Fast Facts

HealthPartners

NOVEMBER 2022

News for Providers from HealthPartners
Provider Relations & Network Management

Administrative

Seeking clinician information on race, language, ethnicity & cultural competencies

HELP SUPPORT DIVERSITY IN OUR COMMUNITY

We have a great opportunity to continue our partnership with you to serve our increasingly diverse members and community.

We're asking clinicians to share information with us, on a voluntary basis, about their race, ethnicity and specific cultural competencies to provide personalized care that members request. We will use this information to:

- Assist members requesting specific types of provider attributes from HealthPartners Nurse Navigators and Member Services staff.
- Display your race, ethnicity and cultural competencies in our online provider directory, with your permission.
- Ensure our provider network is representative of the diversity within our communities.

Providing this information is optional, but we hope clinicians in your practices will complete the **Clinician Information for Diversity and Health Equity form** to support our ethnically, racially and culturally diverse communities.

- For every form completed, HealthPartners will donate $1 in charitable donations to one of the following organizations to continue the advancement of provider diversity and health equity in our communities.
- **Diverse Medicine Inc.**
- **National Black Nurses Association**
- **National Hispanic Health Foundation**

Please share **THIS LINK** to the form with your clinicians so they can complete and submit it, and support the work of these organizations in increasing diversity in medical fields and supporting health equity in our communities. Thank you again for your partnership.

INSIDE THIS ISSUE

Attachments:

- Provider Directory Cultural Competency and ADA Accessibility Questionnaire
- Pip Fax Form

Cultural competency training and office accessibility

HealthPartners and all health plans are required to maintain accurate information in our provider directories including information regarding Cultural Competency Training for providers and whether provider locations are accessible for members with disabilities. Please take a moment to complete the **Questionnaire** included as part of this edition of Fast Facts. Instructions are on the form for returning the information to HealthPartners or send to **providercompliance@healthpartners.com**.

Disease, Case and Lifestyle Management services

Our experienced care navigators take each member's unique preferences, health status and social determinants of health, language and cultural background into account when offering one-on-one support. An important strength of our approach is helping members understand and maximize their health plan benefits. Our medical management team works closely with Member Services to ensure members understand their coverage, network structure and potential costs in relation to their health needs.

SERVICES WE OFFER

HealthPartners offers telephonic support for members of all ages who use high-cost services, have multiple health issues, have deteriorating health or are at risk for a hospitalization in the next six to 12 months.

These include:

- Medical disease management (asthma, COPD, CAD, heart failure, diabetes, rare diseases)
- Complex case management (multiple conditions)
- Behavioral health case management
- Medication therapy management (4+ medications)
- Tobacco cessation
- Adult obesity counseling (BMI 30 or greater)
- High-risk pregnancy support

HOW IT WORKS

HealthPartners case management nurses, pharmacists and behavioral health clinicians work with members between clinic visits to provide complementary support to reinforce provider-established care plans. This includes educating, motivating and engaging them in being active participants in their own care. We make referrals simple and easy.

- Online: Use our **online referral form**
- Email: **hpconnectreferrals@healthpartners.com**; include patient name, DOB and reason for referral
- Phone: **1-800-871-9243;** leave a voicemail on this confidential line if the call is not immediately answered

Discussing denied authorizations for healthcare services

If an authorization request for healthcare services or items was denied based on coverage criteria, the member or provider has the right to discuss the denial with the clinician involved in making the decision in our prior authorization program. Staff is available 8 AM to 5 PM Central Standard Time, Monday through Friday, excluding national holidays.

Call Member Services for assistance at **952-883-5000.**

HealthPartners policy regarding financial incentives

It is the policy of HealthPartners that utilization review decisions are made based only on appropriateness of care, service and existence of coverage. Financial incentives, if any, that are offered by HealthPartners (or any entity that contracts with HealthPartners to provide utilization management services) to individuals or entities involved in making utilization management decisions will not encourage decisions that result in underutilization or inappropriate restrictions of and/or barriers to care and services.

This means that HealthPartners and entities contracting with HealthPartners to provide utilization management services will not specifically reward, hire, promote, compensate, retain or terminate practitioners or other individuals conducting utilization review based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial or benefits.

If you have any additional questions, please contact Susan Gunderson at **952-883-5576**

Reimbursement at Observation Level of Care for Specified Diagnoses

The HealthPartners Reimbursement at Observation Level of Care for Specified Diagnoses policy is being updated with new diagnosis codes and additional applicable products effective 1/1/2023. Please refer to the Reimbursement at Observation Level of Care for Specified Diagnoses policy for a complete list of diagnoses requiring supporting clinical documentation of the inpatient admission. The specified diagnosis will be considered an observation stay and will be paid as an observation visit unless clinical information is submitted supporting the inpatient admission. Failure to submit the supporting clinical documentation once requested may result in denial to provider liability. Providers will be held financially responsible and may not bill members for the cost of service when the supporting documentation is not provided to support the admission. This policy is applicable to all members who have HealthPartners Commercial, Medicaid and Medicare Advantage insurance as their primary coverage.

Vaccine hesitancy training modules available

TRUSTED MESSENGERS

CHW Solutions, the Minnesota Department of Health, the National Resource Center for Refugees, Immigrants, and Migrants (**NRC-RIM**), and others have collaborated to create on-demand training modules for community health workers (CHWs), public health professionals, community groups, nurses and clinicians.

This training uses excerpts from the **Trusted Messenger documentary**, which highlights how a diverse ensemble of healthcare professionals works to overcome COVID-19 vaccine hesitancy in marginalized communities in Minnesota. These excerpts are combined with both facilitation and discussion guides to support the various audiences in their efforts to have effective and compassionate conversations with patients and loved ones about health-related topics. Materials include Spanish versions for CHWs and community groups.

The pandemic has confirmed for us what we already knew: that trusted messengers have incredible influence in their communities, and it is worth the investment of time and patience to be able to have effective conversations with others. The lessons learned through this training can be applied to not just COVID-19, but other public health measures around routine vaccinations, infectious diseases and other health topics.

Hip and knee joint replacement surgery policy change

EFFECTIVE 1/1/2023

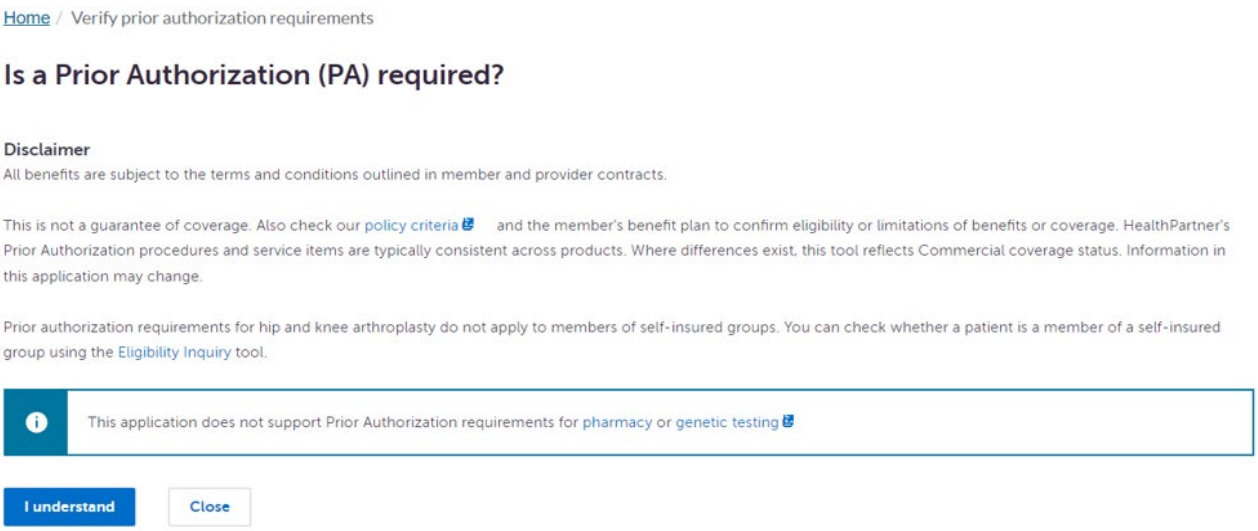
HealthPartners will require provider authorization for hip and knee joint replacement and revision. This policy is applicable to all members who have HealthPartners fully insured coverage, including fully insured commercial members, Minnesota Health Care Programs (Medicaid) members and Medicare Advantage Members. Prior authorization requirements for hip and knee arthroplasty do not apply to self-insured members.

