Fast Facts

HealthPartners

JULY 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

HealthPartners launches new plan offerings

HealthPartners launched two new plan offerings in 2021.

APEX PLAN

Apex is a commercial plan offering for individuals. This plan is offered in the following counties in Minnesota: Anoka, Becker, Benton, Big Stone, Brown, Carver, Chippewa, Chisago, Clay, Cottonwood, Dakota, Douglas, Grant, Hennepin, Isanti, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Morrison, Murray, Nobles, Otter Tail, Pipestone, Pope, Ramsey, Redwood, Renville, Rock, Scott, Sherburne, Sibley, Stearns, Stevens, Swift, Todd, Traverse, Washington, Wilkin, Wright and Yellow Medicine. The network for *Apex* is open access with no wrap network. Providers who have locations in the counties where *Apex* is offered are in-network for all their locations, including locations outside of the service area. Providers who do not have locations within these counties are out-of-network for the *Apex* plan. *Apex* is being sold to individual members effective 1/1/2021.

Members using the *Apex* plan network will have ID cards with a care type that includes the word "Apex."

SELECT PLAN

Select is a commercial plan offering for large group. This plan is offered only in the core Twin Cities metropolitan area. The network for *Select* is the HealthPartners Medical Group, Park Nicollet, and Stillwater Medical Group clinics, along with Methodist Hospital, Regions Hospital and Lakeview Hospital. This plan will generally be sold alongside an Open Access plan, allowing members to choose networks. Care for services outside providers listed above will require a referral for in-network benefits. This plan was offered beginning March 2020 for employers renewing 7/1/2021 or later.

Members using the *Select* plan network will have ID cards with a care type that includes the word "Select."

Please contact your HealthPartners contract manager with any questions.

Medical Policy updates – 7/1/2021

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
Genetic testing: carrier screening, prenatal screening, prenatal diagnosis, and infertility evaluation	**CORRECTION** TO 6/1/2021 – Notification regarding Medical Policy updates Policy will be retired effective 8/15/2021 and not 8/1/2021 as previously indicated. Prenatal genetic testing will be addressed on four new policies, as previously indicated, which will be effective 8/15/2021. Refer to published policies for details.
Genetic testing for prenatal diagnosis (via amniocentesis, CVS or PUBS) and pregnancy loss	**CORRECTION** TO 6/1/2021 – Notification regarding Medical Policy updates Prior authorization IS required for Genetic testing for Prenatal Diagnosis via Exome Sequencing. Prior authorization is not required for all other genetic testing for prenatal diagnosis (via amniocentesis, CVS or PUBS) and pregnancy loss. Policy is Effective 8/15/2021 and not 8/1/2021 as previously indicated. Please refer to published policy for details.
Preimplantation genetic testing	**CORRECTION** TO 6/1/2021 – Notification regarding Medical Policy updates Policy is Effective 8/15/2021 and not 8/1/2021 as previously indicated. New policy. Prior authorization is not required. Please refer to published policy for details.
Genetic testing: non-invasive prenatal screening (NIPS)	**CORRECTION** TO 6/1/2021 – Notification regarding Medical Policy updates Policy is Effective 8/15/2021 and not 8/1/2021 as previously indicated. New policy. Prior authorization is not required. Please refer to published policy for details.

