September 2012

MEDICA Connections

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**General Information**

**Premium Designation reconsideration period underway**

Medica has sent Medica Premium Designation Program notification letters with 2012 results to affected physicians. The data-reconsideration period is currently underway, running through September 15, 2012, after which Medica plans to publish the results in October 2012. To view their data, physicians need to be registered to access secure Premium Designation reports, which are available through the program home page at [medica.com/premium](http://medica.com/premium).

Through the reconsideration process, physicians can request that Medica re-evaluate their quality and cost-efficiency assessments. To learn more, providers can refer to the Reconsideration FAQ.

**Effective October 1, 2012:**

**Medica to make change to locum tenens credentialing process**

Beginning October 1, 2012, Medica will make a change to its locum tenens credentialing policy. The new process requirements for credentialing a practitioner who is applying to be a short-term locum tenens practitioner at a Medica network facility or clinic will allow the practitioner to apply one time and for a maximum of a 90-day period. After a one-time allowance for a 90-day period, the...
practitioner will be required to be fully credentialed by Medica if staying on as a locum tenens or if reapplying for another locum tenens position.

This new process contrasts with the current credentialing requirements for a practitioner to apply multiple times and for a maximum of a six-month period to be a short-term locum tenens practitioner with Medica.

This policy change puts Medica more in line with community standards for credentialing locum tenens. If there are any questions regarding this change, providers may contact the Medica Credentialing department at credinforequest@medica.com or by calling 952-992-8580 or toll-free 1-800-458-5512, option 1, then option 5, ext. 2-8580.

Effective July 18, 2012:
Medica makes new benefit determination

The following benefit determination was effective beginning with July 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.

Keratoprosthesis for corneal opacity
Medica reviewed keratoprosthesis (KPro) for corneal opacity and now covers the Boston KPro for treatment of corneal blindness due to severe corneal opacity after failure of two or more prior corneal transplant procedures or when corneal transplant is not a viable option. KPro remains investigative and therefore not covered for all other indications and devices.

A KPro, or artificial cornea, is a device intended to restore vision to patients with severe corneal disease where corneal transplantation has repeatedly failed or is not an option.

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 October 1, 2012:
Medica makes new benefit determination

The following benefit determination will be effective beginning with October 1, 2012, dates of service. This change will apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

Digital breast tomosynthesis
Medica has reviewed digital breast tomosynthesis (DBT) and has determined that this technology is investigative and therefore will not be covered.

DBT is a three-dimensional breast imaging technique based on full-field digital mammography (FFDM). As opposed to conventional mammography, a tomosynthesis unit's X-ray tube sweeps along an arc around the breast to acquire between 60 and 70 two-dimensional projections from slightly different angles. The resulting images are digitally manipulated to create tomograms in any plane, allowing for 3-D reconstruction that reveals depth. The slices can be displayed individually or in a dynamic (movie) mode. 3-D reconstruction purports to improve resolution and visibility of dense breast tissue.

As of October 1, 2012, the complete text of the policy that applies to the determination above is
Effective October 1, 2012:

**Medica 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 October 1, 2012, unless otherwise noted.

### Coverage Policies — New

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Digital Breast Tomosynthesis</td>
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### Coverage Policies — Revised

*These versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Antigen Leukocyte Cellular Antibody Test (ALCAT Test) for Food &amp; Chemical Allergies</td>
</tr>
<tr>
<td>Breast Pumps (effective 8/1/12)</td>
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<tr>
<td>Cytotoxic Testing for Allergy Diagnosis</td>
</tr>
<tr>
<td>Endoscopic Procedures for Treatment of Gastroesophageal Reflux Disease (GERD) (administrative update — FDA section; effective 8/1/12)</td>
</tr>
<tr>
<td>Keratoprosthesis for Corneal Opacity (effective 7/18/12)</td>
</tr>
<tr>
<td>KRAS Mutation Analysis for Predicting Response to Drug Therapy</td>
</tr>
<tr>
<td>Minimally Invasive Spinal Fusion Surgery Using Axial Lumbar Interbody Fusion (AxiaLIF) or eXtreme Lateral Interbody Fusion (XLIF)</td>
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<tr>
<td>Noncontact Normothermic Wound Therapy</td>
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<tr>
<td>OncoSorb® Therapy (UltraPheresis) for Non-Hematologic Cancer</td>
</tr>
<tr>
<td>Radiofrequency Volumetric Tissue Reduction (RFVTR) for Breathing Disorders (administrative update — coding; effective 8/1/12)</td>
</tr>
<tr>
<td>Repair of Pierced Body Parts (formerly Injury to a Pierced Body Part - Indications for Repair)</td>
</tr>
<tr>
<td>Serial Dilution Endpoint Titration for Diagnosis and Treatment of Airborne Allergy</td>
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</table>

### Coverage Policies — Inactivated

<table>
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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Cleft Lip and Palate - Tooth Extractions and Dental Implants</td>
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As of October 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.