IMPORTANT INFORMATION

- **Prior auth links:** **Prior Authorization Form – Knee** **Prior Authorization Form - Hip**
- Prior authorizations can be submitted online by logging into your HealthPartners Provider Portal account and creating a new **prior auth request**
- Here is a link to the coverage criteria for hip and knee replacement and revisions: **Hip/knee joint replacement policy**
- You can check which procedure codes require prior authorization at **healthpartners.com/verifyparequirements** or visit **healthpartners.com/provider-public/**; then click on *Verify PA requirements* in the **Shortcuts** box on the left-hand side of this landing page. This application can be used to determine if any procedure codes require prior authorization, not just hip and knee replacement and revision codes.

FREQUENTLY ASKED QUESTIONS

1. **How are surgeries scheduled prior to announcement of this policy handled?** All hip and knee replacement and revisions surgeries for fully insured members will require prior authorization effective 1/1/2023, even if the surgery was scheduled before this policy was announced. Prior authorizations for these procedures should still be submitted.
2. **Does the surgical practice or hospital submit the prior authorization form?** The surgical practice should submit the prior authorization form. The surgical practice has the clinical information necessary to complete the form.
3. **Are all fully insured members included?** Yes, commercial fully insured members from plans issued MN, ND, SD, IA and WI are included. Government-sponsored plans are also included.
4. **What happens if I submit a prior authorization form for a self-insured member?** You will receive a response from HealthPartners indicating this member does not require a prior authorization for this service.
5. **Why is HealthPartners choosing to prior authorize these procedures?** Hip and knee replacements and revisions are expensive procedures, cost in excess of $23,000, and we need to verify that members meet surgical criteria prior to incurring an expense of this magnitude.



Mandatory reporting for pregnant women

In July 2021 changes to the mandatory reporting laws in Minnesota took effect in an effort to improve access to prenatal care for people at risk of substance use. As of July 2021, providers in health care and social services who are actively caring for pregnant people are *not required* to report the use of controlled substances. This change has caused a lot of confusion in the medical community.

If you would like to hear about how this change has been operationalized in some settings or have questions about this change, the December 13th Hennepin Healthcare ECHO session about Perinatal Substance Use will focus on this topic. The discussion will be led by Drs Cresta Jones and Katie Thorsness, and is co-sponsored by Hennepin Healthcare, MN Medical Association and the Medicaid health plans Healthy Start PIP Collaborative. Learn more about ECHO at **Project ECHO - Hennepin Healthcare**.

STEPS for increasing colorectal cancer screening rates

The National Colorectal Cancer Roundtable has released an updated guide for increasing colorectal cancer screenings in primary care practices. A primary care clinician recommendation is the most powerful influence on a patient's decision to get screened for cancer. Through a step-by-step format, this newly updated manual provides evidence-based, expert-endorsed strategies to improve colorectal cancer screening rates in primary care practices.

The 2022 edition includes:

- An expanded scope to include all primary care settings
- Current screening guidelines and new screening modalities
- Expert-endorsed strategies
- Samples, templates and tools
- Updated literature references

Find the guide as well as sample social media and other supporting materials at the **NCCR Website**.

No Surprises Act directory verification

In addition to requirements related to billing and reimbursement changes, the No Surprises Act also requires verification of directory information by providers on a quarterly basis. HealthPartners providers are expected to verify:

- Practitioner and location names
- Addresses
- Phone numbers
- Office hours
- Provider website URLs, if available
- Accepting new patients

There are several avenues for providers to verify this information through our secure Provider Data Profiles application on **healthpartners.com/provider** or through submission of provider rosters for medical groups with more than five locations and more than 30 practitioners. Work is underway to connect with providers missing verification to ensure members have the most up-to-date information for informed provider decisions. We are looking forward to working with you to make sure your data is correct.

Fraud, waste and abuse

Fraud, waste and abuse in healthcare ultimately makes care and coverage more expensive and less safe. HealthPartners is committed to preventing, detecting and reporting fraud, waste and abuse (FWA), and conducting business in compliance with all applicable federal and state statutes, regulations and laws. Clinicians are also responsible for exercising due diligence in the detection and prevention of fraud, waste and abuse in accordance with our Fraud, Waste and Abuse (FWA) policies.

Fraud, waste and abuse in healthcare can take many forms, which can make it hard to spot. Health care fraud can be committed by medical providers, patients and others who intentionally deceive the health care system to receive unlawful benefits or payments. Here are a few of the most common types:

- Billing and coding fraud, including
    - Billing a payer for services or supplies that weren't provided
    - Ordering or providing services or supplies that aren't medically necessary
    - Up-coding or billing for more expensive services than those that were provided
- Telehealth schemes, such as kickbacks for referrals for unnecessary testing and medical equipment
- COVID-19 related fraud, which may include ordering unnecessary COVID testing in order to steal and/or sell a patient's information
- Fraud involving prescription drugs, such as:
    - Creating or using forged prescriptions
    - Drug diversion, or the illegal distribution or abuse of prescription drugs
    - Doctor shopping, or visiting multiple providers to get prescriptions for controlled substances, or getting prescriptions from medical offices that engage in unethical practices

Reporting fraud, waste and abuse is everyone's right and responsibility. To report suspected fraud, waste or abuse, you may call the HealthPartners Integrity and Compliance Hotline at **1-866-444-3493**, or the HealthPartners Fraud and Abuse Hotline at **952-883-5099**, or send an e-mail to **reportfraud@healthpartners.com**.

Please review the **Preventing, Detecting & Reporting Fraud, Waste & Abuse policy** and share it with others within your organization who may need to be aware of this information. Feel free to call Steve Bunde, Health Plan Compliance Officer, at **952-883-6541** if you have any questions or concerns.

Spam and phishing emails

Cybercrime in health care is on the rise, and cybercriminals are using phishing emails to target providers. Email scams come in different forms and can be tricky to spot. Phishing emails masquerade as trustworthy messages and try to trick you into doing what fraudsters want. Phishing emails may pressure you to open/download files, click email links or attachments, and/or enter sensitive information into a website. When phishing emails are successful, attackers can steal money, usernames and passwords to access accounts, or infect computer networks – damaging an organization's ability to provide care and services.

Rest assured HealthPartners emails come from the email domain of "@HealthPartners.com." If you hover over links in emails from HealthPartners, they'll lead to HealthPartners.com. If you ever have questions about a HealthPartners communication, reach out to your HealthPartners representative to verify the authenticity of a communication.

SPOT THE SPAM: ASK WHO, WHAT AND WHY?

WHO

Who's the sender? Is the sender familiar? Does the sender's email address match the sender's name?

