Fast Facts

HealthPartners

MAY 2021

News for Providers from HealthPartners
Provider Relations & Network Management

Administrative

Make sure patients can find you

Patients are often seeking to connect with providers. For many, seeing a provider who shares their race, ethnicity or gender is important. This is true for many specialties, but we hear it particularly from those seeking behavioral health providers.

To ensure patients can easily find clinicians in your practice who meet their needs, please update your practice's information in our Provider Data Profile application.

Follow these quick and easy steps:

- Log in at **healthpartners.com/provider** using your username and password
- Click on **Provider Data Profiles**
- Make updates by clicking on **Edit Practitioner**, including race, country of origin and personal profile

If you need access to the Provider Data Profile application, contact your delegate (located in the help center after you log onto the portal).

INSIDE THIS ISSUE

Prior authorization news

The **Verify PA Requirements** tool now supports both medical and injectable HCPC codes as well as behavioral health services. All you need are the service codes (HCPC/CPT) and the tool will determine if a PA is necessary. If a PA is required, the tool will display a link to the coverage policy criteria and guide you to the resource needed to begin the PA request process.

No need to log in! You can find this Verify PA Requirements tool on our home page or by visiting **healthpartners.com/verifyPArequirements**.

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** *(pathway: Provider Portal/Credentialing and Enrollment)*.

INFORMATION ON THE HEALTHPARTNERS CREDENTIALING WEBSITE

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

New option for submitting credentialing applications

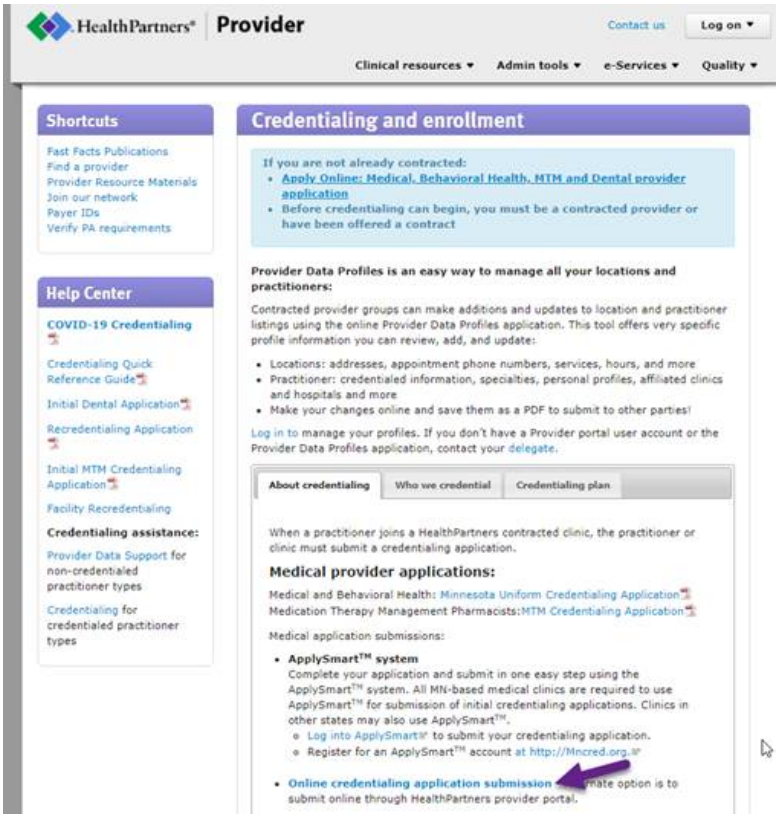
Clinics are now able to submit initial or recredentialing applications securely through the HealthPartners Provider Portal (*no logon required*). The new form significantly improves processing time. This online form ensures data is complete and routes applications to the appropriate department. The form is available for both HealthPartners health plan and hospital recredentialing applications.

It's important to note – this does not replace ApplySmart. That is still our preferred method of application submission and is required for Minnesota clinics when submitting initial applications. If you do not have an ApplySmart account, **Get Started** now.

All clinics that are not using ApplySmart should submit applications using this webpage.

There are three ways to get to the form:

- **healthpartners.com/credentialingsubmission**
- **Through the Provider Forms page:**
  Admin Tools > Forms for providers > online credentialing submission for medical and MTM
- **Through the Credentialing Page**
  (healthpartners.com/credentialing)



Signatures on credentialing applications

Just a reminder that credentialing applications must be signed by the practitioner.

Applications that are digitally or electronically signed (e.g., via ApplySmart) must be digitally/electronically signed by the practitioner as well, and cannot be signed by anyone else (even with permission from the practitioner).

If you have questions, please contact Marilee Forsberg at **marilee.j.forsberg@healthpartners.com**.