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**Pharmacy Information**

**Effective October 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 October 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 October 1, 2012:**

**Medica to implement commercial, PPO fee schedule updates**

Effective October 1, 2012, Medica will implement standard fee schedule updates for commercial products in both its metro and regional service areas. The Medica SelectCare℠ and LaborCare® standard fee schedules will be updated at the same time—i.e., for the Medica preferred provider organizations (PPOs).

These updates will result in an overall estimated increase to physician reimbursement. As always, the effect on reimbursement will vary by specialty and the mix of services provided.

Various fees for services without an assigned Centers for Medicare and Medicaid Services (CMS) relative value unit (RVU) will also be updated. Examples of these services include labs, supplies/durable medical equipment (DME), injectable drugs, and immunizations. This non-RVU update will also have an impact on physician reimbursement that will vary based on specialty and mix of services provided.

Medica will apply CMS-based RVU methodology where applicable. The CMS Medicare physician RVU file (National/Carrier) is available online at the CMS website.

Providers who have further questions may contact their Medica contract manager.

**Effective October 1, 2012:**

**Medica to update Medicare physician fee schedule**

Beginning with October 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 October 2012 Centers for Medicare and Medicaid Services (CMS) update applicable to reimbursement for injectable drugs and immunizations. The reimbursement impact of this quarterly update will vary based on specialty and mix of services provided. Updates for durable medical equipment (DME) and orthotics and prosthetics (O&P) will not be implemented at this time.

Details on Medicare changes to drug 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 September

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

Training class topic
"Roadmap to Coding/Reimbursement Tools and Resources" (class code: CO-WS)
Providers are invited to travel with Medica through the claim-submission process. This class will include stopovers for utilization management policies, prior authorization, coverage policies, and a review of the code-update process. Participants will also visit Medica reimbursement policies, the Administrative Uniformity Committee (AUC) website, the CMS National Physician Fee Schedule Relative Value File (NPFS), and the CMS National Correct Coding Initiative (CCI) Edits. The final destination will be efficient and timely provider reimbursement for services rendered to Medica members.

Class schedule

<table>
<thead>
<tr>
<th>Class code</th>
<th>Topic</th>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO-WS</td>
<td>Roadmap to Coding/Reimbursement Tools and Resources</td>
<td>Sept. 20</td>
<td>10 -11 a.m.</td>
<td>Class code with &quot;WS&quot; means offered via webinar in September</td>
</tr>
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</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 (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.

Medica updates reimbursement/claims policy

Medica has updated the reimbursement/claims policy indicated below. Such policies define when specific services are reimbursable based on the reported codes.

Reimbursement/claims policy — New stand-alone document

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Pulse Oximetry (formerly part of the Bundled Services policy)</td>
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</table>

Note: This change simply clarifies payment intent by Medica with regard to the related services, and does not change the way these claims are handled.

Reimbursement/claims policies are available online or on hard copy:

- View reimbursement policies at medica.com.
Medica implements 2012 legislated PCA changes

Medica is following the guidance of the Minnesota Department of Human Services (DHS) with regard to a timeline for changes to the personal care assistance (PCA) program. Below are brief updates on these changes, passed during the 2012 legislative session:

- Changes were made to the statute removing PCA qualified supervision services provided telephonically from the list of non-covered services in fee-for-service. DHS has stated that health plans are not required to pay for telephonic or web-based qualified professional supervision if a health plan chooses to require this service be provided face-to-face. Medica expects that all qualified supervision services be face-to-face visits for Medica members, and will only reimburse for them in such manner.
- Changes made do not allow PCA providers to request an initial PCA assessment on behalf of a Medica member effective as of August 1, 2012. DHS defines "initial assessment requests" as any assessment request made when a member does not have an active PCA authorization in place. Medica does not anticipate this will have an impact on Medica members who have an assigned care coordinator. Medica is working on an implementation plan for its members who do not have a care coordinator and wants to be sure PCA providers are aware of this.
- Effective September 1, 2012, DHS has asked health plans to implement the change in the notice of action authorization. This is the authorization that is entered when processing a PCA denial, termination or reduction of services, notice of which is currently 30 days but will be changed to 10 days. Medica is aware of the MHCP Provider Notice that was released in early June indicating this change was effective July 1, 2012, but it will not be implemented until September per DHS’s request.

For further information on changes made to the PCA program, providers may refer to the DHS website. Also, later this fall, Medica plans to update its PCA administrative requirements guide with these changes.

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.

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