NOTE – Look closely at the spelling in the email address and domain, along with spelling in the email message. Scammers can be tricky and may know you're likely to receive emails from HealthPartners and may try to replicate our name and email messages. If a sender's name or email address don't match previous communications, use extra caution with the message.

WHAT

What's the email trying to get you to do: Does the email contain a link or attachment? Is the link URL (hover over the link with your mouse) different from the email topic or sender? Is what they're asking strange?

If the answer to all these questions is yes, use extra caution before taking any action with the email. Phishing emails can have a topic that doesn't make sense for the sender or creates a sense of urgency, anxiety, loss or is pushy. They also can leave out details or sounds too good to be true. Hovering your cursor over links may show a different website address than the topic or sender of the email. If the email appears phishy, do not interact with it.

WHY

Why are you receiving the email? Is it expected? Does it sound reasonable?
For example: Do you receive emails or notifications as authorized contact or delegate for your organization? Did you authorize an action on HealthPartners provider account?

You can protect your organization and the people you serve by spotting and not acting on phishing emails.

Medical Policy Updates – 11/1/2022

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
Category III CPT codes – Minnesota Health Care Programs	• Effective 9/13/2022, the following services now covered per updated DHS guidance: ○ **0404T** - Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency. • Prior authorization is not required.
Investigational services – list of non-covered services	• Effective immediately, the following has been added as a non-covered service: ○ **64590** - Implantable peripheral nerve stimulation for treatment of urinary incontinence (e.g., eCoin). **Note**: code provided is not specific to this device, but is considered investigational when used to report this service
Dental services - orthognathic surgery	• Effective immediately: Indications not covered section of this policy has been revised to reflect services not covered under the medical benefit. • Effective 1/1/2023: All guidance related to coverage of orthognathic surgery for treatment of temporomandibular disorder (TMD) will be located exclusively on the Temporomandibular disorder (TMD) treatments policy.

Coverage Policies	Comments / Changes
Temporomandibular disorder (TMD) treatments	• Effective 1/1/2023: Orthognathic surgery for surgical treatment of TMD will be considered when all criteria are met: ○ Physical symptoms including, but not limited to, pain, impaired mandibular range of motion, locking of the jaw; and ○ Observation of TMJ instability or dysfunction; and ○ Documentation of 3-6 months of conservative treatment when determined appropriate that includes but is not limited to, physical therapy, analgesics and oral appliances; and ○ Documentation of significant impairment of function and or internal derangement of the joint which is not amenable to improvement with non-surgical care; and ○ Documentation from a TMD Specialist, Orofacial Pain Specialist, or requesting surgeon clearly explains why a member's clinical condition cannot be treated with conventional surgical TMD procedures.
Breast surgery	Effective 1/1/2023, policy revised to indicate that requests for breast reconstruction due to Poland syndrome are reviewed on a case by case basis and require prior authorization.
Synagis (palivizumab) injections for respiratory syncytial virus (RSV) prophylaxis – Minnesota Health Care Programs	Effective immediately, policy revised to reflect changes to DHS coverage criteria for Synagis for the 2022-2023 RSV season. Members who meet criteria are now eligible for up to eight (8) monthly Synagis injections. This is an increase over the five (5) monthly doses that members were eligible for during the 2021-2022 RSV season. Requests for Synagis continue to require prior authorization.
Genetic testing - pharmacogenetics	Effective 1/1/2023, policy has been updated for alignment with practice guidelines and literature. • Coverage criteria for CYP2C19 variant analysis to determine drug metabolizer status has been expanded to include the following: ○ The member is being considered for or is currently undergoing treatment with clopidogrel (Plavix); **and** ○ The member meets **all** of the following: ▪ Will be undergoing percutaneous coronary intervention (PCI); ▪ Has acute coronary syndromes (ACS); ▪ Is at high risk for poor outcomes (e.g., urgent PCI for ACS event, elective PCI for unprotected left main disease or last patent coronary artery).
Genetic testing: aortopathies and connective tissue disorders	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature. **FBN1 sequencing for Marfan Syndrome** • FBN1 sequencing and/or deletion/duplication analysis is considered medically necessary when: • The member has some of the below symptoms of Marfan syndrome but does not meet the clinical diagnostic criteria for a diagnosis. ○ The clinical diagnostic criteria are as follows: ▪ Aortic root enlargement (Z-score >2.0 or greater) or dissection, and ▪ Ectopia lentis, or

Coverage Policies	Comments / Changes
Genetic testing: aortopathies and connective tissue disorders - Continued	▪ A systemic score of >7 or greater, as demonstrated by the following clinical features and associated scores*: • Wrist and thumb sign (3) • Wrist or thumb sign (1) • Pectus carinatum deformity (2) • Pectus excavatum or chest asymmetry (1) • Hindfoot deformity (2) • Plain flat foot (pes planus) (1) • Pneumothorax (2) • Dural ectasia (2) • Protrusio acetabulae (2) • Reduced upper segment/lower segment AND increased arm span/height ratios (1) • Scoliosis or thoracolumbar kyphosis (1) • Reduced elbow extension (1) • 3 of 5 facial features (dolichocephaly, downward slanting palpebral fissures, enophthalmos, retrognathia, malar hypoplasia) (1) • Skin striae (1) • Myopia (1) • Mitral valve prolapse (1) **or** • The member has a close relative with a documented clinical diagnosis of Marfan syndrome and the member had symptoms of Marfan syndrome, but the member **does not** meet clinical criteria for diagnosis of an individual with a family history of Marfan syndrome, which are: o Clinical diagnostic criteria for an individual with a family history of Marfan syndrome: ▪ Ectopia lentis; or ▪ Multiple systemic features (see above criterion); or ▪ A dilated aortic root (if over 20 years, greater than two standard deviations; if younger than 20, greater than three standard deviations). **Loeys-Dietz Syndrome Multigene Panel** • Loeys-Dietz syndrome (LDS) multigene panel analysis are considered medically necessary when: • The member meets all the following: o Characteristic facial features, including widely spaced eyes and craniosynostosis; and o Bifid uvula or cleft palate; and o Tortuosity of the aorta and its branches; or • The member has a first degree relative with a clinical diagnosis of LDS; and • The panel includes, at a minimum, the following genes: TGFBR1 and TGFBR2.

Coverage Policies	Comments / Changes
Genetic testing: aortopathies and connective tissue disorders - Continued	**Familial Thoracic Aortic Aneurysm and Dissection (TAAD) Multigene Pane** • TAAD multigene panels are considered medically necessary when: • The member has aortic root enlargement (Z-score greater than 2.0) or has had a type A or type B aortic dissection; and • The member does not have any major criteria for diagnosis of another connective tissue disorder; or • The member has a family history of dilation or dissection of the aortic root, consistent with autosomal dominant inheritance; and ○ The panel includes, at a minimum, the following genes: ACTA2, FBN1, MYH11, SMAD3, TGFBR1, TGFBR2.

Genetic testing: epilepsy, neurodegenerative, and neuromuscular disorders	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature.
	Duchenne and Becker Muscular Dystrophy
	• An additional criterion for DMD Sequencing and/or Deletion/Duplication Analysis to establish or confirm a diagnosis of Becker Muscular Dystrophy is added to the current criteria as follows:
	  ○ The member has an elevated serum creatine kinase concentration, typically more than 5 times the normal levels.
	Hereditary Spastic Paraplegia Multigene Panel
	Criteria for multigene panel analysis to establish a genetic diagnosis of hereditary spastic paraplegia is revised as follows:
	• The member has any of the following:
	  ○ Lower-extremity spasticity especially in hamstrings, quadriceps, adductors, and gastrocnemius-soleus muscles; or
	  ○ Weakness especially in the iliopsoas, hamstring, and tibialis anterior; or
	  ○ Lower-extremity hyperreflexia and extensor plantar responses; or
	  ○ Mildly impaired vibration sensation in the distal lower extremities; and
	• A multigene panel must include the following genes, at a minimum: SPAST, ATL1, KIF1A, CYP7B1, SPG7, SPG11.

