HealthPartners®

Fast Facts

JULY 2018

News for Providers from HealthPartners Professional Services and Hospital Network Management

Administrative

IMPORTANT – New outreach locations or telemedicine services?

UPDATE YOUR PROVIDER AND LOCATION INFORMATION

The information you provide to HealthPartners for providers and locations is what members see when they search for care using our online search tool, Find Care. It is critical our members have access to accurate and up-to-date information when seeking care in our networks.

Do you have new outreach locations or telemedicine services? If so, please contact your service specialist and provide details so the information can be added to our system.

Directory information can be reviewed and edited through our Provider Data Profiles 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.

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

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

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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**.

Credentialing website

HealthPartners Provider Home Page has a site to answer many of your common credentialing questions. You can access this site through the HealthPartners website at **healthpartners.com/credentialing** *(path: Provider Portal/Credentialing and Enrollment)*.

You will find the following information on the HealthPartners Credentialing website:

- Frequently asked questions – with detailed answers;
- Convenient link to the ApplySmart web-based credentialing application;
- HealthPartners Credentialing Plan, which includes our credentialing criteria for acceptance into the HealthPartners network;
- Practitioner's rights as they pertain to the credentialing process.

Provider Portal Help Survey

We're always looking for ways to improve our website and your experience with HealthPartners.

Please take this **brief help survey** to tell us how we can improve the portal and how you use it today.

Initial credentialing process

HealthPartners requires all Minnesota-based clinics to submit *initial* credentialing applications through the ApplySmart system. Clinics in Wisconsin, Iowa, North Dakota and South Dakota may use ApplySmart, or they may continue submitting paper applications. Initial applications submitted by Minnesota clinics by paper, fax or email may be returned to the submitter.

If you have questions or concerns about this requirement, please contact Marilee Forsberg at **(952) 883-6210** or at **marilee.j.forsberg@healthpartners.com.**

If you do not have an ApplySmart account, **Get Started** now *(path: mncred.org/getstarted.aspx).*

If you have questions about the ApplySmart system, contact **supportmcc@credentialsmart.net** or call **847-425-4616**.

Medical Policy Updates – 7/1/18

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: 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
Proton Beam Therapy	Effective immediately – Indications covered now include hepatocellular cancer and malignancies in children age 21 and younger.
Cardiac event monitoring	Effective immediately, policy revised. • Standard cardiac monitoring prior to implantable loop recorder (ILR) placement is no longer required to last for 30 days. • “Palpitations” added to list of symptoms eligible for evaluation using ILR. • Clarified that for syncope, dizziness or palpitations, ILR may be covered when suspected arrhythmia is not detected with standard cardiac monitoring or when symptoms are infrequent and thus are unlikely to be found using non-implantable ambulatory event monitoring or mobile cardiac outpatient telemetry (MCOT). • Clarified that MCOT and ILR can also be ordered by a neurologist, electrophysiologist, physician assistant or nurse practitioner supervised by one of these specialties. • Clarified and reordered language in MCOT section so it is apparent which criteria must be met for coverage of MCOT.

Coverage Policies	Comments / Changes
Breast Surgery	Effective 9/1/2018, policy revised. • Added the following clarifying statement to policy: Requests for reconstructive breast surgery for congenital syndromes that are directly associated with the absence of breasts (e.g., ectodermal dysplasia), for which member has tried and failed conservative treatment measures (such as appropriate hormone therapies where considered a standard of care), are reviewed on a case by case basis by a medical director. • The prior authorization requirement for Poland syndrome was removed. Breast reconstructive surgery is covered for members with a diagnosis of Poland syndrome. • Criterion #3 was revised to state that "Additional reconstructive surgeries beyond an initial covered reconstructive surgery unless: B.) the initial reconstruction resulted in a medically adverse outcome." • Criterion #3 under Implant Removal was revised to state that "Removal of silicone implants is covered when there is documented evidence of leaking causing medical complications."
Pneumatic Compression Devices	Effective 9/1/2018, policy revised. The following statement replaces the statement about cold compression therapy: "Devices that deliver heat and/or cold compression therapy are not covered. Therapy administered with these devices has not been proven to be any more effective than traditional delivery of heat/cold and compression (e.g., heating pads, ice packs, compression wraps); therefore, these devices are considered convenience items." Policy title was changed from Pneumatic Compression Devices to Pneumatic Compression Devices and Heat/Cold Therapy Units.
Pneumatic Compression Devices and Heat/Cold Therapy Units – Minnesota Health Care Programs	Effective immediately, policy developed to reflect Minnesota Health Care Programs (MHCP) provider manual criteria.
Pneumatic Compression Devices and Heat/Cold Therapy Units – Medicare	Effective 6/1/18, policy revised to reflect CMS criteria for a water circulating heating pad system. Policy was retitled Pneumatic compression devices and heat/cold therapy units.
Oral Appliances for Sleep Disorders – Minnesota Health Care Programs	Effective immediately, MHCP policy created to reflect DHS coverage criteria.
DME Benefits Grid	In-exsufflation devices and standing frames/stander added as covered items. mySentry™ remote glucose monitor added as a non-covered convenience item.
Hospital beds – commercial	Coverage criteria has not changed. This section has been reordered and some redundancy has been removed.
In-exsufflation devices	Effective immediately, policy is retired. Item was moved to the DME Benefits Grid as covered.

