Fast Facts

HealthPartners

MAY 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

Calling all specialty and primary care providers …

Apply Now: HealthPartners 2018 Innovation in Health Care and Preventive Care Screening Recognition Awards

Is your organization working to change the way it delivers health care? Or has your organization implemented a novel quality improvement process around the way your patients are being screened for preventive care that is leading to greater performance? If so, HealthPartners would like to recognize you for your efforts.

Applications and information for both the Innovation in Health Care and Preventive Care Screening Recognition Awards will be available under **Partners in Quality** *(path: healthpartners.com/provider-public/quality-and-measurement/partners-in-quality/?skin=provider)* online. If you have questions, please email **HPAwards@HealthPartners.com**.

INNOVATION IN HEALTH CARE AWARD

We know that innovative efforts of any one dedicated primary care or specialty clinic can ripple outward to improve care and change business as usual in the care delivery system. This work is transformational for us all. We created the Innovation in Health Care Award to recognize and celebrate these contributions. If you work on or know of an innovative project that focuses on a specific disease or condition, care process, patient population or the entire care delivery model, we encourage you to **Apply for the Innovation in Health Care Award** *(path: healthpartners.com/provider-public/quality-and-measurement/partners-in-quality).*

PREVENTIVE CARE SCREENING RECOGNITION AWARD

Quality improvement is a vital activity in the pursuit of the Triple Aim. We created the Preventive Care Recognition Award to honor primary care and specialty groups for the implementation of projects that result in persistent, sustainable positive change for preventive care screening. The Preventive Care Screening Recognition Award focuses on process and performance improvement results in preventive care screenings relevant to the patient population served. **Apply for the Preventive Care Screening Recognition Award** *(path: healthpartners.com/provider-public/quality-and-measurement/partners-in-quality).*

Submissions for both awards are **DUE BY JULY 16, 2018**.

Coding corner

UPDATE – NEW CLAIMS CODING SOFTWARE & RELEASE OF CLEAR CLAIM CONNECTION (C3)

HealthPartners will upgrade its claims coding software on May 16, 2018. Shortly after this upgrade, we will implement a new tool on our Provider Portal called Clear Claim Connection (C3) in mid-June. 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. Additional information and instructions for accessing C3 via the Provider Portal will be included in upcoming communications and will also be posted on the provider portal closer to the June implementation date. Please call your HealthPartners service specialist for more information.

REMINDERS

New patient versus established patient coding

- HealthPartners expects providers to follow American Medical Association (AMA) coding guidelines when billing for new patient services versus established patient services. The current year AMA CPT Professional Edition includes a definition of "new patient" and a definition of "established patient." As HealthPartners implements its new claims coding software in May 2018, providers will continue to be accountable for accurately coding services for new patient versus established patient care.

National Correct Coding Initiative (NCCI) edits

- HealthPartners follows NCCI coding guidelines for all products.
- Following those guidelines, non-site specific modifiers must be on the deny line only in order to override the edit.

GA and GY modifiers – Medicare products

- Per the HealthPartners GA and GY policy, submissions of these modifiers on a service will automatically result in a denial as member liability.
- If a service is covered per CMS policy or a member's supplemental benefits, the GA and GY modifiers should not be submitted.
- Providers are responsible for verifying coverage in advance. If you are unclear whether or not an item or service is covered by the member's plan, you should request a pre-service organization determination.
- To learn more, please access the **Use of GA, GY or GZ Modifier on Claim Submissions for Medicare Policy** and the **Advance Notice of Noncoverage for Medicare Members Policy**
  (Go to healthpartners.com/provider-public, then click on the Admin tools drop down menu and select Administrative policies).

Documentation

- If you believe HealthPartners will need additional documentation to override a coding edit, please submit it at the time of the original claim submission. This may help to avoid the necessity of a claim appeal.

Attention optometry and ophthalmology providers: eyewear claims

As a reminder, contracted provider groups are expected to submit claims directly to HealthPartners for covered services, including covered eyewear. Therefore, if your patient has coverage for eyewear and purchases eyewear from your clinic or facility, as a contracted provider, you should submit these claims to HealthPartners on behalf of your patients. Benefit examples include:

- Medicare-covered post-cataract eyewear for members on Medicare Cost and Medicare Advantage plans
- Pediatric eyewear
- General eyewear benefit included for Medicaid products

Submitting the claim on your patient's behalf ensures a smooth experience for your patient and your organization. Providers are expected to follow appropriate billing guidelines.