Genetic testing: prenatal diagnosis (via amniocentesis, CVS or PUBS) and pregnancy loss	Effective 1/1/23, policy has been updated for alignment with practice guidelines and literature. • Coverage criteria for **chromosomal microarray analysis and conventional karyotype analysis for prenatal diagnosis** have been revised. These tests are now considered medically necessary when the member has received counseling regarding the benefits and limitations of prenatal screening and diagnostic testing (including chromosomal microarray via amniocentesis, CVS or PUBS) for fetal chromosomal abnormalities. • Coverage criteria for **conventional chromosomal analysis for pregnancy loss** have been revised. These tests are now considered medically necessary in a member who has a history of two or more consecutive clinical pregnancy losses.

Coverage Policies	Comments / Changes

Hip and knee joint replacement surgery	• New policy effective 1/1/2023. Prior authorization is required for hip and knee joint replacement surgery, including hemiarthroplasty, patellofemoral arthroplasty, revision of total hip or knee replacement, and prosthesis removal. HealthPartners will utilize MCG Care Guidelines coverage criteria as follows:
	  ○ For hip replacement, including hemiarthroplasty and revisions: MCG 26th Edition: ISC Hip Arthroplasty (S-560) and MCG 26th Edition: ISC Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty (S-600)
	  ○ For knee replacement and revisions: MCG 26th Edition: ISC Knee Arthroplasty, Total (S-700)
	  ○ For patellofemoral arthroplasty or prosthesis removal: GRG: Musculoskeletal Surgery or Procedure GRG (SG-MS) (General Recovery Care) = GRG
	• Please see published policy for details.
	• Prior authorization is also required for these services for members on Medicare plans beginning 1/1/23. MCG Care Guidelines will apply when a Local Coverage Determination does not exist.
	• Prior authorization requirements do not apply to members of self-insured groups.

Repetitive transcranial magnetic stimulation	Effective 1/1/2023: • Policy title will change to Transcranial magnetic stimulation. • At least two months must pass between initial and repeat courses of treatment. • More than one repeat course of TMS is considered investigational as there is insufficient reliable evidence supporting the efficacy of multiple courses of treatment. • Navigated transcranial magnetic stimulation (nTMS) is considered experimental/investigational for any indication due to a lack of sufficient evidence supporting efficacy. • Direct supervision by a physician will no longer be required.
Outdoor/wilderness therapy programs	Effective immediately: Policy has been retired. This service is a non-covered benefit/contract exclusion.
Genetic testing: hereditary cancer susceptibility	Effective 1/1/2023, policy has significant revisions as follows (Please refer to published policy for specific details.): Prior authorization is still required. • Criteria expanded for Hereditary Breast Cancer Susceptibility Panels, BRCA1/BRCA2 Sequencing/Deletion/Duplication Analysis, and PALB2 Sequencing/Deletion/Duplication Analysis sections in the policy. • Hereditary Colorectal Cancer Susceptibility Panels section title changed to Hereditary GI/Colon Cancer Panel Tests with removal of several covered clinical indications and addition of two colorectal cancer indications. Expanded list of minimum required genes to be included in requested panels. • Addition of two clinical indications for coverage under the Hereditary Pancreatic Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Addition of several clinical indications under the Hereditary Prostate Cancer Susceptibility Panels section.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility - Continued	• Addition of MEN1 and MEN2 under the Hereditary Neuroendocrine Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Removal of several clinical indications under the APC Sequencing and/or Deletion/Duplication Analysis section. Addition of known familial mutation in APC and Multifocal/bilateral congenital hypertrophy of the retinal pigment epithelium (CHRPE). • Under CDH1 sequencing and/or deletion/duplication analysis for Hereditary Diffuse Gastric Cancer, addition of a personal history of cancer and a CDH1 pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis has not yet been performed. • Revision and addition of one clinical indication under the SMAD4/BMPR1A Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under TP53 targeted variant analysis. • Addition of clinical indication under MEN1 sequencing and/or deletion/duplication analysis. • Addition/removal of clinical indications under the TP53 Sequencing and/or Deletion/Duplication Analysis section. • Addition of "all polyps at least 5mm" under MUTYH sequencing and/or deletion/duplication analysis. • Addition of clinical indication under STK11 targeted variant analysis for Peutz-Jeghers syndrome. • Addition/removal of clinical indications under the VHL Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under PTEN Targeted Variant Analysis. • Addition of several clinical indications under PTEN sequencing and/or deletion/duplication analysis. • Clinical indication added for personal history of colorectal and/or endometrial cancer with PREMM5 score of 2.5% or greater under MLH1, MSH2, MSH6, PMS2, or EPCAM Sequencing and/or Deletion/Duplication Analysis. • For Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer testing, PTEN Targeted Variant Analysis, CDH1 Targeted Variant Analysis, SMAD4/BMPR1A Targeted Variant Analysis, TP53 Targeted Variant Analysis, MUTYH Targeted Variant Analysis, and STK11 Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a blood relative with a known pathogenic or likely pathogenic variant of the target gene. • For FLCN Targeted Variant Analysis, FH Targeted Variant Analysis, and VHL Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a first- or second-degree relative with a known pathogenic or likely pathogenic variant of the target gene.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility Minnesota Health Care Programs (MHCP) policy	Effective 1/1/2023, the MHCP policy has significant revisions as follows (Please refer to published policy for specific details.): Prior authorization is still required. • Criteria expanded for Pan-Cancer Hereditary Cancer Susceptibility Panels, Hereditary Breast Cancer Susceptibility Panels, Hereditary Pancreatic Cancer Susceptibility Panels, Hereditary Prostate Cancer Susceptibility Panels, and PALB2 Sequencing/Deletion/ Duplication Analysis sections in the policy. • Hereditary Colorectal Cancer Susceptibility Panels section title changed to Hereditary GI/Colon Cancer Panel Tests with removal of several covered clinical indications and addition of two colorectal cancer indications. Expanded list of minimum required genes to be included in requested panels. • Addition of two clinical indications for coverage under the Hereditary Pancreatic Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Addition of several clinical indications under the Hereditary Prostate Cancer Susceptibility Panels section. • Addition of MEN1 and MEN2 under the Hereditary Neuroendocrine Cancer Susceptibility Panels section. Expanded list of minimum required genes to be included in requested panels. • Removal of several clinical indications under the APC Sequencing and/or Deletion/Duplication Analysis section. Addition of known familial mutation in APC and Multifocal/bilateral congenital hypertrophy of the retinal pigment epithelium (CHRPE). • Under CDH1 sequencing and/or deletion/duplication analysis for Hereditary Diffuse Gastric Cancer, addition of a personal history of cancer and a CDH1 pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis has not yet been performed. • Revision and addition of one clinical indication under the SMAD4/BMPR1A Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under TP53 targeted variant analysis. • Addition of clinical indication under MEN1 sequencing and/or deletion/duplication analysis. • Addition/removal of clinical indications under the TP53 Sequencing and/or Deletion/Duplication Analysis section. • Addition of “all polyps at least 5mm” under MUTYH sequencing and/or deletion/duplication analysis. • Addition of clinical indication under STK11 targeted variant analysis for Peutz-Jeghers syndrome. • Addition/removal of clinical indications under the VHL Sequencing and/or Deletion/Duplication Analysis section. • Addition of clinical indication under PTEN Targeted Variant Analysis. • Addition of several clinical indications under PTEN sequencing and/or deletion/duplication analysis.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility *Minnesota Health Care Programs (MHCP) policy - Continued*	• Clinical indication added for personal history of colorectal and/or endometrial cancer with PREMM5 score of 2.5% or greater under MLH1, MSH2, MSH6, PMS2, or EPCAM Sequencing and/or Deletion/Duplication Analysis. • For Lynch Syndrome/Hereditary Nonpolyposis Colorectal Cancer testing, PTEN Targeted Variant Analysis, CDH1 Targeted Variant Analysis, SMAD4/BMPR1A Targeted Variant Analysis, TP53 Targeted Variant Analysis, MUTYH Targeted Variant Analysis, and STK11 Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a blood relative with a known pathogenic or likely pathogenic variant of the target gene. • For FLCN Targeted Variant Analysis, FH Targeted Variant Analysis, and VHL Targeted Variant Analysis: Changed criteria regarding requirement that a member has a close relative with a known pathogenic or likely pathogenic variant of the target gene to a requirement that a member has a first- or second-degree relative with a known pathogenic or likely pathogenic variant of the target gene.
Genetic testing: immune, autoimmune, and rheumatoid disorders	Effective 1/1/2023, policy revised as follows: • New section added: Genetic Algorithmic Rheumatoid Arthritis Tests for Tumor Necrosis Factor Inhibitor (TNFi) Treatment. These tests are considered investigational and not covered.
Genetic testing: oncology – circulating tumor DNA and circulating tumor cells (liquid biopsy)	Effective 1/1/2023, policy revised as follows: • Metastatic colorectal cancer will be included as an additional covered diagnosis under Comprehensive molecular profiling panel tests via circulating tumor DNA (liquid biopsy). Prior authorization is still required. • For Lung Cancer Focused Panel Tests via Circulating Tumor DNA (ctDNA) and EGFR Variant Analysis via ctDNA sections: Removed clinical indication “The member does not have a biopsy-amenable lesion” from the criteria sets. Replaced with two indications requiring completion of a biopsy with either insufficient material for molecular analysis, or the tissue was not able to be assessed due to availability of testing methodologies. Prior authorization is required. • Removed NRAS Variant Analysis via circulating tumor DNA via ctDNA section from the policy as NRAS Variant Analysis, as a standalone test, is no longer an orderable test. Previously this testing was considered investigational. • Prior Authorization will be required for Colorectal cancer focused panel tests via circulating tumor DNA (ctDNA). Criteria will include coverage when the member has metastatic colorectal cancer, and the panel includes KRAS, NRAS and BRAF analysis. • EGFR variant analysis testing will no longer allow testing for a member who does not have a biopsy amenable lesion. Additional covered indications will include: Biopsy was performed but material was insufficient for molecular analysis, or Biopsy was performed but molecular analysis was not able to be completely assessed on tissue due to availability of testing methodologies. Prior authorization is required.

