Fast Facts

HealthPartners

MARCH 2018

News for Providers from HealthPartners Professional Services and Hospital Network Management

Administrative

IMPORTANT – Accurate information in provider directories is essential for members

It is important that your patients and our members have access to accurate information when seeking care in their network. To ensure our members have the best experience possible, we need your help to ensure your provider information and clinic locations are up-to-date. Regulators, including Medicare and Medicaid, are scrutinizing provider directories for accuracy.

Someone from your clinic or system should be designated to review all your provider information available online on **healthpartners.com** in our search tool *Find Care*. This same online information is used to populate printed directories. Information that should be reviewed includes:

- Office location(s) **where members can be seen for appointments**
- Provider Name with credentials (MD, DO, etc.)
- Specialty(ies)
- Location(s) Name(s)
- Address(es)
- Phone number(s)
- Clinic hours
- Practitioner status for accepting new patients
- Clinic services available

Directory information can be reviewed and edited through provider data profiles, an online tool. Log in at **healthpartners.com/provider log on** *(path: healthpartners.com/provider-public/)*.

If you don't have access to the provider data profiles application, contact your delegate – after you've logged in, your delegate's information appears in the help center section.

If you have further questions regarding updating directory information, please call your HealthPartners Service Specialist.

INSIDE THIS ISSUE

Coming Soon – Provider Survey

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

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

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

Coming soon – Clear Claim Connection (C3)

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

WHAT IS C3?

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

WHAT'S NEXT?

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

Medical Policy Updates – 03/01/2018

MEDICAL AND DURABLE MEDICAL EQUIPMENT (DME) & MEDICAL DENTAL COVERAGE POLICY

Please read this list of new or revised HealthPartners coverage policies. HealthPartners coverage policies and related lists are available online at **healthpartners.com** *(path: healthpartners/Provider/Coverage Criteria).* Upon request, a paper version of revised and new policies can be mailed to clinic groups whose staff does not have Internet access. Providers may speak with a HealthPartners Medical Director if they have a question about a utilization management decision.

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

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

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

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

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

Pharmacy Policy Updates – March 2018

HEALTHPARTNERS DRUG FORMULARY

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

STATE PROGRAMS-ONLY

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

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

COMMERCIAL AND STATE PROGRAMS

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

MEDICARE

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

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

Please see the formulary for details and a complete list at **healthPartners.com/formularies**.

For additional information, please contact **Peter.S.Marshall@HealthPartners.com**.

Quarterly formulary updates and additional information such as Prior Authorization and Exception Forms, Specialty Pharmacy information, and Pharmacy and Therapeutics (P&T) Committee policies are available at **healthpartners.com/provider/admin tools/pharmacy policies**, including the **Drug Formularies** *(healthpartners.com/formulary).*

Pharmacy Customer Service is available to providers (physicians and pharmacies) 24 hours per day and 365 days per year.

- Fax - **952-853-8700** or **1-888-883-5434** Telephone - **952-883-5813** or **1-800-492-7259**
- HealthPartners Pharmacy Services, 8170 33rd Avenue South, PO Box 1309, Mpls, MN 55440

HealthPartners Customer Service is available from 8 AM - 6 PM Central Time, Monday through Friday, and 8 AM – 4 PM Saturday. After hours calls are answered by our Pharmacy Benefit Manager.

PHARMACY MEDICAL POLICIES

Coverage Policies	Comments / Changes
Recently FDA-Approved Medications Coverage Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=AENTRY_046122)*	Revised coverage policy. Authorizations will be effective for six months. Prior authorization from Pharmacy Administration is required for newly approved, professionally-administered specialty medications. Click **HERE*** for a complete and up-to-date list of drugs impacted by the policy or visit healthpartners.com. **(path:healthpartners.com/ucm/groups/public/@hp/@public/@cc/documents/documents/dev_058782.pdf)* As drugs are approved for use, Pharmacy Administration will identify impacted drugs. Effective dates of the prior authorization requirement for each drug will be clearly stated. This list of impacted drugs is subject to updates without further notice. Claims received without prior authorization may be denied effective 1/1/2012 as this policy was published in November 2011.

Patient Perspective

Matrix Outreach continues in 2018

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

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

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

Events

4th annual STI testing day

April is National STD/STI Awareness month and Minnesota is holding our 4th annual "STI Testing Day" on April 25, 2018. This observance promotes testing, heightens the awareness about the epidemic levels of Chlamydia and Gonorrhea in Minnesota and supports teens and young adults seeking testing and treatment.