Medical Policy Updates –May 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
Physical and occupational therapy – rehabilitative	Effective immediately, policy revised. The criterion stating therapy must be specified in a plan of care that is reviewed and revised as medically necessary by the member's health care practitioner has been interpreted by some providers as conflicting with the rule allowing patients to see a physical therapist for 90 days without a doctor's referral. The statement has been removed to avoid confusion.
Cranial remolding helmet/band and protective helmet	Effective immediately, policy revised. Cranial remolding helmets/bands have been added to the DME Benefits Grid coverage policy as covered. Policy now addresses protective helmets only and has been retitled "Protective helmets."
Cranial remolding helmet/band and protective helmet – Minnesota Health Care Programs	Effective immediately, policy revised. Criteria for cranial remolding helmets/bands have been removed. These will be covered according to the MHCP Medical Supply Coverage Guide. A link to the guide appears on the DME Benefits Grid coverage policy. Policy now addresses protective helmets only and has been retitled "Protective helmets – Minnesota Health Care Programs."
DME Benefits Grid	Effective immediately, the following revisions were made: • Cranial remolding helmet/band has been added to the policy as covered. • Oscillatory positive expiratory pressure device, nonelectric, any type added as covered.
Transplants	Effective immediately: • Prior authorization requirement at the time of the evaluation and at the time of the listing added to match the already existing requirements on the prior authorization form. • Added under transplants eligible for coverage: allogeneic stem cell transplant for myelodysplastic syndrome with intermediate – very high IPSS-R scores and autologous stem cell transplant for AL amyloidosis.
Medical necessity	Effective 7/1/18: Policy has been revised to state prior authorization is needed for certain services that are on the prior authorization list. Language added to indicate medical necessity criteria applies to both medical and behavioral health. Luxury treatment programs added as a noncovered service.
Speech therapy – rehabilitative	Effective 3/1/18, policy revised for clarity. The statements that rehab ST beyond 2 years for certain conditions (cleft lip/palate, post cochlear implantation, post receipt of initial hearing aids) must follow the habilitative therapy prior authorization process were removed. There is no change in coverage of these services. Requests for rehabilitative speech therapy beyond two consecutive years may be subject to review.
Spinal cord stimulator	Effective 7/1/2018: • Policy name change to "Spinal cord and implanted peripheral nerve stimulation." • Prior authorization requirements added for the following noncovered stimulators: Ganglion root stimulator, peripheral nerve and peripheral field stimulation and occipital nerve stimulation.
Flutter device	Effective immediately: policy retired, information added to DME Benefits Grid as covered.

Coverage Policies	Comments / Changes
Investigational Services – list of noncovered services	Effective immediately, the following services have been added as there is insufficient reliable evidence in the form of high-quality peer-reviewed medical literature to establish the safety and efficacy of these treatments or their effect on health care outcomes: **0253T, 0474T** – Aqueous drainage device for use in Minimally Invasive Glaucoma Surgery (e.g., CyPass micro stent) **0449T, 0450T** – Aqueous drainage device for use in Minimally Invasive Glaucoma Surgery (e.g., XEN Gel stent) **0501T, 0504T** – Coronary fractional flow reserve, non-invasive, including analysis, interpretation, and report (e.g., HeartFlow FFRct Analysis) **0424T** – Phrenic nerve neurostimulation (e.g., Remede implantable system) for treatment of central sleep apnea; insertion or replacement of complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator) **L8699** – Prosthetic Implant, not otherwise specified, when used to describe a synthetic cartilage implant (SCI) for treatment of first MTP joint arthritis (e.g., Cartiva SCI)

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

BEHAVIORAL HEALTH

Coverage Policies	Comments / Changes
Chronic Pain - Multidisciplinary Intensive Day Treatment Programs	Effective 7/1/2018, policy revised to: • Add psychotherapy such as mindfulness-based stress reduction to the Indications that are covered section. • Add treatment of postural orthostatic tachycardia syndrome (POTS) to the Indications that are not covered section. • Add visceral pain to the list of conditions that are not eligible for coverage at a multidisciplinary pain program because there are other programs more appropriate for this condition. • Add to the definition of Chronic Pain. Chronic pain is pain that persists longer than three months.