Coverage Policies	Comments / Changes

Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies	Effective 1/1/2023, policy revised as follows:
	Prior authorization is still required.
	• Revisions made to Comprehensive Molecular Profiling Panels for Hematologic Malignancies and Myeloid Malignancy Panels section:
	  ○ A member having a suspected or confirmed diagnosis of acute myeloid leukemia is no longer a covered indication. Instead, a member is to have blood work (CBC) and bone marrow evaluation which are consistent with acute myeloid leukemia.
	  ○ A member with a myelodysplastic syndrome newly diagnosed is no longer a covered indication.
	  ○ A member suspected to have a myeloproliferative neoplasm with clinical suspicion for a myeloid neoplasm remaining high is no longer a covered indication.
	  ○ For a suspected myeloproliferative neoplasm, a comprehensive panel is to be ordered, if applicable, as part of an initial evaluation, or ordered after a negative JAK2/CALR/MPL analysis.
	• Adding new section to policy with prior authorization required: Tumor Agnostic Molecular Profiling Panel Tests with Immunohistochemical (IHC) and Cytogenetic Analyses. Testing indicated for a member with recurrent, relapsed, refractory, metastatic, or advanced (stages III or IV) cancer who is seeking further cancer treatment and, either has not had tumor molecular profiling, or has had previous tumor molecular profiling with a new primary cancer diagnosis requiring the testing.
	• Indeterminate thyroid nodules requiring biopsy added as a covered indication under BRAF variant analysis testing.
	• Revisions made to FLT3 Variant Analysis section:
	  ○ Removed previous negative testing for BCR-ABL1 from the list of indications.
	  ○ Added diagnosis of myelodysplastic syndrome to the list of indications for this testing.
	• Revisions made to Tumor Specific KRAS Targeted Mutation Analysis Tests section:
	  ○ Metachronous colorectal cancer revised to unresectable metachronous colorectal cancer.
	  ○ Removed diagnosis of uterine sarcoma from indications.
	• Removed anaplastic oligoastrocytoma from the list of indications under the MGMT Methylation Analysis Tests section.
	• Removed “locally advanced or metastatic pancreatic adenocarcinoma” and “unresectable or metastatic Ewing’s sarcoma” from the list of indications under the Microsatellite Instability Analysis (MSI) section.
	• Removed uterine carcinosarcoma from the list of indications under the Tumor Specific PIK3CA Targeted Mutation Analysis section.

Coverage Policies	Comments / Changes

Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies
 	
Minnesota Health Care Programs (MHCP) policy
	Effective 1/1/2023, the MHCP policy is revised as follows:
	Prior authorization is still required.
	• Revisions made to Comprehensive Molecular Profiling Panels for Hematologic Malignancies and Myeloid Malignancy Panels section:
	  ○ A member having a suspected or confirmed diagnosis of acute myeloid leukemia is no longer a covered indication. Instead, a member is to have blood work (CBC) and bone marrow evaluation which are consistent with acute myeloid leukemia.
	  ○ A member with a myelodysplastic syndrome newly diagnosed is no longer a covered indication.
	  ○ A member suspected to have a myeloproliferative neoplasm with clinical suspicion for a myeloid neoplasm remaining high is no longer a covered indication.
	  ○ For a suspected myeloproliferative neoplasm, a comprehensive panel is to be ordered, if applicable, as part of an initial evaluation, or ordered after a negative JAK2/CALR/MPL analysis.
	• Adding new section to policy with prior authorization required: Tumor Agnostic Molecular Profiling Panel Tests with Immunohistochemical (IHC) and Cytogenetic Analyses. Testing indicated for a member with recurrent, relapsed, refractory, metastatic, or advanced (stages III or IV) cancer who is seeking further cancer treatment and either has not had tumor molecular profiling, or has had previous tumor molecular profiling with a new primary cancer diagnosis requiring the testing.
	• Indeterminate thyroid nodules requiring biopsy added as a covered indication under BRAF variant analysis testing.
	• Revisions made to FLT3 Variant Analysis section:
	  ○ Removed previous negative testing for BCR-ABL1 from the list of indications.
	  ○ Added diagnosis of myelodysplastic syndrome to the list of indications for this testing.
	• Revisions made to Tumor Specific KRAS Targeted Mutation Analysis Tests section:
	  ○ Metachronous colorectal cancer revised to unresectable metachronous colorectal cancer.
	  ○ Removed diagnosis of uterine sarcoma from indications.
	• Removed anaplastic oligoastrocytoma from the list of indications under the MGMT Methylation Analysis Tests section.
	• Removed “locally advanced or metastatic pancreatic adenocarcinoma” and “unresectable or metastatic Ewing’s sarcoma” from the list of indications under the Microsatellite Instability Analysis (MSI) section.
	• Removed uterine carcinosarcoma from the list of indications under the Tumor Specific PIK3CA Targeted Mutation Analysis section.

