Keeping Your Location and Provider Data Updated is Easy

HealthPartners is making it even easier to update provider information. We’ve just added a great feature that will be available in mid-January and save you time when you are adding or terminating practitioners from locations. HealthPartners Provider Data Profiles application now allows you the flexibility to add, remove or change practitioner and location information online AND also save your updates to a pre-populated Minnesota Uniform Practitioner Change form. This form can be used to email or fax to submit your updates to other payers based on your needs.

Consumers of health care want the most up-to-date information to make informed decisions about their health care choices and the availability of providers in the plan’s network. Also, as a HealthPartners provider, it is your contractual obligation to keep your clinic information updated. You can make sure the information about your locations and practitioners is current by updating your information online using our Provider Data Profiles application.

Please take the time to verify the information HealthPartners has for your practitioners and sites so the information that appears in directories is up to date.

Information that is important to our members and should be reviewed closely includes:

- Verifying the accuracy of the locations of providers and whether there are providers who should be added to or removed from sites
- Verifying the accuracy of the clinics or sites listed and whether there are any that should be added or removed
- Practitioner status for accepting new patients
- Practitioner and clinic profiles
- Location addresses and office hours
- Clinic services

Information that is important to our members and should be reviewed closely includes:
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. Find your site delegate (path: healthpartners.com/provider-public/registration/delegate/search.html)

If you have further questions, please contact Provider Relations (path: healthpartners.com/provider-public/forms/provider-relations.html).

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 X12/005010X222A1 Health Care Claim: Professional (837) Version 8.0:

<table>
<thead>
<tr>
<th>v8.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)</th>
<th>Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Claims Processing Manual</strong></td>
<td><strong>Specific Coding Topic</strong></td>
</tr>
<tr>
<td><strong>Chapter Number</strong></td>
<td><strong>Title/Description</strong></td>
</tr>
<tr>
<td>20</td>
<td>Durable Medical Equipment, Prosthetics, Orthotics and Supplies</td>
</tr>
</tbody>
</table>

Upgrades – If 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
**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=ueERP9bjqoueeELATwes0uXjJ7n0DDz862224e27XOQGzWyi/s2zJodn%aqfUGVSHpbg%2b5qYeV6gfdZ2NeN6cHIA190rV6mBxXe2UYb6mz�/c22e96lKee4q6TqX62n594CQGg%2bV6vq2KDefqNc9pNEXSxcqDC%2bX8bV2/5Q0EuMc2bSsptX%2bXGurbLMbEs0%aqfJiOvo6uhF6fTGwrqV9wQ/83d9h).
# Medical and Durable Medical Equipment (DME) Coverage Policy Updates 01/01/2016