Medical Policy updates – 5/1/2021

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
Investigational services – list of non-covered services	Effective immediately, the following services are considered investigational and are not eligible for coverage: 0421T – Aquablation waterjet tissue ablation (e.g., AquaBeam) for treatment of benign prostatic hyperplasia (BPH) 37242, 32743 – When used to report prostatic artery embolization for treatment of benign prostatic hypertrophy 30999 – When used to report nasal airway remodeling for treatment of nasal valve collapse (e.g., VivAer, RhinAer)
Gender affirming surgery	Effective immediately the name of the former Gender reassignment surgery policy has been revised. There are no changes to coverage criteria.
Feeding/oral function therapy, pediatric	Effective immediately, policy is retired.
Dressing supplies	Effective immediately, policy is retired.
Sacroiliac joint pain treatment procedures	Effective immediately, the following changes were made for simplification and clarity: The criteria for initial and repeat sacroiliac joint injections have been divided into separate sections. For repeat injections, when it has been longer than twelve months since the most recent previous sacroiliac joint injection, the criteria for initial sacroiliac joint injection (conservative and physical therapy) must then be met. For minimally invasive sacroiliac joint fusion, either plain radiographs and/or CT/MRI imaging may be submitted for the SI joint, ipsilateral hip and lumbar spine.
Habilitative therapies	Effective immediately, the "Physical and occupational therapy – habilitative" and "Speech therapy – habilitative" policies have been combined into one policy and retitled Habilitative Therapies. There are no criteria changes. A statement was added indicating that prior authorization is not required for oral function therapy (92526).

Coverage Policies	Comments / Changes
Implanted and percutaneous peripheral nerve stimulation for treatment of pain	This new policy is effective immediately. Many procedures addressed on this policy were previously addressed on the policy titled "Spinal cord and implanted peripheral nerve stimulation. " The following procedures are considered investigational and are not covered because reliable evidence does not permit conclusions concerning safety, effectiveness, or effect on health outcomes. Prior authorization is not applicable. 1. Implanted peripheral nerve stimulation (PNS) 2. Percutaneous peripheral nerve stimulation, examples may include, but are not limited to, minimally invasive percutaneously implanted nerve stimulators, auricular electrostimulation, electro acupuncture therapies, percutaneous electrical nerve field stimulation (PENFS), percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapies (PNT) 3. Peripheral nerve field stimulation (PNFS), also known as peripheral subcutaneous field stimulation (PSFS) 4. Occipital nerve stimulation 5. Repair, revision or replacement of previously implanted peripheral nerve stimulators utilized for treatment of pain
Spinal cord stimulation	Effective immediately, the name of the previous policy titled Spinal cord and implanted peripheral nerve stimulation, has been changed to "Spinal cord stimulation." The peripheral nerve and occipital nerve stimulation procedures addressed on the former policy are now addressed on the new policy, Implanted and percutaneous peripheral nerve stimulation for treatment of pain. That policy is described above. Criteria and indications for placement of a spinal cord stimulator have not changed. Dorsal root ganglion stimulation remains experimental, and therefore, not covered. The policy has been updated to state the following: Prior authorization is not required for repair or revision (such as revision of migrated leads) of an existing spinal cord stimulator. Replacement, repair or revision of an existing dorsal root stimulator is not covered. Replacement of a functioning spinal cord stimulator or a functioning component of a spinal cord stimulator (including, but not limited to, replacing or "upgrading" a non-high frequency stimulator with a high frequency stimulator) is not considered medically necessary.

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

Coverage Policies	Comments / Changes
Repetitive transcranial magnetic stimulation (rTMS)	July 1, 2021, the following revisions go into effect for the Repetitive transcranial magnetic stimulation policy. This service will continue to require prior authorization. **Initial treatment** An initial course of up to 36 treatments (30 treatments plus 6 tapering sessions) of rTMS is considered medically necessary for members age 18 and older who have a confirmed diagnosis of major depressive disorder (MDD), single or recurrent episode, and meet the following criteria: 1. Resistance to treatment as evidenced by a lack of a clinically significant response to three (3) trials of psychopharmacologic agents in the current depressive episode; A. Two different agent classes, at or above the minimum effective dose and duration and includes trials of at least two (2) evidence-based augmentation (combination) therapies; **or** 2. Inability to tolerate psychopharmacologic agents as evidenced by three (3) trials of psychopharmacologic agents with distinct side effects; **or** 3. History of response to electroconvulsive therapy (ECT) in a previous or current MDD episode, or history of inability to tolerate ECT, and rTMS is considered a less invasive treatment option; **and** 4. A trial of an evidence-based psychotherapy known to be effective in the treatment of MDD, of an adequate frequency and duration, without significant improvement in depressive symptoms as indicated by one or more standardized rating scales for depression; **and** 5. The rTMS treatment is delivered by a device that is approved by the Food and Drug Administration (FDA) for the treatment of MDD and utilized in accordance with the FDA labeled indications; **and** 6. Prescribed by a psychiatrist who has examined the patient and includes documentation evaluating potential contraindications to rTMS treatment and documentation of the patient's understanding of risks and expected outcomes for the treatment. The treatment must be provided by, or under direct supervision of, a physician trained in administering rTMS therapy.