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

BEHAVIORAL HEALTH

Coverage Policies	Comments / Changes
Repetitive transcranial magnetic stimulation	Effective 1/1/2023: • Policy title will change to Transcranial magnetic stimulation. • At least two months must pass between initial and repeat courses of treatment. • More than one repeat course of TMS is considered investigational as there is insufficient reliable evidence supporting the efficacy of multiple courses of treatment. • Navigated transcranial magnetic stimulation (nTMS) is considered experimental/investigational for any indication due to a lack of sufficient evidence supporting efficacy. • Direct supervision by a physician will no longer be required.
Outdoor/wilderness therapy programs	Effective immediately: Policy has been retired. This service is a non-covered benefit/contract exclusion.

Drug Formulary updates

COMMERCIAL DRUG FORMULARY

Updates include:

- Budesonide (Pulmicort Flexhaler) will require prior authorization (PA), updating from formulary to formulary with PA. Pulmicort is reserved for patients who are pregnant or are trying to become pregnant.
- Insulin detemir (Levemir) is updating from a formulary medication with prior authorization to non-formulary with PA. Levemir is reserved for patients with an inadequate response to preferred alternatives.
- Aspirin 325mg is updating from a formulary ACA medication to a not-covered OTC status due to guideline updates.
- Weight Loss medication coverage is being updated. Semaglutide (Wegovy) and liraglutide (Saxenda) are being added to formulary with PA; and PA criteria for naltrexone/bupropion (Contrave) and phentermine/topiramate (Qsymia) are being updated. Wegovy and Saxenda will be allowed as first-line options.
    - PA Coverage Criteria: These weight loss medications are reserved for:
        - Patients with a body mass index (BMI) greater than 30 kg/m2, or greater than 27 kg/m2 with risk factors; and
        - Provider attestation of participation in a weight loss program addressing diet and exercise for at least two months prior to initiation of therapy (programs can include clinic-based or third-party programs); and
        - Two or more clinic appointments discussing weight loss and lifestyle changes (with provider, diabetes educator or dietician) in the previous six months prior to initiation of therapy.
    - Coverage duration: Initial approvals are for six months. Coverage will be extended for one year for patients with a positive response and continuing participation in a weight loss program addressing diet and exercise.
    - Pharmacy coverage follows benefit plan documents for coverage of weight loss medications.
- Lipase/protease/amylase (Zenpep) is being added to formulary.
- Ofatumumab (Kesimpta) will require prior authorization per FDA indication(s).

Please see the formulary for details, at **healthpartners.com/formularies**. Updates will be posted by October 1.

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.

MEDICARE DRUG FORMULARY

Updates for January 1, 2023 include:

- Brand Advair Diskus will be added to formulary at Tier 2. Generic fluticasone-salmeterol and Wixela, which are currently at Tier 3, will be removed from formulary.
- Several formulary removals.
  - Restasis has been removed, and the generic equivalent is on-formulary.
  - Asmanex and Pulmicort have been removed. Preferred alternatives include fluticasone (Flovent Diskus and HFA), beclomethasone (Qvar), and fluticasone (Arnuity).
- Tier increases, including fluconazole tablet and levothyroxine.
- Tier decreases, lowering copays to members, including potassium chloride and estradiol cream.
- Synthroid is being added to formulary
- Quantity limits, per standard dosing.

Click here for a complete list of our 2023 Medicare Drug Formulary

OPIOID PRESCRIBING

Providers are reminded about opioid prescribing guidelines. CDC guidelines are being updated.

The CDC Guidelines address patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas are:

1. **Determining when to initiate or continue opioids for chronic pain**

- Selection of non-pharmacologic therapy (interventions such as exercise, multidisciplinary rehabilitation, mind-body interventions).
- Selection of nonopioid pharmacologic therapy (including acetaminophen, non-steroidal anti-inflammatory drugs [NSAIDs], and selected antidepressants and anticonvulsants), or opioid therapy.
- Establishment of treatment goals.
- Discussion of risks and benefits of therapy with patients.

2. **Opioid selection, dosage, duration, follow-up and discontinuation**

- Selection of immediate-release or extended-release and long-acting opioids.
- Dosage considerations. Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reducing or tapering opioids, prescribing of naloxone, or other measures to reduce risk of overdose. MME conversion factors are being updated.

Opioid	Conversion Factor
Codeine	0.15
Fentanyl Transdermal (mcg/ hour)	2.4
Hydrocodone	1
Hydromorphone	5
Methadone	4.7
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Tramadol	0.2

- Duration of treatment.
- Considerations for follow-up and discontinuation of opioid therapy.

3. **Assessing risk and addressing harms of opioid use**

- Evaluation of risk factors for opioid-related harms and ways to mitigate risk to patient.
- Review of prescription drug monitoring program (PDMP) data.
- Use of urine drug testing.
- Considerations for co-prescribing benzodiazepines.
- Arrangement of treatment for opioid use disorder.

Link to CDC's opioid guideline overview

HealthPartners utilizes the following Pharmacy Opioid Safety programs for Medicare	
Opioid Cumulative Dosing Program (OCDP)	This program will block an incoming claim that puts a member's daily Morphine Milligram Equivalent (MME) greater than or equal to a soft-stop (pharmacy over-rideable) threshold of 90 MME across a single or multiple opioid-containing claims and/or hard-stop threshold for incoming claims with a cumulative MME greater than or equal to 200 MME.
Duplicative Long-Acting Opioid Therapy Program	This program will identify and deny concurrent use of long-acting opioids when there is any overlap in days' supply. A concurrent or duplicative long-acting opioid drug is defined as another long-acting opioid product with a different active ingredient.
Opioid Naïve Day Supply Limitation	This program will limit initial opioid prescription fills for the treatment of acute pain to no more than a seven days' supply for a member with no opioid history within a defined lookback period. The lookback period is 60 days.
Opioid-Benzodiazepine Concurrent Use Program	This program will identify and deny concurrent use of benzodiazepines and opioids when there is any overlap in days' supply. The program works bi-directionally (i.e., triggered by an incoming claim for an opioid with concurrent use of benzodiazepine or vice versa).
Opioid-Buprenorphine Concurrent Use Limitation	This program will identify and deny concurrent use of opioids when there is any overlap in days' supply with a pre-existing claim for buprenorphine for medication-assisted treatment (MAT). The edit works uni-directionally. This means it will only soft-stop analgesic opioids when members are currently taking buprenorphine for MAT. This edit will never stop a claim for buprenorphine for MAT.

Pharmacy Medical Policy updates

COMMERCIAL UPDATES:

Coverage Policies	Comments / Changes
Medical injectable site of care (MISOC) program	These medications have been added to the medical injectable site of care (MISOC) program: Amvuttra, Enjaymo, Evkeeza, Imfinzi, Nexviazyme, Opdualag, Oxlumo, Saphnelo, Tecentriq, Tezspire, Vyvgart Please note: Imfinzi, Opdualag, Tecentriq will not be required for home infusion. This program prefers more affordable sites of care for medication administration (home infusion, clinics, preferred outpatient hospital sites).
Infliximab	Adding Renflexis as an additional preferred agent. Preferred products are Inflectra and Renflexis.
IV Iron Replacement Therapy (Feraheme, Ferrlecit, Infed, Injectafer, Monoferric, Triferic, Venofer)	Adding a new medical policy requiring the use of preferred agents (Ferrlecit, Infed, Venofer, and Feraheme) unless there is a medical contraindication, prior ineffective response, or intolerance to all of the preferred agents.
Oncology - pegfilgrastim (Neulasta, Fulphila, Nyvepria, Udenyca, and Ziextenzo)	Update to prefer Neulasta and Udenyca on the medical benefit. Please note: biosimilars are preferred on the pharmacy benefit.