<table>
<thead>
<tr>
<th>Medical Coverage Policies</th>
<th>Comments/Changes</th>
<th>When will link work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Mineral Densitometry</td>
<td>Policy revised effective immediately to update with additional indications for coverage for nonscreening purposes.</td>
<td>Completed</td>
</tr>
<tr>
<td>Cardiovascular Risk Assessments</td>
<td>Policy revised effective immediately. Added more specific noncovered indications, definitions, clarification of noncoverage of expanded cardiovascular risk panels and a list of codes related to the policy.</td>
<td>Completed</td>
</tr>
<tr>
<td>Compression Support Garments – HealthPartners Care</td>
<td>Policy revised effective immediately to comply with maximum limits allowed per the Minnesota Health Care Providers (MHCP) manual – Medical Supply Coverage Guide.</td>
<td>Completed</td>
</tr>
</tbody>
</table>
| Investigational Services – List of noncovered services | This policy has been updated effective 1/1/16, adding the following investigational and noncovered services:  
- Topical hyperbaric oxygen therapy for treatment of chronic wounds (Note: This previously had a unique noncoverage policy, which has been retired.)  
- Nonthermal pulsed electromagnetic therapy (PEMF) for wound therapy.  
- Nonthermal pulsed electromagnetic therapy (PEMF) for use in rehab and pain control; example OrthCor Active Knee System.  
- Carotid sinus baroreflex activation device services and treatment to treat hypertension.  
- Actigraphy testing (Note: This previously had a unique noncoverage policy, which has been retired.)  
Please remember that the services included on this policy will deny to either provider or member liability based on use of the GA modifier. | 1/1/16  
Completed web changes  
Will display on 1/1/16 |
| Orthognathic Surgery | Policy revised, effective immediately:  
- Adding coverage for documented speech impairment secondary to a malocclusion, severe cleft deformity or jaw deformity as determined by a multidisciplinary team (e.g., speech pathologist or therapist along with a cleft palate or craniofacial specialist) to determine if improvement can be expected from surgery.  
- Two criteria must be met to be eligible for coverage.  
- Providing clarification between corrective and medically necessary orthognathic surgery.  
- Clarifying that obstructive sleep apnea (OSA) as an indication must be documented by a sleep medicine physician.  
- Prior authorization continues to be required for Orthognathic surgery. | Completed                               |
| Percutaneous Tibial Nerve Stimulation (PTNS) for overactive bladder | Policy revised effective immediately to reduce required conservative treatment to 3 months. | Completed                               |
| Proton Beam Radiation Therapy – commercial | Policy revised, effective 3/1/16 to remove salivary gland tumors from the indications covered and added to the indications not covered.  
Clarification of noncoverage position of prostate cancer, including localized and metastatic cancer coverage positions. | 3/1/16  
Changes will display by 3/1/16 |
| Speech Therapy – habilitative | Policy has been revised, effective 1/1/16 to remove the noncoverage indication for speech therapy related to noncovered devices. | 1/1/16  
Completed web changes  
Will display on 1/1/16 |
<table>
<thead>
<tr>
<th>Medical Coverage Policy</th>
<th>Comments/Changes</th>
<th>When will link work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth – commercial</td>
<td>Policy has been revised, effective 1/1/16, to include behavioral health services, online video consults and applicable CPT/HCPCS codes.</td>
<td>1/1/16 Completed web changes Will display on 1/1/16</td>
</tr>
<tr>
<td>Vision Therapy – Commercial</td>
<td>Policy has been revised, effective 3/1/2016. Will require Prior Authorization after 12 visits. CPT codes added 97110, 97112, and 97530 in addition to the 92605. CPT codes will be counted in combination with the covered diagnosis of convergence insufficiency. See policy for specifics as diagnoses covered for Commercial plans differ from those covered for HealthPartners Care. (see below)</td>
<td>3/1/16 Changes will display by 3/1/16 Not ready for publishing</td>
</tr>
<tr>
<td>Vision Therapy – HealthPartners Care</td>
<td>New Policy, effective 3/1/2016. Will require Prior Authorization after 12 visits. CPT codes added 97110, 97112, and 97530 in addition to the 92605. CPT codes will be counted in combination with the covered diagnoses. Covered diagnoses: amblyopia (up to age 10), sensory or motor strabismus, and accommodative disorders including convergence insufficiency, causing subjective visual complaints which are not relieved by wearing prescription eyewear.</td>
<td>3/1/16 Changes will display by 3/1/16 Not ready for publishing</td>
</tr>
<tr>
<td>Weight Loss Surgery – Commercial</td>
<td>Effective immediately, there has been an additional item added to the noncovered section to clarify as follows: Conditions for which weight loss surgery (and/or any procedures generally used for weight loss surgery) is not covered.</td>
<td>Completed</td>
</tr>
<tr>
<td>Weight Loss Surgery – Iowa</td>
<td>Effective immediately, there has been an additional item added to the noncovered section to clarify as follows: Conditions for which weight loss surgery (and/or any procedures generally used for weight loss surgery) is not covered.</td>
<td>Completed</td>
</tr>
<tr>
<td>Eyewear for children – DME</td>
<td>Policy has been revised, effective 1/1/2016 to include the option of coverage of one pair of contact lenses and up to two contact lens fittings.</td>
<td>1/1/16 Changes will display by 1/1/16</td>
</tr>
</tbody>
</table>

Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at [healthpartners.com](http://healthpartners.com) (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.
**Pharmacy Updates, January 2016**

**DRUG FORMULARY**

<table>
<thead>
<tr>
<th>Changes to our Commercial and State Programs Drug Formularies include:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sildenafil has been added to the formulary for erectile dysfunction</strong></td>
</tr>
<tr>
<td><strong>Generic sildenafil 20mg will be preferred over Viagra, Cialis, and Levitra.</strong></td>
</tr>
<tr>
<td><strong>Viagra, Cialis, and Levitra will be reserved for patients who have tried and failed generic sildenafil tablets. These Brand erectile dysfunction medications average $250 per Rx, versus generic sildenafil 20mg at $20-40. Most members have lower costs for generics ($10-15 versus $50-90 for Brands).</strong></td>
</tr>
<tr>
<td><strong>Price increases for older medications</strong></td>
</tr>
<tr>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol medications</strong></td>
</tr>
<tr>
<td><strong>Annual Prior Authorization Review</strong></td>
</tr>
<tr>
<td><strong>Chronic Inflammatory Disease, including Enbrel and Humira</strong></td>
</tr>
<tr>
<td><strong>Hepatitis C medications</strong></td>
</tr>
</tbody>
</table>

Please see the online formulary for details, at [HealthPartners.com/Formularies](http://HealthPartners.com/Formularies).

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**Fast Facts** January 2016
Changes this year include:

- Doxycycline hyclate has been removed from the formulary. Doxycycline monohydrate remains as the preferred doxycycline product.
- Venlafaxine ER tablets have been removed from the formulary. Venlafaxine ER capsules remain as the preferred venlafaxine product.
- Namenda XR has been removed from the formulary. The immediate-release form is available generically and is preferred.
- Nasonex and Veramyst have been removed from the formulary. Fluticasone, flunisolide and QNasal are preferred.
- Niacin ER tablets have been removed from the formulary.
- Several “tier” changes have been made based on current costs. Levothyroxine and warfarin are increasing from Tier 1 to Tier 2, and levofloxacin is decreasing from Tier 2 to Tier 1.
- Lidocaine patch is changing from Step Therapy (from gabapentin) to Prior Authorization with similar coverage criteria.
- Methotrexate tablet will have a new Prior Authorization required by Medicare to determine Part D coverage or Part B coverage.

PREFERRED DRUG LIST (DRUG FORMULARY)

Drug Formularies are available at [healthpartners.com/formulary](http://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 [Pharmacy Services](http://healthpartners.com/providers/pharmacy-services), including the [Drug Formularies](http://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.
## Fast Facts January 2016

### Pharmacy Policies

<table>
<thead>
<tr>
<th>Pharmacy Policies</th>
<th>Comments/Changes</th>
</tr>
</thead>
</table>
| **Collagenase** *(Xiaflex)* | Updated policy. Requires prior authorization from Pharmacy Administration. [healthpartners.com/public/coverage-criteria/collagenase/](http://healthpartners.com/public/coverage-criteria/collagenase/)  
Updated policy now includes coverage criteria for Peyronie's disease, and updates criteria for coverage of treatment of Dupuytren's contracture.  
Approvals will be given for six months of therapy and a maximum of 3 injections per cord for Dupuytren's contracture. Approvals will be limited to up to four treatment cycles for each plaque causing the curvature deformity for Peyronie's disease.  
Peyronie's disease may be considered treatment for sexual dysfunction and excluded from coverage per member contract language.  
Updated criteria will be effective 4/1/2016. |
| **Specialty Drugs for Chronic Inflammatory Disorders:**  
**Tocilizumab** *(Actemra)*  
**Belimumab** *(Benlysta)*  
**Certolizumab** *(Cimzia)*  
**Vedolizumab** *(Entyvio)*  
**Pegloticase** *(Krystexxa)*  
**Atabacept** *(Orencia)*  
**Infliximab** *(Remicade)*  
**Rituximab** *(Rituxan)*  
**Golimumab** *(Simponi ARIA)*  
**Ustekinumab** *(Stelara)*  
**Natalizumab** *(Tysabri)* | Revised coverage criteria announced previously and effective 1/1/2016.  
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 and attestation forms.  
Self-administered drugs in this category also have updated prior authorization criteria.  
Claims received without prior authorization may be denied effective 1/1/2016. |
Prior authorization from Pharmacy Administration is required for newly approved, professionally-administered specialty medications.  
A complete and up-to-date list of drugs impacted by the policy is available on [healthpartners.com](http://healthpartners.com) at the following link.  
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. |
Oral Oncology Waste Management Program Expansion

