Fast Facts

HealthPartners

MAY 2024

News for Providers from HealthPartners
Provider Relations & Network Management

Administrative

Provider directory verification

Regulations require providers and health plans to verify directory information.

HealthPartners provider compliance staff makes outreach calls, reviews websites and accepts rosters to validate your information is correct.

We verify the following information for each practitioner who appears in directories:

- Practitioner names and practice locations
- Location names
- Location addresses
- Phone numbers where members can call to make appointments to see the provider
- Hospital Affiliations
- Provider website URLs, if available
- Whether the provider is accepting new patients at some or all locations

HealthPartners providers are expected to keep their information up-to-date by using the Provider Data Profiles application on our provider portal at **healthpartners.com/provider**.

You can also request a roster of your provider information by emailing **providercompliance@healthpartners.com.** Use the roster to verify whether the information we have on file is accurate and make updates to the information as needed.

Please note: If your group has a Delegation Agreement for Credentialing in place with HealthPartners, the files that are submitted to our Credentialing Services Bureau are considered our source of truth for your provider information.

INSIDE THIS ISSUE

Claim adjustments and appeals on Provider Portal

In May there will be a new provider portal application for managing claim adjustments and appeals. The new claim adjustments and appeals application allows you to review requests on file, the status of the requests and, when applicable, the adjusted claim information. The application will soon be available to all accounts with access to claims status inquiry.

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**.

Clinician information on race, language, ethnicity and cultural competencies

HELP SUPPORT DIVERSITY IN OUR COMMUNITY

Please share your information with us, on a voluntary basis, about your race, ethnicity and cultural competencies so we can have this information available when members seek help with finding providers for care.

The information will be used to:

- Assist members requesting specific types of provider attributes from HealthPartners Nurse Navigators and Member Services staff.
- Ensure our provider network represents the diversity within our communities.

You have the option to let us know if you do not want your information displayed in our directories.

We hope clinicians in your practices will complete the online **CLINICIAN INFORMATION FOR DIVERSITY AND HEALTH EQUITY FORM** to support our ethnically, racially and culturally diverse communities.

Minnesota Rare Disease Mandate

The Minesota (MN) Rare Disease Mandate is a set of laws and regulations that aim to improve care for the rare disease community in MN. As defined, a rare disease or condition is any disease or condition that affects fewer than 200,000 persons in the United States and is chronic, serious, life altering or life threatening.

Effective January 1, 2024, HealthPartners will be complying with the MN state mandate that no health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring and treatment of a rare disease or condition, including, but not limited to, additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees or other methods.

For more information, please review our Rare Disease and Condition policy on the Provider Portal or review MN Statute § 62Q.451.

Looking for your feedback

PRACTITIONER CULTURAL RESPONSIVENESS SURVEY

You may have recently received a survey from HealthPartners regarding cultural responsiveness. Patients may experience different barriers to care, so taking the survey helps us understand how you support patients with different cultural backgrounds. You can also tell us what resources would be most helpful for providing culturally informed care and addressing barriers to health equity among patients.

Please complete the survey here:

Cultural Responsiveness Survey

Medical Policy updates – 05/01/2024

MEDICAL, BEHAVIORAL HEALTH, 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**. 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: oncology – circulating tumor DNA and circulating tumor cells (liquid biopsy)	• Effective immediately, policy revised.
	  ○ Prior authorization is no longer required for *PIK3CA* Variant Analysis via ctDNA.
	• Effective 7/1/2024, policy revised.
	  ○ Under broad molecular profiling panel tests via circulating tumor DNA (ctDNA):
	  ▪ Added several more approvable indications, when criteria met, to the criteria set.
	  ▪ Replaced language previously stating "Advanced (stage IIIB or higher)" with "Stage IV" for the following indications in the criteria set:
	  • Lung adenocarcinoma
	  • Large cell lung carcinoma
	  • Squamous cell lung carcinoma
	  • Non-small cell lung cancer (NSCLC) not otherwise specified (NOS).
	  ▪ For the following indications in the criteria set, added requirements the cancer type is to be metastatic or advanced:
	  • Gastric cancer
	  • Esophageal or esophagogastric junction cancer.
	  ○ Under Lung Cancer Focused Panel Tests via ctDNA, replaced language previously stating "Advanced (stage IIIB or higher)" with "Stage IV" for the indications listed in the criteria set.
	  ○ Removed Colorectal Cancer Focused Panel Tests via ctDNA criteria set from policy.
	  ○ Removed Melanoma Focused Panel Tests via ctDNA criteria set from policy.
	  ○ Under EGFR Variant Analysis via ctDNA, replaced language previously stating "Advanced (stage IIIB or higher)" with "Stage IB to IIIA or IIIB" for the indications listed in the criteria set.
	  ○ Under the following criteria sets:
	  ▪ Broad molecular profiling panel tests via ctDNA
	  ▪ Lung Cancer Focused Panel Tests via ctDNA
	  ▪ EGFR Variant Analysis via ctDNA
	  ▪ BRAF Variant Analysis via ctDNA
	  ▪ KRAS Variant Analysis via ctDNA

Coverage Policies	Comments / Changes
Genetic testing: oncology – circulating tumor DNA and circulating tumor cells (liquid biopsy) – Cont'd	Removed requirements that a member must meet one of the following: ▪ The member is medically unfit for invasive tissue sampling (biopsy); or ▪ 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. • Please refer to published coverage policy for details.
Genetic testing: metabolic, endocrine, and mitochondrial disorders	• Effective immediately, policy revised. ○ Prior authorization is no longer required for disorders listed in the "Other Covered Metabolic, Endocrine and Mitochondrial Disorders" section of the policy. • Effective 7/1/2024, policy revised. ○ Under the Monogenic Diabetes (Including Maturity-Onset Diabetes of the Young [MODY]) Panels criteria section: ▪ Addition of indication to allow for coverage of this type of testing: • A member has a diagnosis of diabetes within the first 12 months of life. ▪ Revision of current criteria set involving member subset aged <35 years and diagnosed with diabetes: • Lower age to "before 30 years" instead of "before 35 years." • Member is to have one of the following: ○ Autoantibody negative or retained C-peptide levels; or ○ The member must have a diagnosis of diabetes not characteristic of type 1 or type 2 diabetes and have a family history of diabetes consistent with an autosomal dominant pattern of inheritance. ▪ Removed indication that the panel is to have, at a minimum, the following genes: GCK, HNF1A, and HNF4A. ○ Known Familial Variant Analysis for Metabolic, Endocrine and Mitochondrial Disorders criteria section removed from policy. Criteria for this type of testing will now be in the Genetic testing: general approach to genetic and molecular testing policy.
Genetic testing: hereditary cancer susceptibility	• Effective immediately, policy revised. ○ Prior authorization is not required for BRCA1 and/or BRCA2 Targeted Variant Analysis-Ashkenazi Jewish Founder Variants. ○ Prior authorization is not applicable for the following services as they are considered investigational/experimental: ▪ ATM or CHEK2 Sequencing and/or Deletion/Duplication Analysis; ▪ Targeted mRNA sequencing analysis for the interpretation of variants of unknown significance (0130U, 0133U, 0134U, 0136U, 0137U, 0138U, 0157U, 0158U, 0159U, 0160U, 0161U, 0162U).