Pharmacy Policy Updates – May 2018

HEALTHPARTNERS DRUG FORMULARY

Changes for Commercial and State Programs include several updates for opioid medications, starting July 2, 2018:

1. The first opioid prescription for members will be limited to a 7-day supply. Members starting therapy with opioid medications are also limited to a 14-day supply per episode. This limit is intended to allow one refill. Prior authorization is required for longer therapy.
2. The cumulative daily dose of opioids will be limited. This expands our current dose limit to include all opioid prescriptions. Current limits are for individual drugs and allow multiple prescriptions. This expansion "rolls up" the dose limit to include all opioid medications. Prior authorization is required when the cumulative opioid dose is equal or greater than 90 morphine-equivalents per day.

3. Long-acting opioids will require prior authorization for members with new prescriptions.
4. Codeine and tramadol is non-formulary for younger children <= age 11.
5. Codeine cough syrups are non-formulary for younger children <= age 17.

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

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.

Reminder – Provider Survey

HealthPartners mailed a short survey to a sample of psychiatrists, primary care and specialty physicians, as well as their office managers. The survey assesses satisfaction in two key areas where we continue to focus improvement activities – Continuity/Coordination of Care across care settings and experience with the Utilization Management process for services requiring prior authorization.

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

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

View Member's ID card online

You can now view a member's ID card online in our Provider Portal eligibility application. The member ID card can provide additional information such as care type or further administrative information. Simply search for a member and find the "View member card" link in the results.

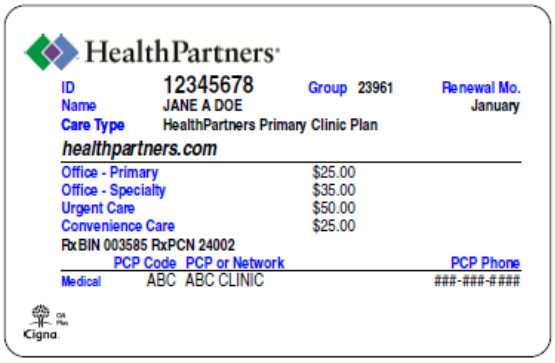
Coverages

If you do not see the date you are looking for, please widen your search by inserting the dates you are looking for into the date of service fields and resubmit your inquiry.

- Benefit records display benefits for a specified time period within a coverage policy.
- Coverage dates indicate the begin and end date of the member's coverage.

View member card – 3502

The view member card link opens the member's card image:



Patient Perspective

Crisis Text Line is offering text-based suicide prevention services across Minnesota

As of April 1, Crisis Text Line is offering **Text-based suicide prevention services** across Minnesota. People who **text MN to 741741** will be connected with a counselor who will help defuse the crisis and connect the texter to local resources. Crisis Text Line is available **24 hours a day, seven days a week**.

In addition, help is available by telephone:

- In the Twin Cities metro area, **call **CRISIS (274747)** from a cell phone to talk to a team of professionals who can help you.
- Outside of the Twin Cities, see the **directory for mental health crisis phone numbers** *(path: mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/adult-mental-health/resources/crisis-contacts.jsp)* in Minnesota by county.

More sources for help:

- The National Suicide Prevention Lifeline is a toll-free number: **800-273-TALK (8255)**.
- **Information for providers** *(path: mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/crisis-services/)*
- **Mobile Crisis Mental Health Services Fact Sheet** *(path: mn.gov/dhs/assets/mobile-crisis-services_tcm1053-333826.pdf)*

Government Programs

Annual wellness visits – What are patients thinking?

There is a lot of focus right now on encouraging Medicare patients to come in for an annual wellness visit. However, there is also confusion among seniors about what it is and why they should do it. HealthPartners decided to ask our members what they understand about the annual wellness visit, what their expectation would be for it and what would make them go. We gave seniors on our online member panel a brief overview of what the annual wellness visit is and why it is important.

We are using these results to improve our member communication. Take a look at this feedback and see if there are any messages you want to add or update in your clinic about the annual wellness visit.