Coverage Policies	Comments / Changes
Genetic testing for prenatal and preconception carrier screening	**CORRECTION** TO 6/1/2021 – Notification regarding Medical Policy updates Policy is Effective 8/15/2021 and not 8/1/2021 as previously indicated. New policy. Prior authorization is not required. Please refer to published policy for details.
Infertility diagnosis and treatment (commercial and Minnesota Health Care Programs)	Effective immediately, policy is retired.
Breast surgery	Effective immediately, policy is revised for clarity. • Breast reconstruction associated with mastectomy is considered medically necessary. • Removal of silicone gel implants is medically necessary when rupture is confirmed on imaging. • Removal of contralateral implant is considered medically necessary when criteria for removal are met unilaterally. • "Covered" and "non-covered" terminology removed throughout policy in favor of more precise language. Please refer to the published policy for details.
Blepharoplasty, blepharoptosis repair, and brow lift	Effective immediately, revised brow lift criteria. • Documentation must include descriptions of functional visual impairments related to the need for a brow lift. • Documentation must include statements indicating why a blepharoplasty or blepharoptosis repair cannot correct the functional visual impairments. • Documentation must include a frontal, straight-ahead photograph showing an eyebrow or eyebrows below the superior orbital rim. Please refer to the published policy for details.
Category III CPT Codes	Effective 9/1/2021, Category III CPT Codes are considered investigational and are not eligible for reimbursement unless coverage is specifically outlined on an existing HealthPartners medical policy. Please refer to the published policy for details.
Genetic testing coverage criteria policies	Effective 9/1/2021, the following policies will be retired and replaced with new policies: • Genetic testing • Genetic testing: blood and cardiovascular disorders • Genetic testing: cancer management • Genetic testing: gastrointestinal and immune function disorders • Genetic testing: hereditary cancer syndromes • Genetic Testing: Neurological, Growth, Structural, and Sensory Disorders

Coverage Policies	Comments / Changes
Oncology: cancer screening	Effective 9/1/2021, new policy that specifically addresses genetic tests used to screen for colorectal cancer and lung cancer. Prior authorization is not applicable for the following tests as they are considered investigational/experimental and therefore not covered: • Urinary biomarker tests for pre-cancerous colon polyps • Blood-based biomarker tests for colorectal cancer screening • Blood-based biomarker tests for lung cancer screening Any tests associated with unlisted laboratory/pathology CPT codes (for example, 81400-81408, 81479, 81599) require medical necessity review. Please refer to published policy for details.
Genetic testing for eye disorders	Effective 9/1/2021, new policy that specifically addresses genetic testing for eye disorders. Prior authorization is required. • Genetic testing for macular degeneration is considered investigational/experimental Please refer to published policy for details.
Genetic testing for kidney disorders	Effective 9/1/2021, new policy that specifically addresses genetic testing for kidney disorders. Prior authorization is required. • Genetic testing for donor-derived cell-free DNA for kidney transplant rejection is considered investigational/experimental Please refer to published policy for details.
Genetic testing for epilepsy, neurodegenerative, and neuromuscular disorders	New policy effective 9/1/2021. Criteria for genetic testing for epilepsy, neurodegenerative, and neuromuscular disorders have been significantly revised. Prior authorization is required. • Criteria for Myotonia Congenita have been revised to reflect current recommendations; now considered medically necessary when criteria are met • New criteria for amyotrophic lateral sclerosis (ALS), hereditary dystonia, and various ataxias Please refer to published policy for details.

Coverage Policies	Comments / Changes
Genetic testing for gastroenterologic disorders (non-cancerous)	New policy effective 9/1/2021. Criteria for genetic testing for non-cancerous gastroenterologic disorders have been significantly revised. Prior authorization is not applicable for the following specific tests as they are considered investigational/experimental and therefore not covered: • ASH FibroSURE (LabCorp) (0002M) • NASH FibroSURE (LabCorp) (0003M) • EsoGuard™ (Lucid Diagnostics) (0114U) Prior authorization is required for the following services: • Known Familial Variant Analysis for Gastroenterologic Disorders • Genetic testing for Lactase Insufficiency • Genetic testing for Hereditary Pancreatitis • Genetic testing for Inflammatory Bowel Disease • Genetic testing for Hereditary Hemochromatosis, unless associated with CPT 81256 and a primary diagnosis code listed on the policy. Prior authorization is not required for genetic testing for Celiac Disease. Please refer to published policy for details.
Genetic testing for aortopathies and connective tissue disorders	New policy effective September 1, 2021. Coverage criteria for genetic testing have been revised for the following; prior authorization is required: • Known familial variant analysis testing for aortopathies and connective tissue disorders • Marfan Syndrome • Loeys-Dietz Syndrome • Familial Thoracic Aortic Aneurysm and Dissection (TAAD) • Classic and Vascular Ehlers-Danlos Syndromes • List of rare connective tissue disorders Comprehensive multiple gene panels for Ehlers-Danlos Syndrome are considered investigational. Targeted gene panels and single gene testing for Ehlers-Danlos Syndromes remain covered with updated criteria. Please refer to the published policy for details.