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility – Cont'd	• Effective 7/1/2024, policy revised. ○ Under the Hereditary Breast Cancer Susceptibility Panels: ▪ Removed "The member is 18 years or older" from the criteria set. This requirement is already part of the need to meet BRCA1 and BRCA2 Sequencing and Deletion/Duplication analysis criteria. ▪ Removed PALB2 from the minimum required gene list for the panel. Panels are to include, at a minimum, the BRCA1 and BRCA2 genes. ○ Under Hereditary Prostate Cancer Susceptibility Panels: ▪ A member no longer needs to have a diagnosis of prostate cancer while meeting another indication included in the criteria set. Instead, a member is to have a personal history of one of the three indications in the criteria set (e.g., metastatic prostate cancer, high- or very-high risk localized prostate cancer, or regional prostate cancer that is node positive). ▪ Adding another indication for when a member has one or more close relatives with listed indications to allow for testing approval. The relative can have triple-negative breast cancer at any age. ▪ Adding an indication that, when met, could lead to approval of this type of testing. The member is to have a personal history of prostate cancer with three or more close relatives with prostate cancer (any grade) and/or breast cancer on the same side of the family as the member. ▪ Adding an indication that, when met, could lead to approval of this type of testing. The member has a first-degree blood relative meeting any of the criteria in the criteria set. ○ Under Hereditary Neuroendocrine Cancer Susceptibility Panels: ▪ A member was to meet criteria under certain sequencing and/or deletion/duplication analysis sections (e.g., Von Hippel Lindau syndrome, Hereditary Paraganglioma Pheochromocytoma syndrome, Multiple Endocrine Neoplasia Type 2). Those sections were removed from the criteria set. MEN1 or RET sequencing and/or deletion/duplication analysis criteria can still be met to allow for Neuroendocrine Cancer Susceptibility Panel testing. ▪ Added indications that a member is to have in order to approve this type of testing: • Adrenocortical carcinoma; or • Paraganglioma/pheochromocytoma; or • Parathyroid adenoma or primary hyperparathyroidism before age 30; or • Multiple parathyroid adenomas; or • Multigland hyperplasia without obvious secondary cause; or • Recurrent primary hyperparathyroidism. ▪ Removing the minimum gene list requirement from the criteria set.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility – Cont'd	○ Under BRCA1 and BRCA2 Sequencing and/or Deletion/Duplication Analysis: ▪ Added new indications to allow for approval of this type of testing: • The member has a personal history of: ○ Breast cancer diagnosed at age 50 or younger; ○ Exocrine pancreatic or ampullary cancer; ○ Breast cancer and three or more total diagnoses of breast cancer and/or prostate cancer (any grade) on the same side of the family as the member. ○ Under PALB2 Sequencing and/or Deletion/Duplication Analysis: ▪ Added new indications to allow for approval of this type of testing: • The member has a personal history of: ○ Breast cancer diagnosed at age 50 or younger; ○ Exocrine pancreatic or ampullary cancer; ○ Breast cancer and one or more close relatives with exocrine pancreatic cancer. ○ Under BAP1 Sequencing and/or Deletion/Duplication Analysis: ▪ Expanded upon the requirements when a member has one of the tumors/cancers listed in the criteria set. Now, the member can have one of the tumors/cancers listed in the criteria set and either a cutaneous melanoma or a basal cell carcinoma, or one of the tumors/cancers listed in the criteria set and a first- or second-degree relative with any of the listed tumors/cancers. ○ Under CDKN2A Sequencing and/or Deletion/Duplication Analysis: ▪ This type of testing is no longer considered investigational. New criteria are added for medical necessity reviews: • The member has had 3 or more invasive cutaneous melanomas; or • The member has had pancreatic adenocarcinoma; or • The member has had at least one cutaneous melanoma; and ○ The member has at least two close relatives with pancreatic cancer or cutaneous melanoma on the same side of the family. ○ Under SMAD4 and/or BMPR1A Sequencing and/or Deletion/Duplication Analysis: ▪ Removed the following indication: • The member has a personal history of cancer and a SMAD4 or BMPR1A pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis has not yet been performed.

Coverage Policies	Comments / Changes
Genetic testing: hereditary cancer susceptibility – Cont'd	○ Under TP53 Sequencing and/or Deletion/Duplication Analysis: ▪ Changed one indication: • A member will no longer be required to be diagnosed with pediatric hypodiploid acute lymphoblastic leukemia. Instead, a member is to have a personal history or a family history of the condition in order to have this type of testing approved. ○ Under RET Sequencing and/or Deletion/Duplication Analysis: ▪ Removed the following indication: • The member has a personal history of an adrenal pheochromocytoma and parathyroid hyperplasia. ▪ Replaced the removed indication with the following: • The member is to have an adrenal pheochromocytoma or parathyroid adenoma or parathyroid hyperplasia in order to be approved for this type of testing. ▪ Removed the following indication: • The member has a diagnosis of primary C-cell hyperplasia. ○ Under FLCN Sequencing and/or Deletion/Duplication Analysis: ▪ A first-degree relative with BHDS is to either not have had genetic testing or had genetic testing but the results are unknown. • Please refer to published coverage policy for details.
Genetic testing: eye disorders	• Effective 7/1/2024, policy revised. ○ Clarified that prior authorization is not applicable for genetic testing for macular degeneration as it is considered investigational and therefore, not covered. ○ Criteria for known familial variant analysis for eye disorders were removed. Criteria for known familial variant tests has been consolidated on the "Genetic Testing: General Approach to Genetic and Molecular Testing" coverage policy. ○ Criteria for glaucoma testing were removed from policy. ○ The coverage criteria section titled "RPE65 Sequencing and/or Deletion/Duplication Analysis" was renamed to "Inherited Retinal Dystrophies Multigene Panel Analysis." Coverage indications for this type of testing have been expanded. Please refer to published policy for details.
Radiofrequency ablative (RFA) denervation procedures for chronic facet-mediated neck, back and sacroiliac joint pain	• Effective immediately, policy revised. ○ Repeat Radiofrequency ablative denervation documentation criteria clarified to state "Documentation of at least a 50 percent reduction in symptoms for at least 3 months duration after the previous RFA, as reported by the patient." ○ Repeat Radiofrequency ablative denervation return of pain, limiting activities clarified to state "Return of pain, limiting activities of daily living for at least 3 months despite conservative treatments (such as, but not limited to, exercise, physical therapy, activity modification or chiropractic care). Documentation of conservative treatments must correspond to the current episode of pain (within 6 months)."

