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MEDICA CONNECTIONS®

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April 2015

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GENERAL INFORMATION

Medica outlines member-liability process for inpatient stays

Beginning with April 1, 2015, dates of service, Medica will no longer cover hospital-based services that do not meet medical criteria for inpatient stays. As a result, Medica may deny inpatient hospital-related charges as provider liability, *unless* members acknowledge their liability for payment. To initiate this, providers need to have members sign a pre-service payment-consent form (such as an Advance Beneficiary Notice of Noncoverage, or ABN). **Forms will be available at medica.com**.

Then, as a next step for inpatient facility claims, hospitals should provide an itemized bill and copy of the signed payment-consent form with the claim when submitting the claim for processing.

(Update to "Medica to expand existing concurrent review program" article in the March 2015 edition of *Medica Connections*. **See March 2015 edition**.)

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Effective January 1, 2015:

New claims process implemented for FQHCs, RHCs

Effective with January 1, 2015, dates of service, and based on Minnesota statute, the Minnesota Department of Human Services (DHS) now pays certain professional claims for federally qualified health centers (FQHC) and rural health clinics (RHC). This change applies for Medica Choice Care℠, Medica MinnesotaCare and Medica AccessAbility Solution® members. Here is a summary of the new process for claims payment:

1. Providers should submit 837P and 837D electronic claim transactions to Medica for Medica members, using Medica member identification numbers.
2. Medica will adjudicate the claims and determine the payable and denied claim lines.
3. All claim lines will be returned to the provider on a remittance advice from Medica.
4. The denial code assigned is 5096 ("Charges will be paid by DHS"). The remittance advice remark code (RARC) is MA07.
5. Medica will submit payable claim lines ($0.00 pay claims) to DHS for processing within seven days of adjudicating a claim.
6. DHS will process the claims, then return paid and denied claims on a remittance advice to the provider, the billing intermediary, and Medica.
7. DHS will submit replacement and voided claims to Medica.
8. Any claims that require an adjustment and a replacement to DHS will be assigned code 5095 ("Charges will be paid by DHS"). The RARC is MA07.

The following types of claims are excluded from the process outlined above.

- Claims for which Medicare is primary payer
- Claims for which third-party liability provides full coverage
- Medica health care home claims (using HCPCS codes S0280 and S0281), which continue to be paid directly to providers
- Institutional claims

To avoid problems or seek additional information:

- FQHC and RHC providers should closely monitor claims activity, track claims from submission to Medica through the payment or denial of a claim by DHS, and report any anomalies to the Minnesota Health Care Programs (MHCP) Provider Call Center at 1-800-366-5411.
- For concern with a Medica claim rejection or denial after submission to Medica, contact the Medica Provider Service Center at 1-800-458-5512.
- For concern with a claim payment or denial after Medica submits the claim to DHS, contact the MHCP Provider Call Center.
- For concern with a pharmacy claim rejection, payment, denial or copayment, contact MedImpact, pharmacy benefit manager for Medica, at 1-800-788-2949.

For more details from DHS:

- **See more about the legislative change at the DHS website**.
- **See billing information in the DHS Provider Manual**.

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Due by April 15, 2015:

Providers encouraged to verify their demographic data

Each year, Medica asks providers to review and validate the information that Medica has about their practice sites. While providers are encouraged to submit data changes to Medica as they occur throughout the year, this annual data-validation project allow providers to verify their information currently listed in the Medica database, which is applicable for all Medica products.

Medica plans to send this data-validation request by e-mail in late March 2015. *Responses are due by April 15, 2015*. The e-mailed notice will include instructions and electronic links for verifying data and making changes using the secure Provider Demographic-update Online Tool (PDOT) found on medica.com. Providers that do not receive an email will receive a postcard directing them how to register on medica.com and access PDOT.

Timely responses will ensure that Medica has accurate provider information in its systems, which is essential for prompt and accurate claims payment as well as displaying current information in printed and online provider directories. Up-to-date demographic data helps ensure efficient claims adjudication, reducing re-work and helping to increase patient satisfaction.

Medica would like to extend a sincere thank-you to provider groups for taking the time to help keep their demographic records with Medica up-to-date.

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Individual short-term plan 'fills the gap' for uninsured

Available outside standard enrollment periods

Medica offers a short-term medical insurance plan available year-round for individuals and families, called "Secure STM," which could help those in a pinch who want some coverage vs. none at all. This plan, with deductibles from $1,000 to $5,000, offers short-term health coverage for individuals or families who might be temporarily uninsured, or for those in transition who need one month to one year of coverage to protect against unexpected major medical expenses.

