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**General Information**

**Effective in July 2012:**

'Cost Estimator' transparency tool to use fee-based estimates

Medica recently launched the "Health Care Cost Estimator," a transparency tool currently used by certain Medica members. In July 2012, there are changes planned for this transparency initiative that will expand its usefulness for these members: estimating costs based on contracted rates vs. historical claims whenever possible, and lowering the tool's minimum claims threshold from 11 to 5 claims per evaluated service, where claims data are still needed.

There will be some services which will still utilize a claims-based methodology, such as a percent-of-billed-charges rate for selected outpatient services, or other circumstances where a set fee schedule does not apply or is not available. When no fixed fee is available, the tool will default to average claims costs.

Once enhanced, the tool will continue to display market average costs, and facility- or physician-
specific estimated costs. With future enhancements planned for late 2012, estimates in the tool will be based on the allowed fee schedule or contracted rate amount in effect at the time the estimate is created.

More details are available on medica.com.

(Update to "Medica to begin next phase of consumer transparency" article in March 2012 edition of Medica Connections. View March 2012 edition.)

Reminder:

Medica to reward innovation in advancing Triple Aim
'Raising the Bar’ awards worth up to $25,000 each

Medica is currently offering its fifth-annual innovations award for provider groups, called "Raising the Bar: Rewarding Innovation in Redesigning Roles and Relationships in Health Care Delivery." Medica wants to recognize the work of provider groups striving to improve the delivery of healthcare services through innovative care solutions that better serve their community and their patients. One or more Medica innovation awards worth up to $25,000 each will be presented in fall 2012.

Any provider group, clinic or facility that administers patient care in the Medica provider network is eligible for this annual award. The deadline for award applications is June 30, 2012. More information, including the award application, is available online at medica.com. See full details.

Providers who have questions may contact Kathleen Miles, Medica provider relations manager, at kathleen.miles@medica.com or 952-992-1721.

U of M Medical School to study smoking causation, addiction
Looking for smokers to volunteer for NIH-funded research

The University of Minnesota Medical School on the Twin Cities campus needs volunteers to participate in a study that will not only help people quit smoking, but help research scientists learn more about why people smoke and why it is difficult for them to quit. The research is being conducted with a major grant from the National Institutes of Health (NIH).

Until fall 2012, providers are welcome to mention this study to patients who they believe would make good study participants. Participants must be 18-70 years of age, be of generally good health, smoke daily, and be ready to quit smoking. Candidates will be asked a series of questions to determine if they qualify for the study. Researchers are seeking 150 participants, who would receive compensation for completing all 12 sessions of the study.

To find out more about this study, providers or patients may:

- Visit the U of M research website
- Call 612-624-5286

Annual notice:
Member rights and responsibilities, for providers to know

Medica recognizes the importance of a three-way relationship among members, their providers and their health plan. Medica believes that education about health care responsibilities is important because it helps members get the greatest benefit from their health plan. Medica outlines member rights and responsibilities for the Medica physician and provider community in order to improve the health of the members Medica serves.

As a reminder, information about member rights and responsibilities is posted online. Providers are
encouraged to review and understand these details. See "Regulatory/Reporting Information" in the Medica Provider Administrative Manual.

Annual notice:

Provider appeals on behalf of Medica members

Medica members have the right to appoint representatives, such as their providers, to initiate member appeals. For cases involving member liability, providers may initiate an appeal on behalf of a Medica member by calling the Medica Provider Service Center. At the request of the member or provider, the appeals staff will conduct a case review of previously denied services to ensure accurate review, and coverage of eligible services according to the member's benefit document.

For more details about appeals:

- See "Benefit Appeals" in the Provider Administrative Manual.
- See "Member Assistance Services" in the Provider Administrative Manual.
- Call the Medica Provider Service Center toll-free at 1-800-458-5512.

Annual notice:

Medica reaffirms its policy regarding utilization management

Utilization management (UM) is a process Medica uses to evaluate health care services for appropriateness and efficacy. UM decisions are based only on the appropriateness of care, service and existence of coverage. Medica does not specifically reward providers, practitioners, staff members or their supervisors who conduct utilization reviews on Medica's behalf for issuing denials of coverage or service. It is important to note that UM decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the under-utilization of services.

Providers who want more information about the UM process may:

- Refer to Medica UM policies at medica.com.
- Call the Medica Provider Service Center.