Coverage Policies	Comments / Changes
Genetic Testing	Effective 9/1/18 – Genetic testing continues to require prior authorization unless otherwise noted. Coverage policy has been revised to clarify noncoverage of the following: genetic testing ordered by a provider other than a licensed healthcare provider or physician, direct-to-consumer genetic testing, comparative analysis using short tandem repeat (STR) markers, genetic testing for acquired disorders, repeat testing, and testing that includes genes not associated with the condition under evaluation. These are considered not medically necessary.
Ankle replacement surgery	Effective 9/1/2018, policy revised. Criteria have been updated to require the following supporting clinical documentation: Reports of radiographic studies such as CT, MRI or x-rays that confirm one of the covered conditions. Clinical information documenting at least 6 months of specific conservative therapies tried and failed, such as physical therapy, medication, injections and/or orthotic devices.
Ambulance and medical transportation	Effective immediately, policy revised. Coverage criteria added for ground transportation. Prior authorization is not required for ground transportation. • Transfers from a hospital or at home to other facilities by ground ambulance when medical supervision is required en route. • Transfers by ground ambulance when the first hospital does not have the required services or facilities to treat the patient.

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

BEHAVIORAL HEALTH

Coverage Policies	Comments / Changes
Adult Mental Health Residential Services Coverage Criteria – Commercial	Effective 9/1/2018, new policy. • All residential services require prior authorization. • HealthPartners follows the MCG Health Behavioral Health Care 22nd Edition Copyright © 2018 MCG Health, LLC. Please contact the Behavioral Health Department at **952-883-7501** for a copy.

Pharmacy Policy updates – 7/1/18

HEALTHPARTNERS DRUG FORMULARY

Reminder: 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 nonformulary for younger children </= age 11.

5. Codeine cough syrups are nonformulary for younger children </= age 17.

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

COMMERCIAL AND STATE PROGRAMS

These changes will be effective July 2018:

- Apalutamide (Erleada) for nonmetastatic prostate cancer will be reserved for members meeting the FDA labeling and with a PSA doubling time of <10 months (per clinical trial).

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** *(path: healthpartners.com/formularies)*.

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
Buprenorphine injectable (Sublocade)	Adding a new medical policy, reserving for patients unable to use oral therapy. This includes patients unable or unwilling to use oral therapy, and patients for whom the provider has concerns about diversion. Claims received without prior authorization may be denied after 7/1/2018.
Eteplirsen (Exondys 51) *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=ENTRY_191266)*	Revised policy, adding clinical criteria to be met prior to payment. See coverage policy for detailed criteria. Requires prior authorization from Pharmacy Administration. Claims received without prior authorization may be denied after 1/1/2017.
Nusinersen (Spinraza) *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=ENTRY_191273)*	Revised policy, adding coverage for patients with Types 1, 2 and 3 symptomatic disease prior to 12 years of age at initiation of treatment. Additional criteria must be met; see coverage policy for detailed criteria. Requires prior authorization from Pharmacy Administration. Claims received without prior authorization may be denied after 1/1/2017.
Recently FDA-Approved Medications Coverage Policy *(path: healthpartners.com/public/coverage-criteria/policy.html?contentid=AENTRY_046122)*	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

2018 direct-to-member test kit program

To improve the health of our members and performance on publically reported measures, HealthPartners is launching a direct-to-member test kit program for three common tests: FIT for colorectal cancer screening, and microalbumin and A1c for diabetes care. HealthPartners will:

- Identify members who are overdue for testing based on claims history using HEDIS specifications.
- Mail test kits to the member's home in July or September.
- After members complete tests at home, they will mail their samples to HealthPartners designated vendor, BioIQ. BioIQ will process the tests and mail the results to the members and the members' attributed providers. HealthPartners attributes members based on the highest number of submitted claims within the reporting period. Result letters for unattributed members will stress the importance of having a primary care provider who can provide recommendations and medical care.

HealthPartners will capture each completed test kit as a medical claim that provider groups will be able to leverage for MNCM reporting.