Coverage Policies	Comments / Changes
Genetic testing: gastroenterologic disorders (non-cancerous)	• Effective 07/01/2024, prior authorization is required for "Non-invasive Liver Fibrosis Serum Tests." • Effective immediately, prior authorization is not required for genetic testing for Hereditary Pancreatitis or Hereditary Hemochromatosis. • Effective 07/01/2024, policy revised. Please refer to published policy for details. ○ Under the "Hereditary Inflammatory Bowel Disease/Crohn's Disease Panel Tests." ▪ The statement "very early onset of IBD symptoms before age 2 years" has been updated to "infantile-onset inflammatory bowel disease (Infantile-IBD) before age 2 years." ▪ There has been a change to the age of diagnosis for Crohn's disease. Updated from "The member had IBD symptoms before age 18 years" to "The member was diagnosed with very early onset inflammatory bowel disease (VEO-IBD) before age 6 years." ▪ Updated criteria for members diagnosed with very early onset inflammatory bowel disease (VEO-IBD) before age 6 years. ○ Known Familial Variant testing removed from policy. Criteria is addressed in the "Genetic testing: general approach to genetic and molecular testing" to consolidate criteria for known familial variant tests. ○ "MCM6 Targeted Variant Analysis" – Retired criteria set. ○ Under "Other Not Covered Gastroenterologic Disorders Tests" FibroSure test have moved to the new "Non-invasive Liver Fibrosis Serum Tests" criteria. The remaining tests moved to the "Genetic testing: general approach to genetic and molecular testing" policy. ○ Under "HLA-DQ Genotyping Analysis," the criteria have been updated. ○ "Non-invasive Liver Fibrosis Serum Tests" – new criteria set added to policy.
Genetic testing: pharmacogenetics	• Effective immediately, prior authorization is not required for CYP3A5 genetic testing. • Effective 07/01/2024, prior authorization is required for CYP2C9 Variant Analysis testing. • Effective 07/01/2024, policy revised. Please refer to published policy for details. ○ New criteria section added to policy, "Warfarin Sensitivity Analysis Panels" with the following criteria: ▪ Multigene analysis to determine drug metabolizer status for warfarin sensitivity is considered **medically necessary** when: • The member is undergoing prophylaxis and treatment of venous thrombosis or pulmonary embolism; or • The member is undergoing prophylaxis and treatment of thromboembolic complications associated with atrial fibrillation and/or cardiac valve replacement; **or** • The member has a history of previous myocardial infarction; and • The member is being considered for or is undergoing treatment with warfarin; **and**

Coverage Policies	Comments / Changes
Genetic testing: pharmacogenetics – Cont'd	• The member has not reached a therapeutic dose. ▪ Multigene panel analysis to confirm drug metabolizer status is considered **investigational** for all other indications. ○ For ease of use, the policy formatting has also been updated.
Genetic testing: prenatal and preconception carrier screening	• Effective 07/01/2024 – policy revised. Please refer to published policy for details. • Under the "HBA1, HBA2 or HBB Targeted Variant Analysis" testing, the following criteria have been removed: ○ The member's reproductive partner is a known carrier of pathogenic or likely pathogenic variant in HBA1, HBA2 or HBB. ○ The member's hematologic screening results are suggestive of or do not conclusively rule out a hemoglobinopathy. • Under "HBA1, HBA2 or HBB Sequencing and/or Deletion/Duplication Analysis:" ○ The following criteria have been removed. ▪ The member meets one of the following: ▪ The member's hematologic screening results (e.g., MCV, MCH, CBC, hemoglobin, electrophoresis, or dichlorophenol indophenol [DCIP]) are suggestive or do not conclusively rule out a hemoglobinopathy. ○ Added clarifying information in the "investigational" statement that this testing does not include fetal hemoglobin testing via circulation fetal DNA. • Under "DMD Sequencing and/or Deletion/Duplication Analysis" criterion 1B has been updated: ○ The criterion will now read, "The member has a first- or second-degree relative diagnosed with Duchenne or Becker muscular dystrophy." • General Criteria for Carrier Screening – Criteria removed from this policy and will be reviewed under the "Genetic Testing: general approach to genetic and molecular testing" policy to align with other general coverage tests. • CFTR Targeted Variant Analysis – Criteria set name changed, formerly "CFTR Known Familial Variant Analysis."
Genetic testing: oncology – cytogenetic testing	• Effective immediately, prior authorization is not required for the following tests: ○ Tumor Specific ALK Gene Rearrangement (Qualitative FISH and PCR) Tests ○ Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) FISH Panel Analysis ○ Tumor Specific ERBB2 (HER2) Deletion/Duplication (FISH and CISH) ○ Tumor Specific PD-L1 Protein Analysis Fusion ○ Multiple Myeloma FISH Panel Analysis ○ Tumor Specific PML/RARA Gene Rearrangement (Qualitative FISH and PCR) ○ Tumor Specific ROS1 Gene Rearrangement

Coverage Policies	Comments / Changes
Genetic testing: oncology – cytogenetic testing – Cont'd	• Effective 07/01/2024, policy revised. Please refer to the published policy online for details. ○ Under "Tumor Specific ALK Gene Rearrangement Qualitative FISH and PCR) Tests," criteria expanded with the addition of new tumor types/indications. ○ Under "Tumor Specific ERBB2 (HER2) Deletion/Duplication (FISH) and (CISH):" ▪ The criteria have been expanded with the addition of new tumor types/indications. ▪ A clarification has been made to the gastric cancer indication. ○ Under "NTRK Fusion Analysis Panel:" ▪ The criteria have been expanded with the addition of new tumor types/indications. ▪ A change replacing the language "a diagnosis of uterine sarcoma" with "metastatic uterine sarcoma." ▪ A change replacing the language "soft tissue sarcoma" with "metastatic soft tissue sarcoma." ○ Under "Tumor Specific FOLR1 Protein Analysis," a change replacing the language "epithelial ovarian, fallopian tube or primary peritoneal cancer" with "recurrent, platinum resistant epithelial ovarian, fallopian tube or primary peritoneal cancer." ○ Under "Tumor Specific RET Gene Rearrangement Tests (FISH), criteria expanded with the addition of new tumor types/indications. ○ Under "Tumor Specific ROS1 Gene Rearrangement," criteria expanded with the addition of new tumor types/indications. ○ The "Tumor Specific BCR/ABL1 Gene Rearrangement (Qualitative FISH and PCR) Tests" criteria have been removed from this policy and combined with BCR/ABL1 criteria in the "Genetic testing: Solid tumor and hematological malignancies" policy to align with the clinical use of this testing.
Genetic testing: oncology – algorithmic testing	• Effective immediately, "Gene Expression Profiling Breast Cancer Subtyping Tests" do not require prior authorization as this testing is considered investigational/experimental. • Effective immediately, "Breast Cancer Extended Endocrine Therapy Algorithmic Tests" do not require prior authorization. • Effective 07/01/2024, the following testing will not require prior authorization as the testing is considered investigational/experimental: ○ Emerging Evidence Prostate Cancer Diagnostic and Algorithmic Tests ○ Emerging Evidence Cutaneous Melanoma Prognostic and Algorithmic Tests ○ Emerging Evidence Lung Cancer Diagnostic Algorithmic Tests ○ Polygenic Risk Score Tests • Effective 07/01/2024, the following testing will require prior authorization: ○ Cutaneous Melanoma Risk Assessment Algorithmic Tests ○ Evidence Based Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests ○ Evidence Based Cutaneous Melanoma Prognostic Algorithmic Tests ○ Evidence Based Lung Cancer Diagnostic Algorithmic Tests