Compliance and FWA training required for Medicare providers

The Centers for Medicare and Medicaid Services (CMS) requires that Medicare providers complete compliance awareness training and fraud, waste, and abuse (FWA) awareness training each year. The training requirement applies to all organizations that provide healthcare services or administrative services for Medicare-eligible individuals under the Medicare Advantage or Medicare Part D programs, and to the organizations' first-tier, downstream, and related entities. (Medicare-certified providers are exempt from the fraud, waste and abuse portion of the training.)

Medica currently has its annual training available on medica.com, where providers can also access the Medica Standards of Conduct and Medica Compliance Reporting Policy. See more about fraud and abuse, including the 2012 compliance training.

This training is also available by clicking on the Fraud & Abuse link at the bottom of any page on to medica.com, scrolling to the section titled Compliance Training, and selecting the Compliance and Fraud Waste and Abuse Awareness Training link. Or if providers prefer, they can choose to take the training from another source as long as it meets CMS requirements.

Training is required at the time of a provider's initial contract, and annually thereafter, by December 31
of each year. Providers should maintain records of all training, including: dates and methods of training; materials used for training; and training logs identifying employees receiving training. Medica, CMS, or agents of CMS may request such records to verify that training occurred.

Clinical Information

Effective April 18, 2012:

Medica makes new benefit determination

The following benefit determination was effective beginning with April 18, 2012, dates of service. This change applies to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

Sacral nerve stimulation
Medica has expanded its coverage for sacral nerve stimulation (SNS) to include treatment of fecal incontinence in a select population of patients. Medica has reviewed SNS for fecal incontinence and has determined that it will be covered for adults who have had a thorough diagnostic work-up and meet all of the following criteria:

- Failed conservative treatments (e.g. pharmacotherapies, dietary management, strengthening exercises);
- Failed surgical treatment or not appropriate candidates for surgical treatment;
- Symptoms result in a significant functional disability; and
- A positive response (50 percent or greater improvement in function) to a trial of temporary percutaneous SNS.

SNS remains investigative and therefore not covered for the treatment of fecal incontinence in children.

SNS also continues to be covered for the treatment of chronic urinary urge incontinence, non-obstructive urinary retention, and urge/frequency syndrome for patients who meet all of the criteria outlined in the coverage policy. SNS for urinary conditions remains investigative and therefore not covered for all other indications, including but not limited to stress incontinence.

SNS is the application of a mild electrical pulse to the sacral nerves through a surgically implanted neuromodulation system to treat urinary or fecal incontinence. The electrical pulses modulate the sacral nerves that influence the functioning of the bladder, bowel, urinary, and anal sphincters, and the pelvic floor muscles.

Medica previously notified providers about this benefit change with a Provider Alert in late April 2012.

The complete text of the policy that applies to the determination above is available online or on hard copy:

- See coverage policies at medica.com.
- Call the Medica Provider Literature Request Line for printed copies of documents: 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355.

Effective May 1, 2012:

Medica updates UM policy for GI surgery for morbid obesity

The following utilization management (UM) policy changes were effective beginning with May 1, 2012, dates of service. These changes apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

GI surgery for morbid obesity
Medica has made revisions to the medical necessity criteria for gastrointestinal (GI) surgery for
morbid obesity. The body mass index (BMI) requirements for performance of any surgical technique Medica covers (including sleeve gastrectomy and biliopancreatic diversion with duodenal switch) have been standardized into two BMI criteria sets: BMI of 35-39.9, and BMI greater than or equal to 40.

- For a BMI greater than or equal to 40:
  - Documentation of an existing comorbidity is no longer required.
  - Submission of documentation is required verifying participation in a diet, nutrition, and exercise counseling regimen as recommended and defined by the bariatric surgical preparatory team.
- For a BMI of 35-39.9:
  - Documentation of one preexisting comorbidity (rather than two) is required.
  - Submission of documentation is required verifying participation in a diet, nutrition, and exercise counseling regimen as recommended and defined by the bariatric surgical preparatory team.

**Note:** Prior authorization continues to be required for GI surgery for morbid obesity.

Gastrointestinal surgery for obesity (aka bariatric surgery) is performed on the stomach and/or intestines to facilitate weight loss in individuals with a BMI that defines an individual as either severely (BMI 35 to 39.9) or morbidly (BMI greater than or equal to 40) obese. Surgical procedures are classified as either restrictive or combined restrictive/malabsorptive. Examples of restrictive procedures include adjustable gastric banding, sleeve gastrectomy, and vertical banded gastropasty. Examples of combined restrictive/malabsorptive procedures include Roux-en-Y gastric bypass and biliopancreatic diversion with duodenal switch.