Coverage Policies	Comments / Changes
Repetitive transcranial magnetic stimulation *(continued)*	**Repeat treatment** A repeat course of up to 36 treatments (30 treatments plus 6 tapering sessions) of rTMS is considered medically necessary for members age 18 and older who have a confirmed diagnosis of major depressive disorder (MDD), and meet **all** the following criteria: 1. All of the above criteria for initial treatment are met; **and** 2. The member has experienced a relapse of major depressive disorder or continued depressive symptoms as documented by one or more standardized rating scales for depression; **and** 3. 50 percent or greater improvement in response to previous rTMS treatment as documented by one or more standardized rating scales for depression.

Drug Formulary updates

COMMERCIAL DRUG FORMULARY

Updates for July 1, 2021 include:

- Several generics have been added to formulary, including budesonide/formoterol inhaler (generic Symbicort), mycophenolate acid (generic Myfortic), and ramelteon.
- Several new medications have been added to formulary with coverage criteria, including:
    - Berotralstat (Orladeyo, a new oral medication, with hereditary angioedema criteria including an inadequate response to Takzyhro).
    - Voclosporin (Lupkynis) and Belimumab (Benlysta), two new medications for lupus nephritis.
    - Lonafarnib (Zokinvy) for Hutchinson-Gilford progeria.
- Several new generics are available and replace the Brand, including lubiprostone (Amitiza).
- Buprenorphine/naloxone (generic Suboxone) quantity limits have been updated, allowing up to #3 units per day.

There are very few negative changes this quarter.

MEDICARE DRUG FORMULARY

Updates are available in our online drug formulary. Most updates occur in January of each year.

MINNESOTA HEALTHCARE PROGRAMS (MHCP) DRUG FORMULARY

Updates are available in our online drug formulary. These policy updates apply only to State Programs, and do not apply to members with Commercial or Part D plans.

Pharmacy Medical Policy updates

MINNESOTA HEALTHCARE PROGRAMS (MHCP) MEDICAL POLICY

Updates are similar to Commercial.

These policy updates apply only to State Programs, and do not apply to members with Commercial or Part D plans.

COMMERCIAL UPDATES

Coverage Policies	Comments / Changes
Chimeric antigen receptor/genetically engineered T-cell receptor (CAR-T) therapy	Lisocabtagene (Breyanzi) is a newly FDA-approved CAR-T medication for the treatment of relapsed/refractory large B-cell lymphoma. Breyanzi is FDA-approved for the following large B-cell subtypes of Non-Hodgkins lymphoma: Diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from indolent lymphoma, High-grade B-cell lymphoma, Primary mediastinal large B-cell lymphoma, and Follicular lymphoma grade 3B. Breyanzi is covered with prior authorization.
Reslizumab (Cinqair®)	Cinqair is currently covered, with prior authorization, for severe asthma. Prior authorization criteria has been updated to require prior trial and failure with Nucala. This criteria is consistent with other non-preferred, professionally administered, biologics for severe asthma criteria (i.e., Fasenra).
Evinacumab (Evkeeza®)	This new medication for homozygous familial hypercholesterolemia (HoFH) is covered with prior authorization.
Mepolizumab (Nucala®)	Nucala obtained an additional FDA-indication for hypereosinophilic syndrome (HES) and is covered with prior authorization.
Lumasiran (Oxlumo®)	This new medication for primary hyperoxaluria is covered with prior authorization.
Rituximab (Rituxan®, Ruxience™, Truxima®, Rituxan Hycela®, and Riabni™)	Riabni (rituximab-arrx) joins Truxima and Ruxience as a biosimilar to Rituxan. Truxima and Ruxience remain preferred products. Riabni adopts a non-preferred status and is eligible for coverage with prior authorization.
Oncology drug coverage	Prior authorization is required for oncology drugs listed on this policy. Drugs recently added to this policy: • Margetuximab (Margenza) • Melphalan Flufenamide (Pepaxto) Additional criteria may apply – see the coverage policy for more information.
Recent Food and Drug Administration (FDA) approved medications covered policy	Prior authorization is required for recently approved drugs listed on this policy. Drugs added to this policy: • Casimersen (Amondys-45) • Nosdenopterin (Nulibry) • Idecabtagene vicleucel (Abecma) 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.