HOW TO PARTICIPATE

Last year 52 clinics around Minnesota participated and tested 806 teens and young adults for Chlamydia and other STIs. Clinics/organizations can support the observance by:

- Signing up and offering no-cost or low-cost walk-in STD/STI testing/treatment;
- Helping to promote the observance; and/or,
- Monetarily sponsoring activities for supplies, printing, publicity, testing, treatment and/or incentives.

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.).

Clinics/agencies that sign up will receive:

- Clinic protocol tool kit;
- Online promotional tool kit; and
- Promotional materials.

HOW TO SIGN UP

Clinics and organizations can sign up to participate by emailing CRUSH at: **crushstimn@gmail.com**. Registration will open at the end of February 2018.

All those who sign up will be invited to link to an informational webinar on March 15th from 11:00 a.m. – 12:00 p.m., and will be able to download supportive resources for the testing day.

FOR MORE INFORMATION

Visit us at **Crush STI** *(path: facebook.com/crushsti)*.

Government Programs

What are our Minnesota health care programs' members saying about their clinics?

HealthPartners gets feedback from our members in a variety of ways including complaints to Member Services and CAHPS surveys conducted by the state. Overall, our members report very positive things about their primary care clinics. For example, they are able to get appointments for routine care when they need them, and they are very loyal to their health care providers.

Overall, our members feel that their healthcare providers treat them with respect; however in 2017 we did notice a spike in complaints about communication by clinic staff. It was the most common complaint received in 2017. Members felt dissatisfied with how clinic staff treated them, felt they were not listened to or that they were treated differently because of the type of insurance they had.

In general, clinic experiences are not as positive for women as they are for men, especially in Greater Minnesota. In fact, for our Special Needs Basic Care (SNBC) membership, our CAHPS survey showed a 26 percentage point disparity between males and females when asked about their doctor showing respect for what the patient had to say.

To address these concerns, HealthPartners strongly encourages the routine use of shared decision-making techniques in clinical practice. Visit the **Minnesota Shared Decision-Making Collaborative** website for more information *(path: msdmc.org/).*

HealthPartners will be accepting Medicare crossover claims electronically in 2018

HealthPartners previously shared in the November Edition that we will be implementing a Coordination of Benefits (COB) Agreement with CMS' national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). The electronic COB crossover project will likely start sometime in 2nd quarter 2018 and will include Medicare Cost, Medicaid and Commercial products. The project will not include HealthPartners Medicare Supplement or Senior Health Advantage products at this time.

HOW WILL I KNOW IF MY CLAIM WAS CROSSED OVER?

You will know that your claim was crossed over to HealthPartners automatically if our name appears on Medicare's Electronic Remittance Advice (ERA). There is also a list of COBA trading partners on **CMS.gov/Medicare**.

Please contact your HealthPartners Service Specialist for questions.

Important Reminder: PCA individual and affiliation

Important reminder: Minnesota Department of Human Services (DHS) requires that Personal Care Assistants (PCAs) must be affiliated with agencies that employ them in order to be paid for authorized services provided to HealthPartners members.

If your agency employs PCAs, each individual PCA must be affiliated with your agency before you bill HealthPartners. Weekly data files from MN DHS are used to update HealthPartners claims adjudication systems with individual PCA affiliations. If the affiliation of the PCA individual and the agency cannot be verified through the weekly data file sent to HealthPartners from MN DHS, we will be unable to process the claim for payment.

Agencies should allow up to 10 days after receiving the individual PCA initial enumeration and/or affiliation notice from MN DHS before billing HealthPartners. Claims submitted before individual PCA affiliations are completed will result in a claim denial. If an agency submits claims before the adjudication system has been updated with the individual PCA affiliation, agencies will need to submit the denied claim as a replacement claim for reprocessing after the affiliation has been received by HealthPartners. If your claim is still denied after waiting 10 days from receiving notice from MN DHS, agencies should submit a **Claim Appeal Form- Fax** *(path: healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/entry_140044.pdf)* or complete the **Claims Appeal Request-online** *(path: healthpartners.com/provider-public/claim-forms/appeal.html)* in the **Provider Portal** *(path: healthpartners.com/provider-public/provider-resource-materials/)*. The appeal should include supporting documentation of the service along with a copy of the DHS enumeration letter and/or copy of DHS PCA agency affiliation letter. Use the **Medical Claim Attachment-Fax form** *(path: healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/entry_140045.pdf)* or complete the **Claims Attachment Submissions-online** *(path: healthpartners.com/provider-public/claim-forms/attachment.html).* As a reminder the attachment control ID must match the ID number in the PWK segment of the electronic claim submission.

HealthPartners will take into consideration DHS retroactive effective dates of the PCA individual approval stated in the initial enumeration and/or affiliation letter. HealthPartners will review and, if appropriate, the claims will be reprocessed.