Coverage Policies	Comments / Changes
Genetic testing: oncology – algorithmic testing – Cont'd	• Effective 07/01/2024, policy revised. Please refer to published policy for details. ○ Under "Prostate Cancer Treatment and Prognostic Algorithmic Tests:" ▪ Clarification to prostate cancer treatment and prognostic algorithmic test Decipher assay when the member has a life expectancy of 10 years or more: • The member has not yet had treatment. ▪ Addition of one criterion to prostate cancer treatment and prognostic algorithmic test Decipher assay when the member has a life expectancy of more than 5 years. • There are no lymph node metastases. ○ Evidence Based Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests ▪ New criteria set. Considered medically necessary for specific tests when criteria are met. ○ Emerging Evidence Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support. ○ Evidence Based Cutaneous Melanoma Prognostic Algorithmic Tests ▪ New criteria set. Considered medically necessary when criteria are met. ○ Emerging Evidence Cutaneous Melanoma Prognostic Algorithmic Tests ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support. ○ Cutaneous Melanoma Risk Assessment Algorithmic Tests ▪ New criteria set. Considered medically necessary when criteria are met. ○ Evidence-Based Lung Cancer Diagnostic and Algorithmic Tests ▪ New criteria set. Considered medically necessary when criteria are met. ○ Emerging Evidence Lung Cancer Diagnostic Algorithmic Tests ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support. ○ Oncology: Test-Specific Not Covered Algorithmic Tests – Removed from this policy. Criteria can now be found on the "Genetic testing: general approach to genetic and molecular testing" policy.

Coverage Policies	Comments / Changes

Genetic testing: oncology – algorithmic testing – Minnesota Health Care Programs	• Effective immediately, "Gene Expression Profiling Breast Cancer Subtyping Tests" do not require prior authorization as this testing is considered investigational/experimental.
	• Effective immediately, "Breast Cancer Extended Endocrine Therapy Algorithmic Tests" do not require prior authorization.
	• Effective 07/01/2024, the following testing will not require prior authorization as the testing is considered investigational/experimental:
	  ○ Emerging Evidence Prostate Cancer Diagnostic and Algorithmic Tests
	  ○ Emerging Evidence Cutaneous Melanoma Prognostic and Algorithmic Tests
	  ○ Emerging Evidence Lung Cancer Diagnostic Algorithmic Tests
	  ○ Polygenic Risk Score Tests
	• Effective 07/01/2024, the following testing will require prior authorization:
	  ○ Cutaneous Melanoma Risk Assessment Algorithmic Tests
	  ○ Evidence Based Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests
	  ○ Evidence Based Cutaneous Melanoma Prognostic Algorithmic Tests
	  ○ Evidence Based Lung Cancer Diagnostic Algorithmic Tests
	• Effective 07/01/2024, policy revised. Please refer to published policy for details.
	  ○ Under "Prostate Cancer Treatment and Prognostic Algorithmic Tests:"
	  ▪ Clarification to prostate cancer treatment and prognostic algorithmic test Decipher assay when the member has a life expectancy of 10 years or more:
	  • The member has not yet had treatment.
	  ▪ Addition of one criterion to prostate cancer treatment and prognostic algorithmic test Decipher assay when the member has a life expectancy of more than 5 years:
	  • There are no lymph node metastases.
	  ○ Evidence Based Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests
	  ▪ New criteria set. Considered medically necessary for specific tests when criteria are met.
	  ○ Emerging Evidence Prostate Cancer Risk Assessment and Diagnostic Algorithmic Tests
	  ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support.
	  ○ Evidence Based Cutaneous Melanoma Prognostic Algorithmic Tests
	  ▪ New criteria set. Considered medically necessary when criteria are met.
	  ○ Emerging Evidence Cutaneous Melanoma Prognostic Algorithmic Tests
	  ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support.
	  ○ Cutaneous Melanoma Risk Assessment Algorithmic Tests
	  ▪ New criteria set. Considered medically necessary when criteria are met.
	  ○ Evidence-Based Lung Cancer Diagnostic and Algorithmic Tests
	  ▪ New criteria set. Considered medically necessary when criteria are met.

Coverage Policies	Comments / Changes
Genetic testing: oncology – algorithmic testing – Minnesota Health Care Programs – Cont'd	○ Emerging Evidence Lung Cancer Diagnostic Algorithmic Tests ▪ New category of testing on this policy; considered investigational. Separate category to distinguish between tests with varying levels of evidence for validity and guideline support. ○ Oncology: Test-Specific Not Covered Algorithmic Tests – Removed from this policy. Criteria can now be found on the "Genetic testing: general approach to genetic and molecular testing" policy.
Hospital bed – Minnesota Health Care Programs	• Effective immediately, policy revised. ○ Updated to include criteria for enclosed bed options and accessories to align with the DHS Provider Manual.
Nutritional support – Minnesota Health Care Programs	• Effective immediately, policy revised. • Policy updated to align with the DHS Provider Manual. ○ The coverage indications under "Oral Nutrition for Pediatric Members" have been updated. ○ Pasteurized Donor Human Milk is now eligible for coverage when criteria are met. ○ The Documentation Requirements section has been updated.
Nutritional support	• Effective immediately, policy revised. ○ Statements regarding prior authorization requirements within the Administrative Process section have been clarified. ○ Updates have been made to the Coverage and Definitions sections for clarity and ease of use.
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies	• Effective 07/01/2024, policy revised. Please refer to published policy for details. ○ Under "Tumor-Type Agnostic Solid Tumor Molecular Profiling Panels:" ▪ Expanded medically necessary indications to include a diagnosis of: • Histiocytosis • Non-small cell lung cancer (NSCLC) regardless of stage ▪ Expanded medically necessary indication to include: • Uterine neoplasm undergoing initial evaluation • Resectable or borderline resectable pancreatic adenocarcinoma when the member is being considered for systemic therapy ○ Under "Broad RNA Fusion Panels:" ▪ Now considered medically necessary when criteria are met (diagnosis of adult or pediatric acute lymphoblastic leukemia [ALL]). ○ Under "Colorectal Cancer Focused Molecular Profiling Panels:" ▪ Criteria updated; the following statements have been removed: • The member is seeking further cancer treatment (e.g., therapeutic chemotherapy). • The member has not had previous somatic testing via a multigene cancer panel for the same primary diagnosis of colorectal cancer. • The member has had previous somatic testing via a multigene cancer panel for a primary colorectal cancer diagnosis and has a new primary colorectal cancer diagnosis for which this testing is being ordered.