Coverage Policies	Comments / Changes
Genetic testing for metabolic, endocrine, and mitochondrial disorders	New policy effective September 1, 2021. Criteria have been revised or added for the following; prior authorization is required: • Familial variant analysis testing for metabolic, endocrine, and mitochondrial disorders • MTHFR variant analysis testing • Maturity Onset Diabetes of the Young (MODY) Panel • Mitochondrial Genome Sequencing, Deletion/Duplication, and/or Nuclear Gene Panel • List of rare metabolic, endocrine and mitochondrial disorders MTHFR variant analysis testing is considered investigational. Please refer to the published policy for details.
Genetic testing for multisystem inherited disorders, intellectual disability, and developmental delay	New policy effective September 1, 2021. Fragile X syndrome (FMR1 Repeat and Methylation Analysis) is covered; prior authorization is not required. Coverage criteria for genetic testing have been revised or added for the following; prior authorization is required: • Familial variant analysis testing for multisystem inherited disorders • Genetic testing related to developmental delay/intellectual disability, autism spectrum disorder, or congenital anomalies • Angelman/Prader-Willi Syndrome • Beckwith-Wiedemann/Russell-Silver Syndrome • CADASIL • Cystic Fibrosis • CHARGE Syndrome • Fanconi Anemia • Hereditary Hemorrhagic Telangiectasia (HHT) • Legius Syndrome • Neurofibromatosis • Noonan Spectrum Disorders • Rett Syndrome • Tuberous Sclerosis Complex (TSC) • List of covered rare multisystem disorders Developmental delay/intellectual disability, autism spectrum disorder, and congenital anomalies panel analysis is considered investigational. Please refer to the published policy for details.

Coverage Policies	Comments / Changes
Genetic testing: Pharmacogenetics	Effective September 1, 2021, Genetic testing: pharmacogenetics has been significantly revised. Prior authorization is not required for the following covered tests: • CYP2C9 genotyping (CPT 81227) • CYP2D6 genotyping (CPT 81226, 0070U-0076U) • DPYD genotyping (CPT 81232) • TPMT genotyping (CPT 81335) • UGT1A1 genotyping (CPT 81350 • HLA variant analysis (CPT 81381, 81374) Prior authorization is not applicable for the following tests as they are considered investigational/experimental: • COMT genotyping (CPT 0032U) • CYP1A2 genotyping (CPT 0031U) • NUDT15 and TPMT genotyping panel (CPT 81306, CPT 0034U, CPT 0169U) • HTR2A and HTR2C genotyping (CPT 0033U) • SLCO1B1 genotyping (CPT 81328) • VKORC1 genotyping (CPT 81355) • Pharmacogenetic panels (CPT 81231,81230, 81306, 0029U-0030U, 0034U, 0078U, 0173U, 0175U) • TYMS genotyping (CPT 81346) Prior authorization is required for all other pharmacogenetic testing including: • Pharmacogenetic Panel Tests not listed above • Other Single Gene Variant Analysis not listed above • CYP2C19 (CPT 81225) • CYP4F2 • KIF6 • OPRM1 Please refer to the published policy for details.