Pharmacy medical policies can be found in the medical coverage policy search page, searchable by drug name or billing codes. Policies will be searchable on or before the effective date at **healthpartners.com/public/coverage-criteria**.

MEDICARE PART B STEP THERAPY PROGRAM

Starting 1/1/2023, step therapy of preferred products will be required for members on Medicare Advantage plans that are newly starting select medical injectable therapies through Medicare Part B. Members stable on a non-preferred medication will have continued coverage of the non-preferred drug. The list of impacted medications are outlined below.

Non-Preferred Medication	Step Through Agent/ Preferred Medication
Remicade (and non-preferred biosimilars)	Inflectra or Renflexis
Herceptin (and non-preferred biosimilars)	Kanjinti or Ogivri
Rituxan (and non-preferred biosimilars)	Ruxience or Truxima
Avastin (and non-preferred biosimilars)	Mvasi or Zirabev
Fulphila, Ziextenzo, Nyvepria (and non-preferred biosimilars)	Neulasta or Udenyca

POLICIES AND CONTACT INFORMATION

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. For additional information, please contact **healthpartnersclinicalpharmacy@healthpartners.com**.

Disclosure of Ownership and Control Interest Form

HealthPartners has automated the process for providers to submit their Disclosure of Ownership information. The primary contact on file for your organization will receive an email with a link to the form. There will be information that will need to be verified, updated and attested to, along with a place for a signature and date. The Minnesota Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) requires health plans, including HealthPartners, to collect information from their contracted providers regarding ownership and control interests, management information, significant business transactions, and the identity of any individuals or entities excluded from participating in government funded health care programs.

If your primary contact has not received the link and submitted a 2022 Disclosure of Ownership and Control Interest Form yet, please click on the link below to print a copy of the form for completion. The form is required to be completed on an annual basis or when changes to ownership occur.

- **Disclosure of Ownership Form - HealthPartners**

If you are a participating provider with other Minnesota payers, any payer will accept this form, so it can be completed once and submitted to any payer with whom you are contracted.

Please submit the form to HealthPartners in one of the following ways:

- Email: **disclosureofownership@healthpartners.com**
- Fax: **952-853-8708**

Physician Incentive Plans (PIP) disclosure

The Centers for Medicare and Medicaid Services (CMS) requires health plans to request information from their contracted providers regarding the existence of physician incentive plans. The information should also include any physician incentive plans that exist between your organization and downstream subcontractors. Physician Incentive Plan disclosure is required even if there are no incentive arrangements or the arrangements have a low level of risk either through referrals or low utilization. If your information has changed since your organization last submitted this form, please submit the fax back form that's attached to this edition of Fast Facts to HealthPartners and a Summary Data Form will be sent to you for completion.

Thank you in advance for your assistance in keeping physician incentive plan information up to date. For more information from CMS on Physician Incentive Plans, please click **CMS Relationships with Providers** and review Section 80 *(path: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c06.pdf).*

If you have questions or need more information, please contact your Service Specialist.

HealthPartners programs and important information

HealthPartners makes many useful resources available to support care for your patients with HealthPartners coverage. These resources and Administrative Policies may change throughout the year. In an effort to remain transparent, we notify you regarding changes via our bi-monthly and Special Edition Fast Facts communications, emails and postal mail.

HealthPartners encourages you to visit our website as it hosts all of our current policies and procedures. Information available online at **healthpartners.com/provider** includes, but is not limited to:

Access to online tools and reports

- Provider Measurement
- Quality Measurement

Administrative Program

- Provider resource materials
- Fast Facts newsletters – current and past
- Policies and procedures, including:
    - Credentialing rights – practitioners
    - Medical records standards
    - Member complaint processes and procedures
    - Member rights and responsibilities

Program descriptions

- Case Management – how to refer a patient
- Disease Management – how to use services and how we work with your patients

Utilization Management

- Access to Utilization Management staff
- Affirmative statement – no incentives used to encourage barriers to care or services
- Clinical guidelines and updates
- Coverage Criteria policies
- How to contact a Medical Director

HealthPartners Provider Resource Materials

HealthPartners is committed to giving the providers who see our members the support and assistance they need.

HealthPartners has a designated online site labeled **Provider Resource Materials** (formerly the Provider Training Manual). Providers can quickly access point of contact information and learn about HealthPartners products, administrative and claims policies, medical policy/prior review requirements and much more. Providers will also find helpful information on our Cigna/HealthPartners Strategic Alliance, as well as current and past issues of our Fast Facts newsletter.

If you have any questions about Provider Resource Materials or suggestions for future improvements, please contact your Service Specialist.

Government Programs

Updating and certifying provider data in the CMS NPPES website

Did you know the Centers for Medicare & Medicaid Services (CMS) is encouraging health plans to use NPPES as a resource for online provider directory information for Medicare and other types of plan directories? This recommendation allows new efficiencies:

- Providers have a central location to update and verify directory information
- HealthPartners is able to utilize this NPPES information for directory verification
- Reduction in the frequency of contacts to verify information
- More accurate provider directories for members

Get started on verifying your information today by visiting the **NPPES website**.

Please verify information and update any inaccurate information in modifiable fields. NPPES allows for additional practice addresses, so please make sure to include all addresses where patients are *actively* seen and where a patient can call and make an appointment. Please remove any practice locations that are no longer used for patients. Be sure to certify the information in NPPES once it's been reviewed and update as changes occur throughout the year.

If you have any questions pertaining to NPPES, please visit **NPPES Help** or **NPPES FAQs** pages.

Enroll with Minnesota Health Care Programs (MHCP) now

HealthPartners contracted providers must be screened and enrolled with the Minnesota Department of Human Services (DHS) in order to be eligible for reimbursement for services provided to Families and Children, Minnesota Senior Health Plus (MSC+), Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) members. This enrollment requirement is part of the 21st Century Cures Act (Cures Act).

Providers and groups who are currently contracted with DHS for FFS or their delegate should register with the Minnesota Provider Screening and Enrollment (MPSE) portal to enroll providers online. The portal also allows providers to manage enrollment records and submit enrollment-related information. The MPSE portal page can be found here **MPSE Portal**.

In the near future, providers who are only contracted with managed care organizations for services provided to state public programs patients will also be required to enroll directly through the MPSE online portal. Stay tuned for updates!

If your providers are not enrolled with DHS yet, visit this page to learn more about enrollment on the DHS website: **MHCP Enrollment**.

HealthPartners Minnesota Senior Health Options (MSHO) 2023 Cost Sharing and Supplemental Benefits

The MSHO plan provides comprehensive coverage for seniors covered by Medicare and Medical Assistance. We want to call your attention to two significant updates for 2023.

$0 COST SHARING

As a reminder, MSHO members don't pay a monthly premium, have no deductibles, and pay $0 for covered services when they go to an in-network provider. New for 2023, all HealthPartners MSHO members have a $0 copay for all covered prescription drugs. HealthPartners is the only MSHO plan with $0 drug costs.