Coverage Policies	Comments / Changes
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies – Cont'd	○ Under "Tumor Specific BCR/ABL1 FISH, Qualitative, or Quantitative Tests:" ▪ Clarification to indicate *quantitative* testing is medically necessary for monitoring of disease progression for: • Acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic myelogenous leukemia (CML), or B-cell lymphoma. ▪ Criteria clarified to include indication for diagnostic workup for acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic myelogenous leukemia (CML), or B-cell lymphoma. ○ Under "Tumor Specific *BRAF* Variant Analysis:" ▪ Expanded medical indications to include: • A diagnosis of resectable or borderline resectable, or locally advanced/metastatic pancreatic adenocarcinoma; • A diagnosis of metastatic small bowel adenocarcinoma; • For members being evaluated for histiocytosis (Langerhans cell histiocytosis or Erdheim-Chester disease). ○ Under "Tumor Specific BRCA 1/2 Variant Analysis:" ▪ Expanded medically necessary indications to include: • Resectable, borderline resectable, or locally advanced/metastatic pancreatic cancer. ○ Under "Tumor Specific *FLT3* Variant Analysis:" ▪ Expanded medically necessary indications to include myeloproliferative neoplasm. ○ Under "Tumor Specific KRAS Variant Analysis": ▪ Expanded medically necessary indications to include resectable, borderline resectable of locally advanced/metastatic pancreatic adenocarcinoma. ○ Under "Tumor Specific Microsatellite Instability (MSI) Analysis": ▪ Expanded medically necessary indications to also include: • Recurrent, progressive or metastatic squamous cell carcinoma of the vulva; • Resectable, borderline resectable or metastatic pancreatic cancer. ▪ Expanded qualifying cancer stages for esophageal and esophagogastric junction cancer to align with guidelines. ○ Under "Tumor Mutational Burden (TMB)": ▪ Removal of recurrent progressive or metastatic cervical cancer from the list of medically necessary indications. ▪ Expanded criteria to include several new medically necessary indications.
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies – Minnesota Health Care Programs	• Effective 07/01/2024, policy revised. Please refer to published policy for details. ○ Under "Tumor-Type Agnostic Solid Tumor Molecular Profiling Panels:" ▪ Expanded medically necessary indications to include a diagnosis of: • Histiocytosis • Non-small cell lung cancer (NSCLC) regardless of stage

Coverage Policies	Comments / Changes
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies – Minnesota Health Care Programs – Cont'd	▪ Expanded medically necessary indication to include: • Uterine neoplasm undergoing initial evaluation; • Resectable or borderline resectable pancreatic adenocarcinoma when the member is being considered for systemic therapy. ○ Under "Broad RNA Fusion Panels:" ▪ Now considered medically necessary when criteria are met (diagnosis of adult or pediatric acute lymphoblastic leukemia [(ALL]). ○ Under "Colorectal Cancer Focused Molecular Profiling Panels:" ▪ Criteria updated; the following statements have been removed: • The member is seeking further cancer treatment (e.g., therapeutic chemotherapy). • The member has not had previous somatic testing via a multigene cancer panel for the same primary diagnosis of colorectal cancer. • The member has had previous somatic testing via a multigene cancer panel for a primary colorectal cancer diagnosis and has a new primary colorectal cancer diagnosis for which this testing is being ordered. ○ Under "Tumor Specific BCR/ABL1 FISH, Qualitative or Quantitative Tests:" ▪ Clarification to indicate *quantitative* testing is medically necessary for monitoring of disease progression for: • Acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic myelogenous leukemia (CML), or B-cell lymphoma. ▪ Criteria clarified to include indication for diagnostic workup for acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic myelogenous leukemia (CML) or B-cell lymphoma. ○ Under "Tumor Specific BRAF Variant Analysis:" ▪ Expanded medically indications to include: • A diagnosis of resectable or borderline resectable, or locally advanced/metastatic pancreatic adenocarcinoma; • A diagnosis of metastatic small bowel adenocarcinoma; • For members being evaluated for histiocytosis (Langerhans cell histiocytosis or Erdheim-Chester disease). ○ Under "Tumor Specific *FLT3* Variant Analysis:" ▪ Expanded medically necessary indications to include myeloproliferative neoplasm. ○ Under "Tumor Specific KRAS Variant Analysis:" ▪ Expanded medically necessary indications to include resectable, borderline resectable of locally advanced/metastatic pancreatic adenocarcinoma. ○ Under "Tumor Specific Microsatellite Instability (MSI) Analysis:" ▪ Expanded medically necessary indications to also include: • Recurrent, progressive or metastatic squamous cell carcinoma of the vulva; • Resectable, borderline resectable or metastatic pancreatic cancer. ▪ Expanded qualifying cancer stages for esophageal and esophagogastric junction cancer to align with guidelines.

Coverage Policies	Comments / Changes
Genetic testing: oncology – molecular analysis of solid tumors and hematologic malignancies – Minnesota Health Care Programs – Cont'd	○ Under "Tumor Mutational Burden (TMB):" ▪ Removal of recurrent progressive or metastatic cervical cancer from the list of medically necessary indications. • Expanded criteria to include several new medically necessary indications.
Genetic testing: aortopathies and connective tissue disorders	• Effective 7/1/2024: ○ Coverage criteria for FBN1 Sequencing and/or Deletion/Duplication Analysis to confirm a diagnosis of Marfan Syndrome are revised as follows. ○ FBN1 sequencing and/or deletion/duplication analysis to confirm a diagnosis of Marfan syndrome is considered medically necessary when: ○ The member has one of the following: ▪ Aortic root enlargement (Z-score 2.0 or greater) or dissection; or ▪ Ectopia lentis; or ▪ The member has a systemic score of 7 or higher (points values are in parentheses): • 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) ○ FBN1 sequencing and/or deletion/duplication analysis to establish or confirm a diagnosis of molecular Marfan syndrome is considered investigational for all other indications. ○ Known Familial Variant Analysis for Aortopathies and Connective Tissue Disorders criteria section will be removed from policy. Criteria for this type of testing will be located in the Genetic testing: general approach to genetic and molecular testing policy.