Medica previously notified providers about the above changes with a Provider Alert in early May 2012.

The complete text of this revised policy is available online or on hard copy:

- **See UM policies at medica.com.**
- Call the Medica Provider Literature Request Line for printed copies of documents.

**Effective July 1, 2012:**

**Medica to implement new utilization management policies**

Beginning with July 1, 2012 dates of service, Medica will implement the following new utilization management (UM) policies that require prior authorization. These changes apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

By instituting prior authorization for the following procedures, Medica aims to support members and providers in making evidence-based decisions about appropriate, medically necessary care. While it is expected that prior authorization be obtained before services are rendered, Medica reserves the right to conduct reviews at the time the claim is received if no authorization was previously requested.

**Comparative genomic hybridization microarray testing**

As of July 1, 2012, comparative genomic hybridization (CGH) microarray testing for neurodevelopmental chromosomal imbalances will require prior authorization as outlined below. A new UM policy will address this change and replace the Medica coverage policy "Comparative Genomic Hybridization (CGH) Microarray Testing for Neurodevelopmental Chromosomal Imbalances."

Prior authorization will be required for CGH microarray testing for neurodevelopmental chromosomal imbalances in the outpatient/clinic setting, but will not be required for neonates in the neonatal intensive care unit (NICU) setting.

CGH microarray testing is considered medically necessary for individuals in the outpatient/clinic setting in the following situations:

- When an individual is clinically suspected of having an underlying genetic condition or
syndrome unrelated to a well-delineated genetic syndrome normally evaluated with conventional genetic evaluation (e.g., karyotyping or fluorescence in situ hybridization (FISH)) and who presents with one of the following: autism spectrum disorder, developmental delay, dysmorphic features, intellectual disabilities (mental retardation), multiple congenital anomalies, or an isolated congenital anomaly when family history suggests autosomal dominant or X-linked inheritance and genetic association of the anomaly has not been indicated with previous conventional genetic evaluation.

- For evaluation of a stillbirth or miscarried fetus with a suspected genetic syndrome when conventional genetic evaluation is not possible (e.g., viable cells are not retrievable) and results will be used for more informed reproductive decision-making.
- For evaluation of biological parents when postnatal CGH microarray testing of a previous offspring confirms a genetic condition or syndrome, conventional genetic evaluation is not adequate, and results will be used for more informed reproductive decision-making.

For individuals in the outpatient/clinic setting, the test must be ordered by a medical geneticist or care provider (e.g., genetic counselor, physician, physician assistant, nurse practitioner) under the supervision of a medical geneticist with expertise in the diagnosis and/or management of a condition associated with neurodevelopmental chromosomal imbalances. In addition, a board-certified genetic counselor or medical geneticist must review and document family history, create a pedigree, advise the patient of the potential benefits and harms of the testing and implications of the test results, and obtain written informed consent.

For neonates in the NICU setting, CGH microarray testing is considered medically necessary when the test is ordered by a medical geneticist, neonatologist, or pediatric cardiologist who has expertise in the diagnosis and/or management of a condition associated with neurodevelopmental chromosomal imbalances. An underlying, life-threatening genetic condition or syndrome unrelated to a well-delineated genetic syndrome normally evaluated with conventional genetic evaluation must be suspected and results of testing are needed in urgent care management determinations.

CGH microarray testing (aka array-based comparative genomic hybridization or aCGH) is a laboratory test performed to detect unbalanced genomic copy number variations such as microdeletions and/or microduplications at a higher resolution level than conventional genetic evaluation (e.g., karyotype analysis or FISH). The test can be performed on blood, body fluid, or tissue specimens.

**HLA-DQ genetic testing for diagnosis of celiac disease**

As of July 1, 2012, human leukocyte antigen-DQ (HLA-DQ) genetic testing for diagnosis of celiac disease will require prior authorization. A new UM policy will address this change and replace the Medica coverage policy "Human Leukocyte Antigen-DQ (HLA-DQ) Genetic Testing for Diagnosis of Celiac Disease."

