformity Committee (MN AUC) guidelines as follows on page 36 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Version 8.0:

<table>
<thead>
<tr>
<th>Medicare Claims Processing Manual</th>
<th>Specific Coding Topic</th>
<th>Minnesota Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter Number</td>
<td>Title/Description</td>
<td>Upgrades</td>
</tr>
<tr>
<td>20</td>
<td>Durable Medical Equipment, Prosthetics, Orthotics and Supplies</td>
<td></td>
</tr>
</tbody>
</table>

When a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.

Per the above guidelines, claims should be submitted as follows when billing for upgrades:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXX</td>
<td>GK</td>
<td>DME or Hearing Aid</td>
</tr>
<tr>
<td>XXXXX</td>
<td>GA</td>
<td>DME or Hearing Aid</td>
</tr>
</tbody>
</table>

To learn about the MN AUC guidelines, please access [health.state.mn.us/auc/index.html](http://health.state.mn.us/auc/index.html).

Upgraded hearing aid claims using GK/GA modifiers

Below is a suggested way to bill for upgraded hearing aid(s). Please note there is a difference in billing practices for Commercial versus Medicare and Medicaid members.

**For Commercial members:**

- **Line 1** – should include the appropriate code for the hearing aid
  - the cost for the basic model
  - the GK modifier

- **Line 2** – should include the appropriate code for the hearing aid
  - the cost difference between the basic model and the upgraded model
  - the GA modifier

**For Medicare/Medicaid members:**

- **Line 1** – should include the appropriate code for the hearing aid
  - the cost for the basic model
  - the GK modifier

- **Line 2** – should include the appropriate code for the hearing aid
  - the total cost for the basic model and the upgraded model
  - the GA modifier
**Please note, if you do not have a signed waiver for the upgraded costs prior to the claims submission, claims cannot be billed with the GK/GA modifier. As a result, the claim will default to provider liability. If you have forgotten the GK/GA modifier, but have a copy of the waiver, please resubmit the claim with a copy of the signed and dated waiver.**

To learn about HealthPartners GA modifier policy, please access the HealthPartners Administrative Policy - GA Modifier (path: https://secure5.compliance360.com/Common/ViewUploadedFile.aspx?PD=ueRP8higqeu2ELATeooaJx877oDD5jRXNONQCgWyYxZswhr%3fUGVSHqbg%29PeYd15dG2N'zN6eH1H1peoW6MqynXLorjIXBaoAp8unze8flhatoq568%fDKfKPTq4NHo27ufyW8DdovVJXorSTAm%2bqt4eKKnq0c3ue6QFWXuxaUNIbTuXBknneFqKsgFj5Bo%2fFj2fP%2bWITPTQ7zC0Yg%2bVe6aqKDuqNcysqJNEXS0qDC%2bX8l8v8vVQo0aM%2bXqurLMbEoO%fPtorO6uaFj6fTGuQkqVjQ3d%3d).}

**HealthPartners PMAP and MinnesotaCare Service Area Expansion Effective 1/1/16**

HealthPartners is pleased to be expanding our PMAP and MinnesotaCare service area in 2016. Effective January 1, 2016, we will be a health plan option in 33 counties in the metro, central, northeast and northwest regions of the state (see counties listed below). We will continue to be offered in our current service area, with the exception of Hennepin County.

This expansion is the result of the recent statewide procurement for PMAP and MinnesotaCare, which has changed health plan options throughout the state. We have compiled a FAQ to help address questions related to these changes; the FAQ is also posted on the Provider Portal: FAQ*. Please contact your HealthPartners contract manager with any additional questions. We look forward to continuing to work with you in 2016 to care for PMAP and MinnesotaCare patients. *(path: https://secure5.compliance360.com/Common/ViewUploadedFile.aspx?PD=ueRP8higqeu2ELATeooaJx877oDD5jRXNONQCgWyYxZswhr%3fUGVSHqbg%29PeYd15dG2N'zN6eH1H1peoW6MqynXLorjIXBaoAp8unze8flhatoq568%fDKfKPTq4NHo27ufyW8DdovVJXorSTAm%2bqt4eKKnq0c3ue6QFWXuxaUNIbTuXBknneFqKsgFj5Bo%2fFj2fP%2bWITPTQ7zC0Yg%2bVe6aqKDuqNcysqJNEXS0qDC%2bX8l8v8vVQo0aM%2bXqurLMbEoO%fPtorO6uaFj6fTGuQkqVjQ3d%3d).

**Q. Is HealthPartners one of the 2016 health plan options for Medical Assistance (PMAP) and MinnesotaCare enrollees?**

A: For 2016 HealthPartners health plan is an option for enrollees residing in the metro area (except Hennepin County), in the central counties, and in the northeast and northwest counties in the state. See complete list of counties below. Current HealthPartners enrollees residing in Hennepin County will need to choose a new health plan.