TEST	MEDICARE TARGET POPULATION	COMMERCIAL TARGET POPULATION
FIT – colorectal cancer screening	All unscreened members	All unscreened and unattributed members
Microalbumin test for diabetic nephropathy	All unscreened members	Select unscreened members (focus on subpopulations such as unattributed)
A1c test for diabetic control monitoring	All unscreened members	No outreach

BACKGROUND

In 2017 HealthPartners conducted a pilot project mailing FIT kits to a random sample of 530 unattributed members between the ages of 50 and 75 who, by our claims history, were not up to date for colorectal cancer screening.

The pilot assessed the effectiveness of this approach to reach out to our members and improve screening adherence rates.

KEY FINDINGS

We achieved a 16.2 percent response rate from members who were mailed kits. Of the members who returned kits, nearly half had never been screened for colorectal cancer at any point in the past as determined by using best available data. Two members had positive results. HealthPartners health plan nurses conducted outreach to members with positive results to educate about appropriate follow-up care. We feel our 16.2 percent response rate was a strong result considering we targeted unattributed members who did not have a history of interacting with the health care system.

To learn more about the 2018 direct-to-member test kit program, contact Jaclyn Popehn, Manager Provider Relations and Contracting at **jaclyn.e.popehn@healthpartners.com** or Sylvia Bobbitt, RN Clinical Quality Consultant at **sylvia.f.bobbitt@healthpartners.com**.

Help your patients prepare for 2019 expenses

The high cost of health care can prevent people from seeking behavioral health treatment. For many people, the fall season is the time they sign up for health insurance and plan for ongoing or potential future healthcare expenses. Many employers offer the opportunity to set aside tax-free money for health care costs through one of three types of accounts:

- Flexible Spending Account (FSA);
- Health Saving Account (HSA); or
- Health Reimbursement Account (HRA).

For patients with ongoing needs, the amount needed to cover future health care expenses can be estimated from current expenditures.

IMPORTANT THINGS TO KNOW

- For Flexible Spending Accounts (FSA) and Health Saving Accounts (HSA), in general, the service or care provided **does not** need to be a covered service under the medical benefits. However, it is always best for patients to contact the administrators of their plans to double check.
- It is the opposite for people with a Health Reimbursement Account (HRA). Generally, the service or care provided **does** need to be a covered benefit. However, it is always best for patients to contact the administrators of their plans to double check.

Helping your patients plan for future expenses can be a value-add service.

Government Programs

HealthPartners Medicare Supplement (Medigap) plan offerings

This summer HealthPartners will be offering Basic Medicare Supplement and Extended Basic Medicare Supplement plans effective as early as August 1, 2018.

Facts about HealthPartners Supplement plans:

- The Basic and Extended Basic Medicare Supplement plans will be available in all Minnesota counties.
- Medicare is the primary payer for all covered Part A and Part B services. After Medicare pays, HealthPartners covers the Medicare coinsurance and copayments and, depending on the level of coverage purchased, the Medicare deductibles.
- Plan members may see any provider that accepts and is enrolled in Medicare.
- Coverage is provided for certain state-mandated benefits.

The Provider Resource Manual and the **Medicare and Medicaid Resources** *(path: healthpartners.com/provider-public/medicare-and-medicaid-resources/)* page on the Provider Portal will be updated in the near future to include more information and details about our Medicare Supplement plans. Please contact your HealthPartners Service Specialist with any questions.

Medicare crossover claims are now being accepted

As we have shared previously in the November 2017 and March 2018 editions, HealthPartners is implementing a coordination of benefits (COB) crossover process to receive electronic claims from CMS national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). It will include Medicare Cost, Medicaid and Commercial products. Claims submitted to Medicare as of June 25, 2018 will begin to cross over to HealthPartners automatically if they fit our claim selection criteria.

HealthPartners will be implementing a COB agreement for Medigap (Medicare Supplement and Senior Health Advantage) later in 2018.

There are circumstances where a provider may bill Medicare and HealthPartners differently. In the event that a claim is automatically crossed over, you may receive a denial on the remittance. Please submit to HealthPartners secondary and bill as you typically would.

The COBA ID numbers for our three lines of business are:

- Medicare Cost and Commercial (combined): 00593
- Medicaid: 77150
- Medigap (not in production yet): 30396

Please contact your HealthPartners Service Specialist for questions.

State of Minnesota employer group providers

The State of Minnesota Advantage Health Plan is the tiered network plan offered to both the State Employee Group Insurance Program (SEGIP), as well as groups participating in the Public Employee Insurance Program (PEIP). The initial cost levels or tiers for the 2019 network are complete. Minnesota Management and Budget, the state agency that manages the plan, recently sent letters to providers with their initial 2019 cost level. The letters include information regarding the analysis and what can be done if your group wants to move to a lower cost level.

If you have any questions or are interested in moving to a lower-cost level, please contact your HealthPartners Service Specialist or Contract Manager.

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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