HealthPartners is expanding its waste management program for select oral oncology agents as of March 1, 2016. High cost and high discontinuation rates are often observed with these agents, and this program helps reduce resulting drug waste.

Two changes will be made to the program:

- Additional drugs will be included. Please see the table below.
- The first three months of therapy will require split fills. The current program only applies to the first month of therapy.

The pharmacy filling the prescription will administer the program. All HealthPartners members filling a script for an eligible drug will be offered the program. Copays will be adjusted accordingly. No prescribing changes are required for this program. Physicians should continue to write prescriptions for up to a one-month supply at each dispense.

<table>
<thead>
<tr>
<th>Medication</th>
<th>HealthPartners (Current)</th>
<th>HealthPartners (3/1/2016)</th>
<th>Days Supply Per Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afinitor</td>
<td>X</td>
<td>X</td>
<td>14</td>
</tr>
<tr>
<td>Bosulif</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Erivedge</td>
<td></td>
<td>X</td>
<td>14</td>
</tr>
<tr>
<td>Gleevec</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Inlyta</td>
<td></td>
<td>X</td>
<td>15</td>
</tr>
<tr>
<td>Jakafi</td>
<td></td>
<td>X</td>
<td>15</td>
</tr>
<tr>
<td>Nexavar</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Sprycel</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Sutent</td>
<td>X</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Tarceva</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Targetin</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Tasigna</td>
<td>X</td>
<td></td>
<td>14</td>
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<tr>
<td>Votrient</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Xalkori</td>
<td></td>
<td>X</td>
<td>15</td>
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<tr>
<td>Xtandi</td>
<td></td>
<td>X</td>
<td>15</td>
</tr>
<tr>
<td>Zolinza</td>
<td>X</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Zykadia</td>
<td></td>
<td>X</td>
<td>14</td>
</tr>
<tr>
<td>Zytiga</td>
<td></td>
<td>X</td>
<td>15</td>
</tr>
</tbody>
</table>
Primary Care Connection Pilot

HealthPartners, in partnership with one employer, is implementing a pilot program in 2016 that will identify primary care practitioners that are accepting new patients to members who don’t have evidence of a primary care relationship.

The pilot program will identify members who don’t have claims from a primary care practitioner. The program will then identify local primary care practitioners that are accepting new patients and identify other attributes of the recommended practitioner that could likely be of interest to the member in context of a practitioner relationship such as; age, gender, and identified interests. The program will target three primary care practitioner options representing different clinics close to the member’s home. The program will use information about primary care practitioners available on healthpartners.com and information on primary care clinic websites.

This pilot hopes to achieve Triple Aim impacts on experience, health, and cost. Literature suggests that that when people can select a physician that matches their individual wants and needs, stronger relationships are created and that creating the personal connection with a physician is more important than a convenient clinic. Furthermore these relationships are connected with health and affordability. Source: Starfield, Barbara, Leiyu Shi, and James Macinko. "Contribution of primary care to health systems and health." Milbank quarterly 83.3 (2005): 457-502. In addition, if people develop meaningful, relevant, and long lasting primary care relationships these people will have a high likelihood of achieving improved and lengthened quality of life. Source: Priorities Among Effective Clinical Preventive Services. Maciosek, Michael V. et al. American Journal of Preventive Medicine, Volume 31, Issue 1, 90 – 96.