Coverage Policies	Comments / Changes
Genetic testing for cardiac disorders	New policy effective September 1, 2021. Coverage criteria for genetic testing have been revised or added for the following; prior authorization is required: • Known familial variant analysis testing for cardiac disorders • Comprehensive cardiomyopathy panels and comprehensive arrhythmia panels • Combined comprehensive panels for sudden cardiac death or unexplained death that include genes for both arrhythmias and cardiomyopathies • Congenital Heart Malformation Panels • Multiple gene panels for the following conditions: o Hypertrophic Cardiomyopathy (HCM) o Dilated Cardiomyopathy (DCM), o Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC), o Long QT Syndrome (LQTS) o Brugada Syndrome (BrS) o Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) o Left Ventricular Restrictive Cardiomyopathy (LVNC) o Restrictive Cardiomyopathy (RCM) o Short QT Syndrome (SQTS) o Familial Hypercholesterolemia The following are considered investigational: • Multiple gene panels for Left Ventricular Restrictive Cardiomyopathy (LVNC), Restrictive Cardiomyopathy (RCM), Short QT Syndrome (SQTS) • Combined comprehensive panels for sudden cardiac death or unexplained death that include genes for both arrhythmias and cardiomyopathies Please refer to the published policy for details.
Oncology: Circulating tumor DNA and circulating tumor cells (liquid biopsy)	New policy effective 9/1/2021. Criteria for genetic testing for circulating tumor DNA and circulating tumor cells (liquid biopsy) have been significantly revised. Prior authorization is required for the following: • Molecular Profiling Panel Tests via Circulating Tumor DNA (ctDNA) • Single Gene Molecular Profiling Tests via Circulating Tumor DNA (ctDNA) • AR-V7 Androgen Receptor Splice Variant Analysis in Circulating Tumor Cells (CTCs) Prior Authorization is not required for Circulating Tumor Cell (CTC) Enumeration Analysis as this is considered investigational/experimental and therefore not covered. Please refer to published policy for details.

Coverage Policies	Comments / Changes
Oncology: Cytogenic testing	New policy effective 9/1/2021. Criteria for cytogenic testing have been significantly revised. Prior authorization is required for the following: • ALK Rearrangement Analysis • BCR/ABL Rearrangement Analysis • Bladder Cancer Diagnostic and Recurrence FISH Tests • Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) FISH Panel Analysis • ERBB2 (HER2) Amplification Analysis • Multiple Myeloma FISH Panel Analysis • NTRK Fusion Analysis • PD-L1 Protein Expression Analysis • PML/RARA Rearrangement Analysis • ROS1 Rearrangement Analysis Bladder Cancer Diagnostic and Recurrence FISH Tests (e.g., UroVysion) are considered investigational/experimental and therefore not covered. Please refer to published policy for details.
Oncology: algorithmic testing	New policy effective 9/1/2021. Criteria for algorithmic testing have been significantly revised. Prior authorization is required for the following: • Breast Cancer Treatment and Prognostic Algorithmic Tests • Hormone receptor positive breast cancer prognostic algorithmic tests • Hormone Receptor Agnostic Breast Cancer Prognostic Algorithmic Tests • Gene Expression Profiling Breast Cancer Subtyping Tests • Prostate Cancer Prognostic Algorithmic Tests • Thyroid Cancer Diagnostic Algorithmic Tests • Uveal Melanoma Prognostic Algorithmic Tests • Cutaneous Melanoma Prognostic Algorithmic Tests • Polygenic Risk Score Tests

Coverage Policies	Comments / Changes
Oncology: algorithmic testing – Continued	Prior authorization is not required for the following tests as these are considered investigational/experimental and therefore not covered: • Prostate Cancer Risk Assessment Algorithmic Tests • Prostate Cancer Diagnostic Algorithmic Tests • Breast DCIS Prognostic Algorithmic Tests (0045U) • Colorectal Cancer Prognostic Algorithmic Tests • Gene Expression Profiling Breast Cancer Subtyping Tests • Cutaneous Melanoma Diagnostic Algorithmic Tests • Cutaneous Melanoma Risk Assessment Algorithmic Tests • Ovarian cancer diagnostic algorithmic tests • Ovarian cancer treatment algorithmic tests • Gynecologic Cancer Treatment Algorithmic Tests • Lung Cancer Treatment Algorithmic Tests • Lung Cancer Diagnostic Algorithmic Tests • Bladder Cancer Diagnostic and Recurrence Algorithmic Tests • Urinary Tract Cancer Recurrence Algorithmic Tests • Cancer of Unknown Primary Gene Expression Profiling Tests • BBDRisk Dx™ (0067U) • Onco4D™ (0083U) • Lymph3Cx Lymphoma Molecular Subtyping Assay • LC-MS/MS Targeted Proteomic Assay • PreciseDx™ Breast Cancer Test Prostate cancer risk assessment algorithmic tests specifically—e.g., 4Kscore (81539), Prostate Health Index (86316), SelectMDx™ (81599), ExoDx™ Prostate Test (0005U), Apfinity (0021U)—are considered **investigational**. This does not include 84153 and 84154. Please refer to published policy for details.
Genetic testing for hereditary hearing loss	New policy effective 9/1/2021. Criteria for genetic testing related to hereditary hearing loss have been significantly revised. Prior authorization is required for the following: • Known Familial Variant Analysis related to hearing loss • GJB2 and GJB6 Sequencing and/or Deletion Duplication Analysis or Multigene Panel Analysis Note: Prior authorization is not required for GJB2 and/or GJB6 gene analysis for sensorineural hearing loss when associated with procedure codes 81252-81254 and a primary diagnosis code within H90.3-H90.8. Please refer to published policy for details.