Coverage Policies	Comments / Changes

Wheelchairs - mobility assistive equipment (MAE)	• Effective immediately, policy revised.
	  ○ A power seat elevating system is now eligible for coverage when the following medical necessity criteria are met:
	  ▪ All of the coverage criteria for a power wheelchair are met; and
	  ▪ A specialty evaluation documenting the medical necessity for the power seat elevating feature was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experience in rehabilitation wheelchair evaluations. The PT, OT or physician may have no financial relationship with the supplier; and
	  ▪ One of the following applies:
	  • The member must routinely transfer between uneven surfaces, and the surfaces cannot be adjusted and the seat elevating feature allows them to independently transfer; or
	  • The member cannot be safely transferred using a patient lift or standing transfer but can safely transfer with the seat elevating feature; or
	  • The member is at high risk for repetitive strain injury or has limited range of reach of the upper extremities, which prohibits participation in MRADLs from a static seat height due to:
	  ○ Limited upper extremity strength; or
	  ○ Limited upper extremity active range of motion; or
	  ○ Deformity; or
	  ○ Short stature.
	• Prior authorization continues to be required for a power seat elevating system.

Genetic testing: prenatal diagnosis (via amniocentesis, CVS or PUBS) and pregnancy loss	• Effective 7/1/2024, policy revised:
	  ○ Prenatal Diagnosis for Noonan Spectrum Disorders/RASopathies:
	  ▪ The nuchal translucency requirement has changed from 3.5 mm to 3.0 mm.
	  ▪ This section will no longer specify a minimum gene list that must be included in panel tests.
	  ○ Chromosomal Microarray Analysis (CMA) for Pregnancy Loss: Removed criteria which listed specific practitioners that could order and provide counselling for this test. Instead the requirement will state that member has received counseling regarding the benefits and limitations of chromosome microarray analysis on products of conception.
	  ○ Prenatal Diagnosis via Exome Sequencing: Removed statement that exome or genome sequencing for pregnancy loss on products of conception is considered investigational.
	  ○ Definitions section has been updated to include intrauterine growth restriction/fetal growth restriction as an example of a major musculoskeletal malformation.

Coverage Policies	Comments / Changes
Genetic testing: prenatal diagnosis (via amniocentesis, CVS, or PUBS) and pregnancy loss	○ Prior authorization statements on the policy have been updated to read as follows: ▪ Prior authorization is required for genetic testing for exome sequencing for prenatal diagnosis. ▪ Prior authorization is not required for all other tests addressed on this policy.
Artificial intervertebral disc replacement	• Effective 7/1/2024, policy revised: ○ Under cervical artificial intervertebral disc replacement: ▪ Clinical documentation is to indicate a member has failed to respond to at least six weeks of conservative treatments. • Prior authorization continues to be required.
Genetic testing: multisystem inherited disorders, intellectual disability and developmental delay	• Effective 7/1/2024, policy revised. ○ Neurofibromatosis 1 genetic testing: added having a parent who meets the diagnostic criteria for Neurofibromatosis 1 as an additional coverage indication for testing. ○ Known familial variant analysis for multisystem inherited disorders: Criteria removed. Criteria for known familial variant tests has been consolidated on the "Genetic Testing: General Approach to Genetic and Molecular Testing" coverage policy . ○ Fanconi Anemia Multigene Panel: Removed minimum gene list requirement. ○ Noonan Spectrum Disorders/RASopathies Multigene Panel: Removed minimum gene list requirement. ○ Genetic testing for Cystic Fibrosis: Prior authorization is no longer required. ○ Genetic testing for Angelman/Prader-Willi Syndrome: Prior authorization is no longer required. ○ Autism Spectrum Disorder/Intellectual Disability Panel Analysis: Clarified that prior authorization is not applicable as testing is considered investigational/ experimental and therefore not covered. • Please refer to published policy for details.
Genetic testing: lung disorders	• Effective 7/1/2024, policy revised. ○ SERPINA1 Common Variant Analysis or Sequencing and/or Deletion/Duplication Analysis to establish a diagnosis of alpha-1 antitrypsin (AAT) deficiency: Coverage criteria have been expanded to allow AAT levels in the abnormally low or borderline range as a standalone indication for testing, instead of requiring low/borderline levels plus another condition. ○ Prior authorization is no longer required for the following services, unless they are billed with a general molecular pathology code (CPT 81400-81408, 81479) or unlisted multianalyte assay code (CPT 81599): ▪ SERPINA1 Common Variant Analysis or Sequencing and/or Deletion/Duplication Analysis ▪ Familial Pulmonary Fibrosis ▪ Primary Ciliary Dyskinesia ▪ Pulmonary lymphangioleiomyomatosis (LAM) ▪ Pulmonary alveolar proteinosis (PAP)

Coverage Policies	Comments / Changes
Genetic testing: lung disorders – Cont'd	○ SERPINA1 known familial variant analysis: Criteria removed. Criteria for known familial variant tests have been consolidated on the "Genetic Testing: General Approach to Genetic and Molecular Testing" coverage policy.
Blepharoplasty, blepharoptosis repair and brow lift	• Effective 7/1/2024, policy revised. ○ Update to "Indications that are not covered" to revise myasthenia gravis exclusion to state, "Surgical correction for members with myasthenia gravis when the disease has not been stable for a minimum of three years." ○ Under Blepharoplasty requirements, the provider's interpretation of the visual field testing now needs to correspond with the visual field testing submitted. This will change from "Written documentation of the provider's interpretation of the visual field testing," to "Written documentation of the provider's interpretation of the visual field testing that corresponds with the visual field testing submitted." ○ Criterion related to Brow Lift will change from "Diagnosis or description of a functional visual impairment that relates to the need for a brow lift," to "Diagnosis a*nd* description of a functional visual impairment that relates to the need for a brow lift."
Genetic testing: general approach to genetic and molecular testing	• Effective 7/1/2024, policy revised. ○ Single Gene or Multigene Panel Analysis/General Criteria for Oncology Algorithmic Tests/General Criteria for Other Tests sections: Added a requirement that the test being performed has clinical validity. ○ Single Gene or Multigene Panel Analysis/General Criteria for Tumor Biomarker Analysis/General Criteria for Oncology Algorithmic Tests/General Criteria for Other Tests: Requirements for clinical utility are now addressed consistently under each section. ○ General Criteria for Oncology Algorithmic Tests: Added "suspected neoplasm and/or malignancy" to the coverage criteria, as testing was previously only allowed for confirmed neoplasm. ○ General Criteria for Known Familial Variant Analysis for a Genetic Condition: Removed criterion "The genetic condition is associated with a significant health problem or problems." ○ General Criteria for Targeted Carrier Screening: Criteria moved from policy "Genetic Testing: Prenatal and Preconception Carrier Screening" to this policy to align with other general coverage criteria tests. Prior authorization is not required. ○ General Criteria for Tumor Biomarker Analysis: Criteria set name changed (formerly General Tumor Biomarker Analysis). ○ General Criteria for Oncology Algorithmic Tests: Criteria set name changed (formerly Oncology Algorithmic Tests). ○ General Criteria for Other Tests: Criteria set name changed (formerly Other Tests).