If an agency disagrees with the processing of a claim related to individual PCA enumeration and/or affiliation, contact Claims Provider Services at **952-883-7699** or **888-663-6464**.

For additional information regarding HealthPartners claim submission requirements, visit the **Provider Portal** *(path: healthpartners.com/provider-public)*. There you can reference the **Quick Claims Submission Guide** *(path: healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/entry_141033.pdf)* or visit the **Provider resource materials** *(path: healthpartners.com/provider-public/provider-resource-materials/).*

For additional information about the DHS enrollment and affiliation criteria for PCAs, please visit the MHCP Provider Manual – **Personal Care Assistance (PCA) Services** *(path: dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137828#.*

If you have further questions regarding this, please call your HealthPartners Service Specialist.

Reminder - Training Requirement for Providers

HEALTHPARTNERS MINNESOTA SENIOR HEALTH OPTIONS (MSHO) MODEL OF CARE 2018

The MSHO Model of Care provides a description of the management, procedures and operational systems that HealthPartners has in place to provide the access to services, coordination of care and structure needed to best provide services and care to our MSHO population. The training provides a general understanding of how a member would access the benefits provided through the MSHO Model of Care.

Annual training on the Model of Care is a Center for Medicare and Medicaid Services (CMS) requirement for Special Needs Plans. The Model of Care contains the following components:

1. Description of the MSHO population
2. Care Coordination
    a. Staff
    b. Health Risk Assessment Tool (HRAT)
    c. Individualized Care Plan (ICP)
    d. Interdisciplinary Care Team (ICT)
    e. Care Transition Protocols
3. MSHO Provider Network
4. MSHO Quality Measurement & Performance Improvement

The HealthPartners 2018 MSHO Model of Care Training PowerPoint can be accessed on the Provider Portal at *(path: healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_041302.pdf)* or click **MSHO Model of Care**.

Performance Improvement Project: Focus on Reducing Chronic Opioid Use in Medicaid Community

HealthPartners is collaborating with the other PMAP, SNBC and MSHO health plans in Minnesota on a project to reduce chronic opioid use among our members. We will focus our efforts on opioid naïve patients to prevent more people from becoming chronic users of opioids.

WHY IS THIS IMPORTANT?

The surge in opioid use in the United States is well known and highly publicized. From 1999 to 2015, the amount of prescription opioids dispensed in the United States nearly quadrupled; yet Americans did not report lower pain levels. During the same time, deaths from prescription opioids have more than quadrupled.

Minnesota has not escaped the rise in opioid prescribing or the increase in tragic outcomes related to opioids – both prescription and illicit. In Minnesota, unintentional poisoning/drug deaths will soon exceed motor vehicle traffic deaths. This project will focus on our Medicaid membership, but we expect that raising awareness of opioid issues will impact all patients and members across Minnesota.

WHAT ARE WE MEASURING?

DHS has created a measure to monitor the rate at which opioid naïve members become chronic users of opioids.

- An opioid-naïve patient is defined as someone who has not had a prescription for opioids for at least 90 days prior to a new prescription.
- For this project that person is considered a 'chronic user' if they use opioids for *45 days within the next 90 days* of a new prescription.

WHAT DOES THE PROJECT INCLUDE?

This project will include provider interventions as well as member and community education and outreach.

PROVIDERS

- The health plan collaborative is creating an Opioid Toolkit for Providers. This toolkit will be a compilation of tools, trainings and resources for clinics and pharmacies related to opioid prescribing. It will be posted on the Stratis Health website when it is available.
- Provider education in the form of webinars will promote the new DHS prescribing guidelines and other issues related to opioid prescribing in Minnesota.
- HealthPartners will monitor the prescribing rates for Medicaid members who receive care at our network of providers. These rates will be posted on a secure location on our provider portal so clinic systems can compare themselves to other systems. More information on this will be coming soon.
- The plans will work with the Uniform Pharmacy Policy Workgroup to establish common pharmacy practices across all Medicaid plans in Minnesota.
- Primary Care Providers for SNBC members will receive notification of a new opioid prescription in the event that it was prescribed by another clinician.
- The health plans will collaborate with others working on this issue across Minnesota.

HEALTHPARTNERS MEMBERS

- New opioid users who refill a new prescription will receive a letter with information on the risks of opioids and suggestions for talking to their doctor about alternative treatment options.
- A limited MTM pilot will target SNBC members who begin opioid medications to discuss potential medication interaction.

COMMUNITY AWARENESS

- The health plans will be sharing information with the community including on social media, on topics such as the risks of opioids, alternative therapies and safe storage and disposal.

For more information on this project, contact Patty Graham at **patty.r.graham@healthpartners.com**.

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 online at **healthpartners.com/fastfacts**.

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