**Q: Why are these changes happening?**

A: The State of Minnesota Department of Human Services (DHS) has changed the health plan options for Medical Assistance and MinnesotaCare enrollees starting in January 2016. **Q: When will enrollees receive notice from the State about their 2016 health plan options?**

A: Enrollees will receive an annual health plan selection notice from DHS beginning mid-September about the Annual Health Plan Selection period. The DHS notice identifies which health plan options will be available in 2016 and provides instructions on how to select a 2016 health plan. Enrollees can also call their current health plan to ask questions.

**Q: What happens if enrollees don’t select a health plan?**

A: If the enrollee’s current health plan is offered in their county in 2016, they do not need to do anything to stay enrolled in their current plan. If their current health plan is NOT offered in their county in 2016 and they take no action, they’ll automatically be enrolled in the default health plan for Medical Assistance or MinnesotaCare. Enrollees may call to check and see if their current clinic and physician are in their new health plan’s network of providers.

**Q: When is the latest that enrollees can be seen and covered under their current health plan?**

A: Enrollees’ current coverage will remain effective through December 31, 2015. These changes go into effect beginning January 1, 2016.

**Q: Who should enrollees call if they have questions?**

A: DHS will provide enrollees with information about their options for 2016. Here is additional contact information for health plans and DHS:

- HealthPartners member services at 952-967-7998 or 1-866-885-8880
- Blue Plus member services at 612-662-5545 or 1-800-711-9862
- Hennepin Health member services at 1-800-647-0550
- Medica member services at 952-992-2322 or 1-800-373-8335
• DHS Member Help Desk at 651-431-2670 or 1-800-657-3739
• Enrollees can also contact their county with questions.

Q: Is there a website with additional information?

A: On Friday, September 18, DHS released a new web page on their website with information and resources about the PMAP and MinnesotaCare Annual Health Plan Selection process. It contains FAQs, the health plan primary care network listing and additional contact information. Visit the DHS website (path: dhs.state.mn.us/) for more information.

Counties in HealthPartners 2016 PMAP and MinnesotaCare service area:
Aitkin, Anoka, Becker, Benton, Carlton, Carver, Cass, Chisago, Clay, Cook, Crow Wing, Dakota, Kittson, Koochiching, Lake, Mahnomen, Marshall, Mille Lacs, Norman, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Roseau, St. Louis, Scott, Sherburne, Stearns, Washington, Wilkin, Wright

HealthPartners Minnesota Senior Health Options
2016 Supplemental Benefits

The MSHO plan provides comprehensive coverage for seniors covered by Medicare and Medical Assistance. HealthPartners also offers supplemental benefits to MSHO members. These benefits may change each year.

2016 Supplemental Benefits

Dental

• Second annual visit for exam
• Adult fluoride
• Scaling and root planning
• Periodontal maintenance
• Root canals on molars
• Denture services – tissue conditioning
• Porcelain crowns, up to $2,000

Health and Wellness

• Silver&Fit Exercise and Healthy Aging Program
  (health club membership or home fitness kits)
• Health education classes
• Transportation to/from supplemental benefit covered services

Beginning January 1, 2016, the following will no longer be available as MSHO supplemental benefits

• Additional dental prophylaxis
• Tints and coatings on eyeglasses
• Home delivery meals
• Personal Emergency Response Systems (PERS)*
• Safety & falls prevention kit
• Foot care visits
• In-home bathroom safety devices and installation*
• Light therapy lamp
• Additional hearing aid coverage
• Wig for hair loss related to chemotherapy
• Pocket hearing amplifiers
• First aid kit
• Food scale

*Benefit for non-Elderly Waiver community members only
EVENTS

Personal Care Assistance (PCA) Revalidation Paperwork Workshop

The Department of Human Services (DHS) is offering a Personal Care Assistance (PCA) Revalidation Paperwork workshop at no cost for PCA provider agencies. PCA providers must complete the revalidation forms in order to receive payment from DHS as well as HealthPartners as an eligible MHCP provider.

Registration and revalidation forms are now available on the DHS website (path: dhs.state.mn.us).

Webinar: Shared Decision-Making & Depression Treatment in Primary Care

Date: Thursday, November 12, 2015
Time: 12:00 – 1:00 pm

Topic: Understanding how to incorporate shared decision-making into primary care when working with patients who experience depression.

Presented by:

- Vicki Olson, Program Manager, Stratis Health
- Dr. Art Wineman, MD, HealthPartners
- Tasha Gastony, PA-C, Park Nicollet

Click HERE (path: stratishealth.org/pip/antidepressant.html) for the full flyer and registration information.

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.

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