Coverage Policies	Comments / Changes
Genetic testing: epilepsy, neurodegenerative and neuromuscular disorders	• Effective 7/1/2024, policy revised. ○ Amyotrophic Lateral Sclerosis (ALS) Multigene Panel: Removed requirement that member is age 18 or older. ○ Huntington Disease: Added that predictive testing should not be done on asymptomatic minors. ○ Alzheimer Disease - PSEN1, PSEN2, and APP Sequencing and/or Deletion/Duplication Analysis: Clarified age requirements for symptomatic individuals. ○ Inherited Peripheral Neuropathies (examples: Charcot-Marie-Tooth Disease and Hereditary Neuropathy with Liability to Pressure Palsies) PMP22 Sequencing and/or Deletion/Duplication Analysis or Multigene Panel: Removed minimum gene list requirement. ○ Known familial variant analysis for epilepsy, neurodegenerative and neuromuscular disorders: Criteria removed. Criteria for known familial variant tests has been consolidated on the "Genetic Testing: General Approach to Genetic and Molecular Testing" coverage policy. ○ Genetic testing for Spinal Muscular Atrophy: Prior authorization is no longer required. ○ Amyotrophic Lateral Sclerosis (ALS) Multigene Panel: Prior authorization is no longer required. ○ Genetic testing for Duchenne and Becker Muscular Dystrophy: Prior authorization is no longer required. ○ Huntington Disease (HD) HTT repeat analysis: Prior authorization is no longer required. ○ Genetic testing for Myotonic Dystrophy: Prior authorization is no longer required. ○ Inherited Peripheral Neuropathy (Charcot-Marie-Tooth and Hereditary Neuropathy with Liability to Pressure Palsies) PMP22 Sequencing and/or Deletion/Duplication Analysis (81324, 81325): Prior authorization is no longer required. ○ D4Z4 Haplotype Analysis, and/or SMCHD1 and DNMT3B Sequencing and/or Deletion/Duplication Analysis or Multigene Panel: Criteria set name changed (formerly FSHD1 Deletion/Duplication or Haplotype Analysis, and/or SMCHD1 and DNMT3B Sequencing and/or Deletion/Duplication Analysis or Multigene Panel). • Please refer to published policy for details.
Genetic testing: exome and genome sequencing for the diagnosis of genetic disorders (Commercial and MHCP versions)	• Effective 7/1/2024, policy revised. ○ **Standard exome sequencing:** ▪ The list of indications that are covered when at least two conditions are present was updated. ▪ Removed abnormality of at least one organ system; dysmorphic features; encephalopathy; and added bilateral sensorineural hearing loss of unknown etiology; autism; severe neuropsychiatric condition; and period of unexplained developmental regression. ▪ Revised "developmental delay" requirement to "global developmental delay."

Coverage Policies	Comments / Changes
Genetic testing: exome and genome sequencing for the diagnosis of genetic disorders *(Commercial and MHCP versions) – Cont'd*	▪ Clarified that repeat standard exome sequencing is considered investigational instead of not medically necessary. ○ **Reanalysis of Exome or Genome Sequencing Data:** ▪ Criteria set name changed (formerly "Reanalysis of Whole Exome Sequencing Data"). ▪ Criteria expanded to allow a path to approval for a member to get reanalysis prior to 18 months if they have new qualifying findings not explained by results of previous sequencing. ▪ Clarified that reanalysis of exome or genome sequencing data is considered investigational for all other indications, instead of not medically necessary for all other indications. ○ **Rapid exome sequencing:** ▪ Added requirement that member has not previously had genome sequencing. ▪ Added coverage indications for unexplained epilepsy; global developmental delay or intellectual disability with onset prior to age 18 years; and being diagnosed with at least one congenital anomaly. ▪ The list of indications that are covered when at least two conditions are present was updated. ▪ Removed abnormality affecting at least one organ system; dysmorphic features; encephalopathy; and added bilateral sensorineural hearing loss of unknown etiology; autism; severe neuropsychiatric condition; and period of unexplained developmental regression. ▪ Removed criterion that member does not have isolated transient neonatal tachypnea, isolated unconjugated hyperbilirubinemia, isolated hypoxic ischemic encephalopathy or isolated meconium aspiration. ○ **Standard genome sequencing:** ▪ Added requirement that the member's personal and family histories have been evaluated by a Medical Geneticist, Genetic Counselor or an Advanced Practice Nurse in Genetics (APGN). ▪ The list of indications that are covered when at least two conditions are present was updated. ▪ Removed abnormality of at least one organ system; dysmorphic features; encephalopathy; and added bilateral sensorineural hearing loss of unknown etiology; autism; severe neuropsychiatric condition; and period of unexplained developmental regression. ▪ Added that repeat standard genome sequencing is considered investigational. ○ **Rapid genome sequencing:** ▪ Removed criterion for encephalopathy plus another listed condition. ▪ Added epileptic encephalopathy as a standalone indication for coverage. ▪ Removed criterion that member does not have isolated transient neonatal tachypnea, isolated unconjugated hyperbilirubinemia, isolated hypoxic ischemic encephalopathy or isolated meconium aspiration.

Coverage Policies	Comments / Changes
Genetic testing: exome and genome sequencing for the diagnosis of genetic disorders *(Commercial and MHCP versions) – Cont'd*	• Please refer to published policy for details. • Please note, these changes also apply to the Minnesota Health Care Providers (MHCP) version of this policy, with the exception of the Rapid Genome Sequencing section. That section reflects MHCP provider manual criteria and has not been revised.

Wheelchairs – mobility assistive equipment (MAE) – Minnesota Health Care Programs	• Effective 7/1/2024, policy revised.
	  ○ Policy updated to align with criteria in MHCP provider manual.
	  ○ Prior authorization will be required for robotic arms used with power wheelchairs effective 7/1/2024.

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

Drug Formulary updates

COMMERCIAL DRUG FORMULARY

Updates include:

- Methylphenidate ER Brands (Quillivant and Quillichew) are being removed from the formulary. Members will be asked to update to preferred products.
- Teriparatide (generic Bonsity) is being removed from the formulary. Teriparatide (generic Forteo) is a preferred alternative. Current PAs are being honored (members are not required to make changes), but copays may increase.