Coverage Policies	Comments / Changes
Genetic testing for hematologic conditions (non-cancerous)	New policy effective 9/1/2021. Criteria for genetic testing related to hematologic conditions have been significantly revised. Prior authorization is required for the following: • Known Familial Variant Analysis for Hematologic Conditions (non-cancerous) • HBA1/HBA2 variant analysis • F8 variant analysis for hemophilia • F9 variant analysis for hemophilia • G6PD variant analysis • Other Covered Hematologic (non-cancerous) Disorders Prior authorization is not required for the following: • Factor V Leiden (F5) and Prothrombin (F2) Variant Analysis for Inherited Thrombophilia (81240) • F5 (Factor V Leiden) Variant Analysis (81241) • HBB Variant Analysis Note: G6PD variant analysis to confirm or establish a diagnosis of glucose-6-phosphate dehydrogenase deficiency is considered not medically necessary. Please refer to published policy for details.
Genetic testing for immune disorders	New policy effective 9/1/2021. Criteria for genetic testing related to immune disorders have been significantly revised. Prior authorization is required for the following: • Periodic Fever Syndromes Multigene Panel • Covered Immune Disorders Prior authorization is not applicable for the following, as the tests are considered investigational/experimental, and therefore, not covered: • Rheumatoid Arthritis Biomarker Tests (81490) • HLA Typing for Ankylosing Spondylitis, Rheumatoid Arthritis, and Autoimmune Disorders Please refer to published policy for details.

Coverage Policies	Comments / Changes

Genetic testing for lung disorders	New policy effective 9/1/2021.
	
	Criteria for genetic testing related to lung disorders have been significantly revised.
	
	Prior authorization is required for the following:
	
	• SERPINA1 Known Familial Variant Analysis
	• SERPINA1 Common Variant Analysis or Sequencing Analysis
	• Other covered lung disorders:
	  o Familial Pulmonary Fibrosis
	  o Primary Ciliary Dyskinesia
	  o Pulmonary lymphangioleiomyomatosis (LAM)
	  o Pulmonary alveolar proteinosis (PAP)
	
	Please refer to published policy for details.

Genetic testing: exome and genome sequencing for the diagnosis of genetic disorders	New policy effective 9/1/2021. Criteria for genetic testing related to exome and genome sequencing have been significantly revised. Prior authorization is required for the following: • Standard exome sequencing • Rapid exome sequencing Prior authorization is not applicable for the following, as the tests are considered investigational/experimental, and therefore, not covered: • Standard Genome Sequencing • Rapid Genome Sequencing Note: Prior Authorization will no longer be needed for the following tests, as the tests are now considered investigational/experimental, and therefore, will no longer be covered: • MNGenome (MNG Laboratories) (0094U) • CNGnome (PerkinElmer Genomics) (0209U) • Rapid Whole Genome Sequencing (Rady Children's Institute for Genomic Medicine) (0094U) Please refer to published policy for details.