SUPPLEMENTAL BENEFITS

HealthPartners also offers supplemental benefits to MSHO members. These benefits may change each year. Members can contact Member Services with questions about these and other benefits. The Supplemental Benefits for 2023 are as follows:

CARE & SUPPORT

- A tablet with education and wellness tools for members with diabetes, heart disease, cognitive impairment or depression*
- RideCare transportation to/from SilverSneakers* health club, health and weight management classes, Alcoholics Anonymous or Narcotics Anonymous meetings
- Foot care visits
- Independent Living Skills*
- Home delivered meals
- Unlimited visits to Virtuwell®, a 24/7 online medical clinic
- An animatronic cat or dog that gives companionship and joy; lowers anxiety and loneliness*

SAFETY & PREVENTION

- Motion sensor night lights (2)
- Pedaler
- In-home bathroom safety devices and installation
- Personal Emergency Response System (PERS)
- First aid kit

DENTAL & VISION

- Adult fluoride
- Periodic exams
- Additional coverage for root canals on molars
- Crowns coverage
- An electric toothbrush and three toothbrush heads
- Eyeglasses coatings

HEALTHY LIVING

- Weight management program
- FarmboxRx fresh produce boxes with nutrition education (delivered up to two times each month)*
- SilverSneakers® fitness program
- Healthy aging and cooking classes
- Wearable activity tracker
- Pocket hearing amplifier

FOR MEMBERS WITH A COGNITIVE IMPAIRMENT DIAGNOSIS, LIKE DEMENTIA OR ALZHEIMER'S

- Caregiver support including coaching and counseling through family caregiver services, short-term respite care, psychotherapy and transportation to these services*

*Available to members with specific diagnoses who meet eligibility criteria.

Medicare Advantage service area expansion and Medicare Cost service area reduction for 2023

Beginning January 2023, HealthPartners will begin offering Medicare Advantage in 10 additional counties in Minnesota and stop offering Medicare Cost in those same counties.

Due to rules established by the Centers for Medicare & Medicaid Services (CMS), we are unable to offer both Medicare Cost and Medicare Advantage plans in a county.

The affected counties are as follows:

New Medicare Advantage Counties and Closing Medicare Cost Counties in 2023	
1. Aitkin	6. Koochiching
2. Carlton	7. Lake
3. Cook	8. Mille Lacs
4. Itasca	9. Pine
5. Kanabec	10. Saint Louis

In addition, beginning January 2023, we will no longer offer Medicare Cost in Goodhue County, but Goodhue County eligible beneficiaries will still have a HealthPartners Medicare Supplement plan available to them.

If your patients ask you about this change, please direct them to call the HealthPartners Medicare Sales Team at **952-883-5090** or **844-363-8979** to discuss plan options. They are available from 8 a.m. – 8 p.m. seven days a week, starting October 1.

- Members can pick a new plan during the Medicare annual open enrollment period, October 15 – December 31st.
- We are sending two mailings to affected members in October providing them with information about the plan closing and plan options.
- If members don't enroll in a plan by December 31, they will have Medicare fee-for-service coverage beginning January 1, 2023.
- Members have a special election period that runs through February 28, 2023. However, we encourage enrollment in a new plan by December 31 so members do not experience a gap in coverage.

HealthPartners Medicare Advantage plans earn 5 out of 5 stars from CMS

For the second year in a row, HealthPartners Medicare Advantage plans in Minnesota and Wisconsin have earned an overall 5 out of 5-Star Rating from the Centers for Medicare and Medicaid Services (CMS) for 2023. Our Medicare Advantage plans in Iowa and Illinois also earned an overall high rating of 4.5 out of 5 stars, including 5 stars in Customer Service and 5 stars in Health Care Quality.

Every year, CMS rates health plans based on overall performance, evaluating key measures including quality of care, member experience and customer service. Plans are rated on a 1 to 5-star scale – the closer to 5 stars, the better.

These top overall ratings place us as one of the highest rated Medicare plans in the nation.

During Medicare Annual Enrollment Period (AEP) (Oct. 15-Dec. 7), connecting Medicare-eligible patients with the right health plans, especially Medicare Advantage plans, is one way you can help provide high-value, coordinated care. Visit our website to learn more about our **2023 Star Ratings results** and **Medicare Advantage** plans.

HealthPartners SNBC Inspire virtual stakeholder meeting

Providers are invited to join us for a virtual SNBC stakeholder meeting on Thursday, November 17, 2022 from 3-4 PM.

This meeting is an opportunity for providers, members, advocates and other stakeholders to learn and discuss important topics related to SNBC.

Questions about this meeting can be sent to Jacob Hunt (**jacob.d.hunt@healthpartners.com**).

Location:	Microsoft Teams
Meeting link	tinyurl.com/hpsnbcfall2022
OR	Call **612-428-2306** Conference ID: 782 731 617#
Date & Time:	Thursday, November 17, 2022 3-4 PM

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 Editor: Mary Jones

HealthPartners

Last updated: March 2022

Provider Directory Cultural Competency and ADA Accessibility Questionnaire

Purpose:
Managed Care Federal Regulations require providers to confirm their cultural competency training and office accessibility for people with disabilities.

Instructions:
Please complete this form for each office location and submit the completed form to providercompliance@healthpartners.com or fax the form back to 952-853-8708.

If you have any questions regarding completing this form, call 844-732-3537.

Clinic/Facility Name_____

Office Location Address_____

City_____State_____Zip Code_____

NPI Number(s)_____

Clinic/Facility/Sole Practitioner Website URL_____

Clinic/Facility/Sole Practitioner Phone Number (including area code)_____

Is your office accepting new patients? Yes ☐ No ☐

Cultural Competency:

Cultural and linguistic competence is the ability of managed care organizations and the providers within their network to provide care to recipients with diverse values, beliefs and behaviors, and to tailor the delivery of care to meet recipients' social, cultural and linguistic needs. The ultimate goal is a health care delivery system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, sexual orientation, disability, religion or socioeconomic status.

Has office staff completed cultural competency training in the past 12 months?

Yes ☐ Type of training _____
Month/Year completed _____
No ☐

HealthPartners

Last updated: March 2022

Cultural Capabilities:

Cultural capabilities include cultural awareness, cultural safety and cultural competence offered by health care providers to better adapt and serve members' backgrounds, values, and beliefs to meet social, cultural, and language needs.

Do any staff in your office possess the following cultural capabilities (select all that apply)?

Cultural Awareness ☐
Please Describe _____

Cultural Safety ☐
Please Describe_____

Cultural Competence ☐ (check box if you answered Yes to Cultural Competency Training)
Please Describe_____

Accessibility:

Home Health, Home and Community Based Services (HCBS), Nursing Homes,Personal Care Assistance (PCA), and Transportation providers do not need to complete this section.

The Americans with Disabilities Act (ADA) requires public accommodations to take steps to ensure that persons with disabilities have equal access to their goods and services. For example, the ADA requires public accommodations to make reasonable changes in their policies, practices and procedures; to provide communication aids and services; and to remove physical barriers to access when it is readily achievable to do so. Visit **www.ada.gov.**

Is your office, including parking, entry ways, and other relevant space, accessible for people with disabilities? Yes ☐ No ☐

Are your office exam rooms accessible for people with disabilities? Yes ☐ No ☐

Does your office have equipment accessible for people with disabilities? Yes ☐ No ☐

Please provide a contact name and phone number in case there are questions regarding your responses to this questionnaire:

_____ _____
Print Name Phone Number

_____ _____
Signature Date

HealthPartners®

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Company/Department Provider Compliance and Networks	*Department*
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☐ Urgent ☐ For your review ☐ Per your request ☐ Please comment ☐ Reply ASAP

Comments:

Please send Physician Incentive Plan disclosure forms to me upon receipt of this e-mail to the fax number above so our information can be updated.