This pilot with begin in January 2016 and last for 12-18 months.

Patient Perspective

TXT4Life

TXT4Life is a suicide prevention resource available to Minnesota residents. It is ideally suited to teens and young people who research demonstrates are more likely to text during a crisis than call a crisis line. Legislation in 2015 provided funds to expand the program from parts of the state to all of Minnesota. It is free and confidential. Individuals are connected to trained counselors by texting “Life” to 61222. The expansion also allows TXT4Life to be available 24 hours a day, 7 days a week, 365 days a year. It is estimated that the program could respond to more than 10,000 text messages this year. More information is available on the website: TXT4Life.org.
For our Behavioral Health Providers

We know you are working to provide best outcomes and best experience for your patients. We also know insurance coverage can be confusing for members and patients. While the rate of complaints is very low, a topic that is frequently mentioned is that members don’t understand how much they will owe the therapist.

Many employers change their insurance coverage at the beginning of the year. This means it is even more crucial that confirming coverage at each appointment is completed. Please consider some of the following suggestions of how you might be able to help your patients/our members:

- Verify that the specific provider at the specific location is in network for each patient. This can be done by calling Member Services.
- Review with the patient their insurance coverage as you understand it to be.
- Encourage the patient to contact HealthPartners Members Services department to review their insurance coverage in depth.

Please be aware that some employers may have different coverage criteria (e.g., deductibles, out-of-network benefits, etc.) and networks for their employees. For example, Company XYZ may have four (4) different deductible amounts for their employees.

You Can Make a Difference in HPV Vaccination Rates

HPV causes 28,000 vaccine-preventable cancers in the U.S. each year, including about 10,000 cervical cancers. In spite of this, HPV vaccination rates lag compared to other recommended adolescent vaccines (Tdap and Meningococcal). January is Cervical Health Awareness Month and a great time to promote the benefits of HPV vaccination. Here are some tips and resources:

- Offer and give all three recommended vaccines at age 11-12 years.
- A strong provider recommendation is vital to HPV vaccine uptake. We created an HPV Vaccine Video for Health Care Providers at [http://www.health.state.mn.us/divs/idepc/immunize/hcp/adol/hpvvideos.html](http://www.health.state.mn.us/divs/idepc/immunize/hcp/adol/hpvvideos.html) that shows you how to talk about HPV vaccine. Additional provider resources are available at [http://www.health.state.mn.us/divs/idepc/immunize/hcp/adol/index.html](http://www.health.state.mn.us/divs/idepc/immunize/hcp/adol/index.html).
- Watch CDC’s #PreteenVaxScene webinar series in January on increasing uptake of routinely recommended vaccines for preteens and teens. Get more information under the Provider Education section of their Preteen and Teen Vaccines Information for Health Care Professionals website at [http://www.cdc.gov/vaccines/who/teens/for-hcp.html](http://www.cdc.gov/vaccines/who/teens/for-hcp.html).

Pediatric Vision Benefit Update

As you may know, the mandated pediatric vision benefit went into effect on 1/1/2014 and provides coverage for eyewear to members that meet both of the following eligibility requirements:

- Under the age of 19 AND
- Enrolled under Small Employer Group or Individual plans (Contact Member Services to confirm eligibility.)

**EFFECTIVE 1/1/2016**, HealthPartners is adding coverage for contact lenses under this benefit.

For more information, please review the following resources:


If you have additional questions, please contact your Service Specialist.