Coverage Policies	Comments / Changes
General approach to genetic testing	New policy effective 9/1/2021. Criteria for genetic testing related to general approach to genetic testing have been significantly revised. Prior authorization is required for known familial variant analysis of a genetic condition, single gene analysis of a genetic condition, and multigene panel analysis of a genetic condition. Prior authorization is not required for the following services: • Transplant-related testing for chimerism (81265-81268) Please refer to published policy for details.
Genetic testing for hereditary cancer susceptibility	New policy effective 9/1/2021. Criteria for genetic testing for hereditary cancer susceptibility have been significantly revised. Prior authorization is sometimes required for BRCA1 and BRCA2 testing or hereditary breast cancer susceptibility panels (CPT 0138U, 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217). Prior authorization requirements are based on both the procedure code (CPT) and primary diagnosis code (ICD-10-CM) associated with the genetic testing. Refer to the related content section of the policy for specific information. **Prior authorization is required for all other hereditary cancer susceptibility genetic testing including:** • Pan-Cancer Hereditary Cancer Susceptibility Panels • Hereditary Colorectal Cancer Susceptibility Panels • Hereditary Gastric Cancer Susceptibility Panels • Hereditary Pancreatic Cancer Susceptibility Panels • Hereditary Polyposis Panels • Hereditary Prostate Cancer Susceptibility Panels • Hereditary Neuroendocrine Cancer Susceptibility Panels • Simultaneous Germline and Tumor Molecular Profiling • PALB2 Gene Testing • ATM and/or CHEK2 Gene Testing • Genetic testing for Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer (HNPCC) • Genetic testing for BAP1-Tumor Predisposition syndrome • Genetic testing for Birt-Hogg-Dube syndrome (BHDS) • Genetic testing for Cowden Syndrome (CS)/PTEN Hamartoma Tumor Syndrome (PHTS) • Genetic testing for Familial Adenomatous Polyposis (FAP)/Attenuated FAP (AFAP) • Genetic testing for Familial Atypical Multiple Mole Melanoma Syndrome (FAMMM)

Coverage Policies	Comments / Changes
Genetic testing for hereditary cancer susceptibility – Continued	• Genetic testing for Hereditary Diffuse Gastric Cancer (aka, Signet Ring Cell Gastric Cancer) • Genetic testing for Juvenile Polyposis Syndrome (JPS) • Genetic testing for Hereditary Leiomyomatosis and Renal Cell Cancer (HLRCC) • Genetic testing for Li-Fraumeni Syndrome (LFS) • Genetic testing for Multiple Endocrine Neoplasia – Type 1 (MEN1) and Type 2 (MEN2) • Genetic testing for MUTYH-associated Polyposis (MAP) • Genetic testing for Nevoid Basal Cell Carcinoma (NBCC) syndrome (aka Gorlin syndrome) • Genetic testing for Hereditary Paraganglioma-Pheochromocytoma Syndrome (PGL/PCC) • Genetic testing for Peutz-Jeghers Syndrome (PJS) • Genetic testing for Retinoblastoma • Genetic testing for Von Hippel-Lindau Syndrome (VHL) Please refer to published policy for details.
Oncology: molecular analysis of solid tumors and hematologic malignancies	New Policy Effective 9/1/2021. Prior authorization is not required for some targeted testing related to solid tumors and hematological malignancies. See related content for a list of procedure codes and associated diagnosis codes. Prior authorization is sometimes required for BRCA1 and BRCA2 testing. See related content for a list of procedure codes and associated diagnosis codes. Prior Authorization is not required for the following as these are considered investigational and therefore not covered: • Whole Exome and Whole Genome Sequencing in Solid Tumors • Hematologic Malignancies Prior authorization is required for all other genetic testing including: • Molecular Profiling Panel Testing • Single Gene Testing • Measurable (Minimal) Residual Disease (MRD) Analysis • Genetic Testing to Confirm the Identity of Laboratory Specimens Please refer to the published policy for details.

Coverage Policies	Comments / Changes
Breast and Cervical Cancer (BRCA) Genetic Mutation Testing for Breast and Ovarian Cancer Susceptibility – Minnesota Health Care Programs	New policy effective 9/1/2021. Prior authorization is sometimes required for BRCA1 and BRCA2 testing. See related content for a list of procedure codes and associated diagnosis codes. Coverage criteria per MN Department of Human Services Provider Manual. Please refer to the published policy for details.

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

Pharmacy Medical Policy updates

COMMERCIAL UPDATES

Coverage Policies	Comments / Changes
Avastin (bevacizumab)	Avastin (bevacizumab) has been updated, as of 5/13/2021, to allow coverage of certain eye conditions without prior authorization.

Coverage policy can be found in the medical coverage policy search page, searchable by drug name or billing codes 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.

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