Here's what we learned:

- Seniors were unclear about what an annual wellness visit includes and how it is different than an annual physical.
- What seniors like about the annual wellness visit includes:
    - Knowing my doctor/care team has time to focus on me and my health and wellbeing
    - Time to talk about my physical health
    - Not having any out-of-pocket cost
- Seniors would be more likely to schedule an annual wellness visit if they:
    - Understand what the annual wellness visit includes
    - Know there is no cost to them
    - Understand how the annual wellness visit would help
- They would find the annual wellness visit more valuable if it included a physical exam. Some stated they needed more information on the difference between the annual wellness visit and physical exam, so explaining the difference in the two types of exams is important in helping patients see the value of the annual wellness visit. HealthPartners note: Clinics can bill HealthPartners for an annual wellness visit and physical exam on the same day. Some clinics add on to a scheduled physical exam to also have the annual wellness visit.

Do you have anything to add to this feedback? Email **Stacey.m.engler@healthpartners.com** if you'd like to share your experience in providing Annual Wellness Visits.

Update - Focus on reducing chronic opioid use in Medicaid community

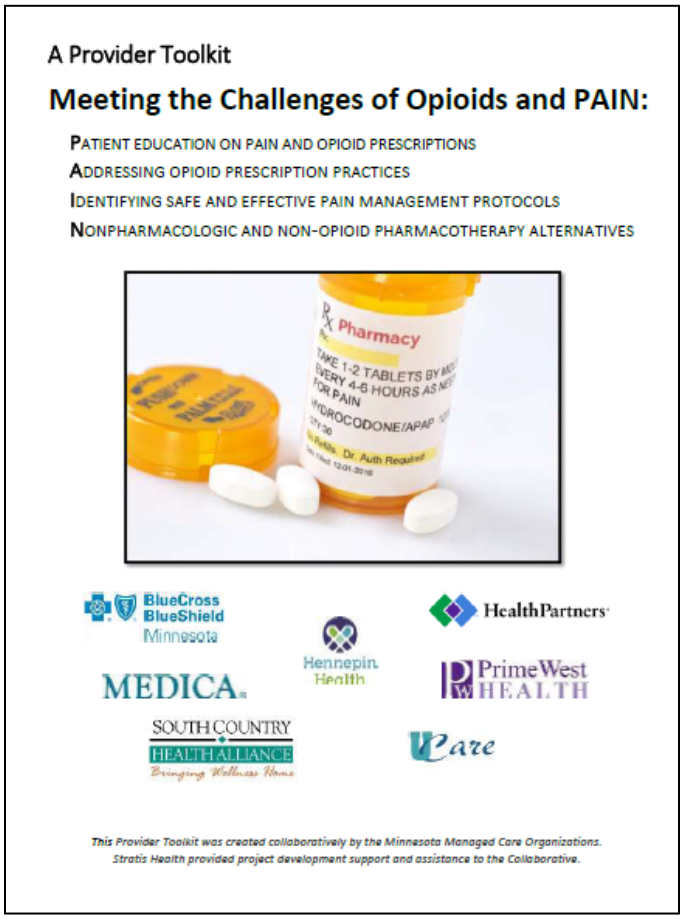
HealthPartners is collaborating with the other Medicaid health plans in Minnesota on a project to reduce chronic opioid use among our members. This project will focus on opioid-naïve patients to prevent more people from becoming chronic users of opioids.

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 has created an Opioid Toolkit for Providers. This toolkit is a compilation of tools, trainings and resources for clinics and pharmacies related to opioid prescribing. It is available on the project page of the **Stratis Health website**. *(path: stratishealth.org/pip/opioids.html).* This toolkit includes opioid prescribing guidelines, best practices and resources for improving clinical skills around partnering with patients to determine the best approach to pain management, screening for risk factors, shared decision making, patient education and pharmacy resources.
- Provider education in the form of webinars will promote the new DHS prescribing guidelines and other issues related to opioid prescribing in Minnesota. Information on webinars will also be found on the Stratis Health website as it becomes available.
- 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.
- Primary care providers for Special Needs Basic Care (SNBC) members will receive notification of a new opioid prescription in the event that it was prescribed by another clinician.



HealthPartners Members

- When a member who is opioid naïve fills a new prescription for an opioid, we will monitor if they get a refill and send them a letter with information about opioid risks and recommend they talk with their doctor about alternative pain treatments.
- A limited Medication Therapy Management (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 use of 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.**

Claims edits aligning with National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

Just a reminder, as of January 1, 2018, HealthPartners began applying claim edits to align with NCDs and LCDs to all of our Medicare products. Providers should follow Medicare criteria when billing unless otherwise indicated.