HLA-DQ testing to assist in the diagnosis of celiac disease is considered medically necessary when testing is ordered by a gastroenterologist and all of the following criteria are met:

- Diagnosis of celiac disease is uncertain following small bowel biopsy and serology testing
- The individual has displayed small bowel symptoms and/or symptoms associated with possible celiac disease
- Symptoms have improved on a monitored gluten-free diet.

HLA-DQ genetic testing for celiac disease is a laboratory blood test performed to evaluate genetic variants associated with celiac disease. Celiac disease is a multifactorial systemic autoimmune disorder, with environmental as well as HLA and non-HLA genetic components. The diagnosis of celiac disease typically relies on serological antibody testing, small-bowel biopsy, and/or improvement seen on biopsy following adherence to a gluten-free diet. Since 30-40 percent of the general population carries one of the celiac disease-associated HLA alleles and only about 3 percent develop celiac disease, the presence of celiac disease-associated HLA alleles cannot be used to confirm a diagnosis of celiac disease. However, absence of these alleles essentially excludes a diagnosis of celiac disease.

As of July 1, 2012, the complete text of the above UM policies will be available online or on hard copy:

- [See UM policies at medica.com](#)
Effective July 1, 2012:

Medica to make utilization management policy change

Effective with July 1, 2012, dates of service, Medica will revise the following utilization management (UM) policy that requires prior authorization. These changes apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

Through prior authorization for procedures, Medica aims to support members and providers in making evidence-based decisions about appropriate, medically necessary care. While it is expected that prior authorization be obtained before services are rendered, Medica reserves the right to conduct reviews at the time the claim is received if no authorization was previously requested.

Varicose vein and venous insufficiency treatments
Medica has revised the medical necessity criteria for treatment of varicose veins using ultrasound-guided sclerotherapy. Beginning with July 1, 2012 dates of service, treatment of varicose veins using ultrasound-guided sclerotherapy will be considered medically necessary when the revised criteria below are met.

The revised criteria will address treatment of significant small varicose veins (sometimes called small tributary veins, truncal, lateral truncal, pudendal or branch veins) in two populations: patients who have undergone initial saphenous vein ligation, stripping, or endovenous radiofrequency/laser ablation of the great saphenous vein (GSV) and/or the small saphenous vein (SSV) and those who have not.

- For treatment of significant small varicose veins with ultrasound-guided foam sclerotherapy in a patient who has undergone saphenous vein ligation, stripping, or endovenous radiofrequency/laser ablation of the GSV and/or SSV, criteria will need to be met regarding time elapsed since initial surgery, reflux duration, vein size, and functional impairments related to varicose vein to be treated.
- For treatment of significant small varicose veins with ultrasound-guided foam sclerotherapy in a patient who has not undergone saphenous vein ligation, stripping, or endovenous radiofrequency/laser ablation of the GSV and/or SSV, criteria will need to be met regarding three-month trial of compression stockings, reflux duration, vein size, and functional impairments related to varicose vein to be treated.

As of July 1, 2012, the complete text of this revised UM policy will be available online or on hard copy:

- See UM policies at medica.com.
- Call the Medica Provider Literature Request Line for printed copies of documents.

Medical policies and clinical guidelines to be updated

Medica will soon update one or more utilization management (UM) policies, coverage policies, Institute for Clinical Systems Improvement (ICSI) guidelines, and Medica clinical guidelines, as indicated below. These policies will be effective July 1, 2012, unless otherwise noted.

<table>
<thead>
<tr>
<th>UM Policies — New</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative Genomic Hybridization (CGH) Microarray Testing for Neurodevelopmental Chromosomal Imbalances</td>
<td>III-DIA.09</td>
</tr>
</tbody>
</table>
Human Leukocyte Antigen-DQ (HLA-DQ) Genetic Testing for Diagnosis of Celiac Disease

UM Policies — Revised
These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Growth Stimulators</td>
<td>III-DEV.07</td>
</tr>
<tr>
<td>Gastrointestinal Surgery for Morbid Obesity (effective 5/1/12)</td>
<td>III-SUR.30</td>
</tr>
<tr>
<td>Implantable Deep Brain Stimulation</td>
<td>III-DEV.19</td>
</tr>
<tr>
<td>Microprocessor Controlled Knee Prostheses, with or without Polycentric, Three-Dimensional Endoskeletal Hip Joint System</td>
<td>III-DEV.17</td>
</tr>
<tr>
<td>Outpatient Enteral Nutrition Therapy</td>
<td>III-MED.03</td>
</tr>
<tr>
<td>Varicose Vein and Venous Insufficiency Treatments: Including Ligation/Stripping, Phlebectomy, Endovenous Radiofrequency Ablation, Endovenous Laser Ablation, Sclerotherapy Procedures</td>
<td>III-SUR.26</td>
</tr>
</tbody>
</table>