Coverage policy can be found in the medical coverage policy search page, searchable by drug name or billing codes. Policies will be searchable on, or in some cases before, the effective date of July 1, 2021 at: **healthpartners.com/public/coverage-criteria.**

Please see the HealthPartners Formulary for details and a complete list of updates 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 Committee policies are available at: **healthpartners.com/provider/admin tools/pharmacy policies**, including the **Drug 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.

New administrative policy for genetic and molecular testing

Advancements in genetics and genomics have led to a vast array of new options for medical professionals to diagnose, treat, and prevent disease. As increases in genetic and molecular testing continue, HealthPartners is committed to improving the sustainability of care by ensuring high-quality, appropriate care is delivered at a fair price.

Effective July 1, 2021, HealthPartners will expand the requirements for billing of genetic and molecular testing. In accordance with the new HealthPartners administrative policy for Genetic and Molecular Lab Testing, all providers billing for genetic and molecular testing services will be required to adhere to the coding recommendations from Concert Genetics, our industry-leading genetic testing technology partner. Billing integrity requirements in the administrative policy will be administered on a post-payment review basis by Concert Genetics.

The provider portal can be accessed at: **concertgenetics.com/join-healthpartners/**

LIST OF IMPACTED TESTS INCLUDED IN ADMINISTRATIVE POLICY (SECTIONS IN CPT/HCPCS MANUAL)

- Molecular Pathology
- Genomic Sequencing Procedures and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses
- Proprietary Lab Analysis (PLA)

PRODUCTS IMPACTED

This program applies to commercial (fully-insured and self-insured) and state public programs products. Please check the member's benefits and confirm network status.

NEXT STEPS FOR PROVIDERS

- Register with Concert Genetics and complete the quality profile for your laboratory.
- Verify accuracy of test catalog data and review Concert Coding Engine recommendations.
- Review impact of fee schedule (if available) on test pricing.
- Utilize Concert Genetics' recommended codes when billing for genetic and molecular tests.

REGISTRATION

Please visit the Concert Genetics website (see link above) and submit a registration request. Labs will receive a welcome packet via email from Concert Genetics with an invitation to the Concert Genetics Platform, where labs can review and validate the accuracy of their test catalog data and complete the Quality Profile.

During onboarding, Concert Genetics will work with laboratories to gather the necessary information to calculate coding recommendations. Labs will use the 'Report as Inaccurate' feature to report specific test corrections. To assist providers:

- Concert Genetics will provide training materials and other documentation to assist labs with registration.
- Concert Genetics will provide online, email, and phone support during and after registration.
- For general inquiries, labs are encouraged to connect with a Concert Genetics representative by email: **help@concertgenetics.com**; or phone: **(855) 435-7643**.

PASS-THROUGH BILLING

HealthPartners currently allows pass-through billing for laboratory services, but clinics/facilities are strongly encouraged to only bill for laboratory services they provide. If a clinic/facility does bill for a genetic or molecular test performed by an independent laboratory, they should bill in accordance with Concert Genetics' coding recommendation for the performing laboratory and append the 90 modifier.

PROVIDER IMPACT OF NON-COMPLIANCE

HealthPartners requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal. Non-compliance with this policy will result in a written notification from HealthPartners. Continued non-compliance may result in a denied payment or termination of the provider's contract.

The new policy will be available online before the effective date of July 1, 2021.

To access the administrative policy: **Go to healthpartners.com/provider**

- Under Admin Tools, select "Administrative Policies"
- Locate "Genetic and Molecular Lab Testing"

QUESTIONS?

If you have questions regarding the administrative policy, please contact your HealthPartners Provider Relations & Network Management representative.

ADDITIONAL INFORMATION (ABOUT CONCERT GENETICS)

Concert Genetics (formerly NextGxDx, Inc.) launched in 2010 as a technology company dedicated to enhancing the transparency and efficiency of genetic testing for clinicians, hospitals, laboratories and health insurers. Concert Genetics' mission is to provide tools that connect, unify & simplify the world of genetic testing. To learn more, visit **concertgenetics.com/**.

2021 Hospice Program

CLAIMS PROCESS CHANGE REMINDER

Please note changes to our claims process for patients admitted to our HealthPartners Hospice Program. Beginning February 1st all claims for provided services, DME and Pharmacy should be remitted to HealthPartners Hospice.

Please remit these claims via email, fax or mail to the following:

Email: HomecareHospiceBilling@healthpartners.com

Fax: 651-430-8505

Mail: 5803 Neal Avenue N.
Oak Park Heights, MN 55082

Please direct all submissions
Attention: HealthPartners Hospice Billing Office

Please call **952-883-6877 f**or any claim inquiries.

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**.

Fast Facts Editors: Mary Jones and David Ohmann