HealthPartners hearing aid billing and claim processing changes

Historically HealthPartners expectation was that providers submit hearing aid claims based on a member's product type: commercial or Medicare/Medicaid.

To simplify hearing aid claims billing and processing, HealthPartners will ask providers to bill all hearing aid claims uniformly following the commercial method.

EFFECTIVE APRIL 1, 2018: All hearing aid claims processing on or after April 1, 2018 (regardless of date of service), should be billed using the following methodology.

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

- **Medicare product clarification:** The above billing is for Medicare Cost and Advantage plans that include coverage for hearing aids. If the plan does not include hearing aid coverage, then providers should follow the requirements outlined in the HealthPartners **Advance Notice of Noncoverage for Medicare Members** administrative policy. *(Go to healthpartners.com/provider-public, then click on the Admin tools drop down menu and select Administrative policies).*

If you have any questions, please contact your service specialist.

REVIEW of Hearing Aid Information from January 2016 edition

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.

Hearing aid rate information can 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:

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

Code	Modifier	Description
XXXXX	GK	DME or Hearing Aid
XXXXX	GA	DME or Hearing Aid

To learn about the MN AUC guidelines, please access **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).

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

***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** *(Go to healthpartners.com/provider-public, then select Admin Tools and administrative policies from the drop down menus).*

Medicare Reimbursement Alignment

CONTRACTED PROVIDERS REIMBURSEMENT FOR MEDICARE MEMBERS

HealthPartners requires contracted providers to bill for services using Medicare guidelines for Medicare members.

Effective July 1, 2018, the following CPT codes will be aligned with Medicare reimbursement for Medicare members.

Non-covered Code	Code Description	Non-covered Code	Code Description
58300	INSERT INTRAUTERINE DEVICE	**E0243**	TOILET RAIL
74263	CT COLONOGRAPHY SCREENING	**E0245**	TUB STOOL OR BENCH
80050	GENERAL HEALTH PANEL	**E0637**	COMBINATION SIT TO STAND SYS
92590	HEARING AID EXAM ONE EAR	**E0936**	CPM DEVICE, OTHER THAN KNEE
92591	HEARING AID EXAM BOTH EARS	**J3535**	METERED DOSE INHALER DRUG
92592	HEARING AID CHECK ONE EAR	**J7298**	LEVONORGESTREL IU 52MG 5 YR
92593	HEARING AID CHECK BOTH EARS	**J8499**	ORAL PRESCRIP DRUG NON CHEMO
92594	ELECTRO HEARNG AID TEST ONE	**Q0144**	AZITHROMYCIN DIHYDRATE, ORAL
92595	ELECTRO HEARNG AID TST BOTH	**T4521**	ADULT SIZE BRIEF/DIAPER SM
99173	VISUAL ACUITY SCREEN	**T4522**	ADULT SIZE BRIEF/DIAPER MED
99401	PREVENTIVE COUNSELING INDIV	**T4523**	ADULT SIZE BRIEF/DIAPER LG
99402	PREVENTIVE COUNSELING INDIV	**T4524**	ADULT SIZE BRIEF/DIAPER XL
99403	PREVENTIVE COUNSELING INDIV	**T4525**	ADULT SIZE PULL-ON SM
99404	PREVENTIVE COUNSELING INDIV	**T4526**	ADULT SIZE PULL-ON MED
99408	AUDIT/DAST 15-30 MIN	**T4527**	ADULT SIZE PULL-ON LG
99411	PREVENTIVE COUNSELING GROUP	**T4528**	ADULT SIZE PULL-ON XL
99412	PREVENTIVE COUNSELING GROUP	**T4535**	DISPOSABLE LINER/SHIELD/PAD
A0888	NONCOVERED AMBULANCE MILEAGE	**T4543**	ADULT DISP BRIEF/DIAP ABV XL
A4627	SPACER BAG/RESERVOIR	**T4544**	ADLT DISP UND/PULL ON ABV XL
A4670	AUTOMATIC BP MONITOR, DIAL	**V5008**	HEARING SCREENING
A9300	EXERCISE EQUIPMENT	**V5010**	ASSESSMENT FOR HEARING AID
E0203	THERAPEUTIC LIGHTBOX TABLETP	**V5011**	HEARING AID FITTING/CHECKING
E0240	BATH/SHOWER CHAIR	**V5020**	CONFORMITY EVALUATION

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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