Coverage Policies — Revised
These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Magnetic Resonance Imaging (MRI) (administrative update only; effective 5/1/12)</td>
<td>III-DEV.07</td>
</tr>
<tr>
<td>Noncontact, Low-frequency Ultrasound Therapy for Healing of Chronic Wounds</td>
<td>III-DEV.19</td>
</tr>
<tr>
<td>Sacral Nerve Stimulation (SNS) (effective 4/18/12)</td>
<td>III-MED.03</td>
</tr>
<tr>
<td>Thoracic Electrical Bioimpedance (TEB) for Cardiac Output Measurement</td>
<td>III-SUR.26</td>
</tr>
</tbody>
</table>

Coverage Policies — Inactivated

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Comparative Genomic Hybridization (CGH) Microarray Testing for Neurodevelopmental Chromosomal Imbalances</td>
</tr>
<tr>
<td>Human Leukocyte Antigen-DQ (HLA-DQ) Genetic Testing for Diagnosis of Celiac Disease</td>
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</table>

ICSI Guidelines — Revised
These guidelines are available on medica.com.

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents (released March 2012)</td>
</tr>
<tr>
<td>Immunizations (released March 2012)</td>
</tr>
</tbody>
</table>

As of July 1, 2012, these documents will be available online or on hard copy:

- View medical policies and clinical guidelines at medica.com;
- Call the Medica Provider Literature Request Line for printed copies of documents.

Pharmacy Information

Effective July 1, 2012:
Changes to Medica Part D drug formulary

Medica posts changes to its Part D drug formularies on medica.com 60 days prior to the effective date of change. The latest lists notify Medicare enrollees of drugs that will either be removed from the Medica Part D formulary or be subject to a change in preferred or tiered cost-sharing status effective July 1, 2012. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Medica periodically makes changes to the following Medica Medicare Part D formularies: the Part D open formulary (3 tier + specialty tier), the Part D closed formulary (2-tier), and the Part D thrift formulary. View the latest Medicare Part D drug formulary changes.
The Medica Medicare Part D drug formularies are available online or on paper:

- View the Medica Part D formularies at medica.com.
- Call the Medica Provider Literature Request Line to request a printed copy.

Medication request forms
A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information. To request formulary exceptions, providers can:

- Download a coverage determination form at medica.com.
- Call MedImpact at 1-800-788-2949.

Network Information

Effective July 1, 2012:
Medica to update Medicare physician fee schedule

Effective with July 1, 2012, dates of service, Medica will implement the quarterly update to its Medicare physician fee schedule for applicable Medica products. This fee schedule change will reflect the July 2012 Centers for Medicare and Medicaid Services (CMS) update applicable to reimbursement for injectable drugs, immunizations, durable medical equipment (DME), and orthotics and prosthetics (O&P). The reimbursement impact of this quarterly update will vary based on specialty and mix of services provided.

Details on Medicare changes to drug, DME and O&P fees are available online from CMS. Providers who have further questions may contact their Medica contract manager.

Administrative Information

Provider College administrative training topic for June

The Medica Provider College offers educational sessions on various administrative topics throughout the Medica service area. The following class is available by webinar for all Medica network providers.

Training class topic
"Medica Prime Solution Medicare Product in ND/SD" (class code: PS-WJune)
This course will review information to assist North Dakota and South Dakota providers in understanding when Medica follows Centers for Medicare and Medicaid Services (CMS) guidelines for the Medica Prime Solution® product. Topics covered will include billing requirements and reimbursement. Time will also be provided for questions and answers as part of this discussion.

<table>
<thead>
<tr>
<th>Class code</th>
<th>Topic</th>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS-WJune</td>
<td>Medica Prime Solution Medicare Product in ND/SD</td>
<td>June 27</td>
<td>10 -11 a.m.</td>
<td>Class code with &quot;WJune&quot; means offered via webinar in June</td>
</tr>
</tbody>
</table>

For webinar trainings, login information and class materials are e-mailed close to the class date. To ensure that training materials are received prior to a class, providers should sign up as soon as possible.
The time reflected above allows for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement.