Please see the formulary for details, at **healthpartners.com/formularies**. Updates will be posted by July 1, 2024.

Pharmacy Medical Policies

COMMERCIAL UPDATES

Coverage policies	Comments / changes
ADAMTS13, recombinant-krhn (Adzynma)	A new FDA approval for the treatment of congenital thrombotic thrombocytopenic purpura (cTTP).
Biologics for Chronic Inflammatory Disease	Mirikizumab (Omvoh) has been added to this policy.
Botulinum toxins	A policy update. For the prevention of chronic migraine headaches, the number of prior preventive therapies has been reduced from three to two.
Burosumab (Crysvita)	A policy update for expanded indications.
Complement inhibitors (Soliris, Ultomiris, Empaveli)	A policy update to allow coverage of Soliris for CHAPLE disease.
Ketamine infusion	Ketamine is considered investigational for depression.
Oncology – long-acting G-CSF	Brand Neulasta will be non-preferred. Fulphila has been added, and both Udenyca (and Udenyca Onpro) and Fulphila are preferred.

Coverage policies	Comments / changes
Oncology drug coverage	Prior authorization is required for oncology drugs listed on this policy. Drugs recently added to this policy: • Toripalimab (Loqtorzi) Additional criteria may apply – see the coverage policy for more information.
Pompe disease enzyme replacement therapy	Cipaglucosidase (Pombiliti) has been added to this policy.
Pozelimab-bbfg (Veopoz)	A new FDA- approval for the treatment of CHAPLE disease.

SELF-ADMINISTERED DRUGS (SAD) POLICY UPDATES

This policy identifies self-administered drugs that are only available for coverage under a member's pharmacy benefit, subject to the member's coverage document. The following additions are effective July 1, 2024.

Generic Name	Brand Name
adalimumab-ryvk	SIMLANDI
infliximab-dyyb	ZYMFENTRA
mirikizumab-mrkz	OMVOH
teduglutide	GATTEX
ustekinumab-auub	WEZLANA
vedolizumab	ENTYVIO SQ

MEDICARE UPDATES

Coverage policies	Comments / changes
Medicare Part B Step Program	Viscosupplement injections: Euflexxa and Synvisc are preferred. All others are non-preferred. Step therapy only applies to new starts – patients stable on non-preferred medications can continue therapy with the non-preferred agent.

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**.

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**.

Government Programs

Moving expenses now a covered benefit through MHCP

EFFECTIVE APRIL 1, 2024

Moving expenses for Housing Stabilization Services are now a covered benefit through Minnesota Health Care Programs (MHCP). This service is available to enrollees receiving Housing Stabilization-Transition services who have been approved by the Minnesota Department of Human Services (DHS) and are transitioning out of a Medicaid-funded institution, leaving a provider-operated living arrangement, or currently homeless and staying in a shelter in the last 12 months and moving into their own home.

Moving expenses are non-reoccurring and limited to a maximum of $3,000 annually within an approved Housing Stabilization Services eligibility span, and are reimbursed to providers. Moving expenses are covered only to the extent that they are determined reasonable and necessary.

Providers should follow DHS guidelines on submitting requests to add moving expenses to a person's current approved Housing Stabilization Services eligibility span, or submit an initial, renewal or provider change requesting adding moving expenses. Moving Expenses must occur *after* DHS has issued the approval letter.

Once HealthPartners receives the Eligibility Approval Notice, providers will be able to submit moving expenses claims for those members.

- Submit itemized receipts to show proof of transaction; the submission method must be reflected on the claim.
- Fax receipts to HealthPartners at **952-853-8860** using an Administrative Uniformity Committee (AUC) cover sheet. The attachment control number on the cover sheet must be an exact match to the control number submitted in the PWK segment of the electronic claim.
- Fax the cover sheet at the same time claims are submitted. All claims without substantiating receipts will be denied. We recommend providers not include other services on the same claim as moving expenses because it will result in a delay.

Claims will be reviewed in a timely manner not exceeding 90 days. Please review **Housing Stabilization Services / Minnesota Department of Human Services (mn.gov)** for a complete list of requirements. If there are questions about submitting Moving Expenses claims to HealthPartners, please contact **rvscproviderinquiry@healthpartners.com** or call **952-883-7699 / 888-663-6464**.

URGENT

Provider Enrollment Requirement for Minnesota Health Care Programs (MHCP)

If your practitioners and locations have not enrolled with the Minnesota Department of Human Services (DHS) yet, please do so as soon as possible. All National Provider Identifiers (NPIs) including group, facility and individual NPIs need to be enrolled with DHS.

Your enrollment must be completed before the **July 15, 2024 deadline,** with the exception of these provider types that have until December 31, 2024 to enroll:

- Community Mental Health Centers
- Rehab Agencies
- Day Treatment
- Home Care Nursing Organizations
- Medical Transportation

If your locations and practitioners are already enrolled with DHS as a fee-for-service provider, you do not need to go through the screening and enrollment process again.

DHS uses additional sources such as **NPPES** and **Medicare** to verify your enrollment. Please review your information on **NPPES** and **Medicare** to ensure your records are up to date when enrolling with DHS.

For more information regarding enrollment with DHS, visit these resources:

- FAQ: **Enrollment for MCO Network Providers**
- DHS Enrollment Process: **Enrollment with MHCP**
- DHS Enrollment Portal Training and FAQ: **Minnesota Provider Screening and Enrollment (MPSE) portal training**

HealthPartners MSHO Model of Care 2024

REMINDER – TRAINING REQUIREMENT FOR PROVIDERS

The Minnesota Senior Health Options (MSHO) Model of Care provides a description of the management, procedures and operational systems that HealthPartners has in place to provide the access to services, coordination of care and structure needed to best provide services and care to our MSHO population. The training provides a general understanding of how a member would access the benefits provided through the MSHO Model of Care.

Annual training on the Model of Care is a Centers for Medicare and Medicaid Services (CMS) requirement for Special Needs Plans. The Model of Care contains the following components:

1. Description of the MSHO population
2. Care Coordination
3. MSHO Provider Network
4. MSHO Quality Measurement & Performance Improvement

The HealthPartners 2024 MSHO Model of Care Training PowerPoint can be accessed on the Provider Portal at **2024 MSHO Model of Care Training**.

HealthPartners Inspire (SNBC) Stakeholder Meeting - Virtual

Click to access meeting

Providers are invited to join us for a virtual SNBC stakeholder meeting on **Thursday, May 16th, 2024 from 1-2:30 PM**, via Microsoft Teams.

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 Bouachanh Vue – **bouachanh.n.vue@healthpartners.com**.

Access the meeting at: **https://tinyurl.com/hpsnbcspring2024** *OR* Call **612-428-2306**, **conference ID 298 756 169#**

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 **compliance@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 ☐

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