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**Fast Facts** January 2016
January 1, 2016 Medicare will pay doctors to discuss end-of-life care planning with patients

Having conversations with our patients about goals of care and identifying who they would choose as a spokesperson when they couldn’t speak for themselves is an important part of high quality care for patients and their families. HealthPartners supports the emphasis on this work. Although it is critical for our older patients with chronic illness, it is also important for all adults. Less than 25% of U.S. adults age 18 and older have an advance directive.

In October of 2015 the Centers for Medicare and Medicaid Services (CMS) posted the codes for physicians to document advance care planning conversations, one code for the first 30 minutes and a second add-on code for additional 30-minute conversations. Now in the calendar year 2016 final rule, reimbursement is provided. CMS allows physicians to include advance care planning as part of a patient’s yearly check-up in addition to the ruling already in place for reimbursement for these discussions during a patient’s Welcome to Medicare visit.

This is such an important part of an individual’s care plan that HealthPartners does extensive chart review to look for evidence of your work with patients around this topic.

The Minnesota Department of Health (MDH) requires the health plan to annually audit medical records of State and Public Program members for compliance on documentation of Advance Care Planning. Here are the kinds of details we are looking for when we audit charts.

ADVANCE CARE PLANNING - DOCUMENTATION FOR MEMBERS 19 YEARS AND OLDER

- Evidence of advance care planning (e.g., advance directives, written instructions regarding life-sustaining treatment, living wills, surrogate decision maker); or
- Documentation of a conversation with provider concerning advance care planning (discussion with member, family or friends about life-sustaining treatment); or
- Notation that the member previously executed an advance care plan (does not need to be included with the record).

We are sharing this information and asking that you discuss this with your staff to encourage them to improve their advance care planning documentation.

Events

Mark Your Calendar for STI Testing Day, April 12, 2016

To promote testing and heighten awareness for STD/STI Awareness Month (April), the second annual STI Testing Day will be observed in Minnesota on April 12, 2016. The observance is led by the Community Restoring Urban Youth Sexual Health (CRUSH) in partnership with the Minnesota Chlamydia Partnership (MCP).

Chlamydia remains Minnesota’s number one reported infectious disease with a record high of 19,897 cases reported in 2014. Teens and young adults between the ages of 15 and 24 have the highest rates of chlamydia, particularly from those communities experiencing social, economic and health-related inequalities. Increasing awareness and adding testing opportunities are needed for this observance and these communities.

Teen friendly clinics that can offer no-cost or low-cost STD/STI testing/treatment on that day may wish to participate. All interested clinics/agencies should have the capacity to sign up youth for the MNFP waiver or other reimbursement methods (sliding scale, billing insurance, etc.). There will be a website and link set up where clinics can sign up online during January 2016: crushsti.com. All clinics that sign up will be asked to join an online webinar on February 24 for orientation purposes and materials.
Government Programs

MinnesotaCare Cost Sharing Changes, Effective 1/1/16

As a result of legislation that passed in 2015, MinnesotaCare cost sharing amounts will change effective January 1, 2016. The increases will apply to all MinnesotaCare enrollees except for children, American Indians, and preventive or mental health services. Below is a comparison of the 2015 and 2016 cost sharing amounts.

<table>
<thead>
<tr>
<th>Service or Item</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory surgery</td>
<td>None</td>
<td>$50</td>
</tr>
<tr>
<td>Emergency Department visit (not resulting in admission)</td>
<td>$3.50 (non-emergent)</td>
<td>$50</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Inpatient hospital admission</td>
<td>None</td>
<td>$150</td>
</tr>
<tr>
<td>Nonpreventive office visit (excl. chemical dependency and mental health)</td>
<td>$3</td>
<td>$15</td>
</tr>
<tr>
<td>Outpatient hospital visit</td>
<td>None</td>
<td>$25</td>
</tr>
</tbody>
</table>
| Prescription drugs                                  | $3      | Generic: $6
                                                      |         | Brand: $20
                                                      |         | Combined Out of Pocket Max: $60/mo
| Radiology services                                  | None    | $25     |

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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