**Registration**

*The registration deadline for all classes is one week prior to the class date.* To register for the session listed, providers may do either of the following:

- Fill out the [Provider College registration form](https://medica.com/events-and-training) (available online at medica.com under "Events and Training") and e-mail it to providercollege@medica.com.
- Send an e-mail with the same details as listed on the registration form to providercollege@medica.com.

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**Effective July 1, 2012:**

**Medica to update reimbursement/claims policy**

Medica will soon update the reimbursement/claims policy indicated below, effective with July 1, 2012, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

**3-Day Payment Window**

It is Medica’s policy to apply the Centers for Medicare and Medicaid Services (CMS) 3-Day Payment Window Policy for all Medica Medicare products. According to the 3-Day Payment Window Policy, a hospital (or an entity wholly owned or operated by the hospital) is required to include in its claim for an inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and non-diagnostic admission-related services provided during the 3 days prior to admission to the hospital.

CMS recently updated the 3-Day Payment Window Policy to include new requirements specific to entities/physician groups that are wholly owned or wholly operated by a hospital. These requirements apply to services provided on or after January 1, 2012, with full compliance required by July 1, 2012.

Medica has added the following information to its 3-Day Payment Window Policy to reflect the new CMS requirements:

- The 3-day payment window applies to entities/physician groups that are wholly owned or wholly operated by a hospital. The hospital is responsible for notifying such entities/physician groups of an inpatient admission of a patient who received services at the entity/physician group within the 3-day payment window.
- When billing for services subject to the 3-Day Payment Window policy, wholly owned/operated entities must identify applicable charges through the use of the PD modifier:
  - The PD modifier ("Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days") is to be applied to all claim lines for diagnostic services and to those claim lines for nondiagnostic services that have been identified as related to the inpatient stay.
  - Physician nondiagnostic/therapeutic services that are unrelated to the hospital inpatient admission are not subject to the payment window and should be billed without the PD modifier.
- When a wholly owned or wholly operated entity/physician group has provided a service subject to the 3-Day Window Policy, services with payment rates that include a professional and technical split will be reimbursed for the professional component only. Services that do not have a professional and technical split will be reimbursed at the facility rate according to the site-of-service differential.

As of July 1, 2012, the revised policy will be available online or on hard copy:

- View reimbursement policies at medica.com.
- Call the Medica Provider Literature Request Line for printed copies

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Effective April 1, 2012:

**Medica updates reimbursement/claims policies**

Medica has updated the reimbursement/claims policies indicated below, effective with April 1, 2012, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

**Reimbursement/Claims Policies — Revised**

*These versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
<th>Add-On Code</th>
<th>Same Day Same Service</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><em>(updated code list)</em></td>
<td><em>(updated code list)</em></td>
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</tbody>
</table>

These revised policies are available online or on hard copy:

- [View reimbursement policies at medica.com](#).
- Call the Medica Provider Literature Request Line for printed copies of documents.

**Update to Medica Provider Administrative Manual**

To ensure that providers receive information in a timely manner, changes are often announced in *Medica Connections* that are not yet reflected in the Medica Provider Administrative Manual. Every effort is made to keep the manual as current as possible. The table below highlights the updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

<table>
<thead>
<tr>
<th>Location in manual</th>
<th>Information updated</th>
<th>When posted online in manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Fraud and Abuse&quot; section, in &quot;Compliance Training for Medica Providers and Business Partners&quot; subsection</td>
<td>Updated &quot;Fraud, Waste and Abuse&quot; content related to 2012 compliance trainings.</td>
<td>May 2012</td>
</tr>
</tbody>
</table>

For the current version, providers may [view the Medica Provider Administrative Manual online](#).

**Know of colleagues who should get this regularly?** [Have them sign up.](#)

*Medica Connections* is published monthly by Medica and can be accessed online. [View the *Medica Connections* archive.](#)

**Physician leadership at Medica:**

Jim Guyn, MD  
Vice President and Senior Medical Officer

Ted Loftness, MD  
Vice President and Medical Director

Thomas Becker, MD  
Medical Director for Care Management and Reimbursement

**Medica Connections editor:**

Hugh Curtler III  
Medica, Marketing & Communications  
Phone: 952-992-3354  
Fax: 952-992-3377  
Email: [hugh.curtler@medica.com](mailto:hugh.curtler@medica.com)

For Medica contact and reference information, [see Medica Points of Contact for Providers.](#)