Secure STM "fills the gap" for those who:

- Missed signing up during open enrollment (whether through a state Exchange or a commercial group) and are not eligible for special enrollment,
- Are between jobs or waiting for coverage to start through a new job, or
- Recently graduated and are looking for a job.

For more information:

- **Visit medica.com**.
- Call Medica at 1-800-670-5935.
- Or send an e-mail to **MedicaIndividualProducts@medica.com**.

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CLINICAL INFORMATION

Effective February 18, 2015:

Medica makes UM policy change

The following benefit determination was effective beginning with February 18, 2015, 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.

Transcatheter mitral valve leaflet repair

Medica has reviewed transcatheter mitral valve leaflet repair and has determined that this technology *is medically necessary* for the following defined population:

- The individual demonstrates severe mitral regurgitation due to primary abnormality of the mitral valve;
- The individual is *inoperable* or at *high risk* for open mitral valve replacement; and
- Existing co-morbidities would not preclude the expected benefit from correction of the mitral regurgitation.

To date, the MitraClip Clip Delivery System (MitraClip CDS) is the only system granted approval by the U.S. Food and Drug Administration (FDA). The device is approved for the percutaneous reduction of significant symptomatic mitral regurgitation due to primary abnormality of the mitral valve in patients

determined to be at prohibitive risk for standard mitral valve surgery. Refer to the Medica utilization management (UM) policy "Transcatheter Heart Valve Replacement and Repair Procedures" for complete medical necessity criteria.

Note that transcatheter aortic valve replacement/implantation *remains medically necessary* for a defined population, while percutaneous pulmonary valve implantation *remains investigative and therefore will not be covered* unless using a device granted FDA approval under a FDA Humanitarian Device Exemption.

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

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

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Effective May 1, 2015:

Medica to implement new coverage policy

The following benefit determination will be effective beginning with May 1, 2015, dates of service. This new policy will apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

Multivariate biomarker blood tests for predicting malignancy in women with adnexal mass
Medica has reviewed multivariate biomarker blood tests for predicting malignancy in women with adnexal mass and has determined that this technology *is investigative and therefore will not be covered*.

Two commercially available biomarker blood tests for predicting ovarian cancer in women with adnexal mass are the OVA1® and the Risk of Ovarian Malignancy Algorithm™ (ROMA™) test. These tests are intended to measure the quantity of specific proteins associated with a risk of ovarian cancer. The higher the quantity of these biomarkers identified the higher probability of a malignancy. Testing is purported for use in women with a pelvic mass who are considering surgery for definitive diagnosis, who have not selected a surgeon, and who have not been referred to a gynecological oncologist. These tests do not replace established methods for diagnosing ovarian cancer (e.g., radiography), and they are not intended for screening or to determine if the individual should proceed with surgery.

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

- **See coverage policies at medica.com** as of May 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Effective May 1, 2015:

Medica to inactivate UM policy

The following benefit determination will be effective beginning with May 1, 2015, 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.

Coronary artery calcium scoring

Medica previously covered coronary artery calcium scoring (CACS) for a select population of symptomatic individuals and required prior authorization. However, Medica has re-reviewed CACS and determined that it *is now investigative for all indications and therefore will no longer be covered*. Consequently, Medica will no longer require prior authorization and the related utilization management (UM) policy will be inactivated and replaced by a new coverage policy titled "Coronary Artery Calcium Scoring (CACS)."

CACS to assess the risk of coronary artery disease involves the use of CT scanning to detect calcification, related to atherosclerosis, in the coronary arteries.

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

- **See coverage policies at medica.com** as of May 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Adherence to antidepressant treatment: a benefit to all

About 21 million Americans suffer from some form of depression each year. There are 6.7 percent of adults in the United States who have major depression. However, less than one-half of these people receive treatment.

Left untreated, depression can lead to serious impairment in daily functioning as well as a change in sleep patterns, appetite, energy, and self-esteem. Of the 50 percent of patients who are receiving treatment, nearly 68 percent of them are not taking their medication (i.e., not adherent to their antidepressant therapy). People with untreated or poorly controlled depression tend to be high health care utilizers, which leads to an economic burden for both the member and the health care system. Antidepressant non-adherence is a key factor that contributes to poorly controlled or uncontrolled depression.

Studies have found that rates of antidepressant adherence are significantly associated with how much

information physicians give patients about the drug being prescribed. When prescribing antidepressants, it is important to educate patients on:

- How the medication works
- What the patient can expect from the medication
- A description of common side effects they may experience

Along with pharmacological therapy, lifestyle changes and behavioral therapy are crucial components to treating depression. Exercise, diet, and psychosocial interventions should all be considered as part of a patient's treatment plan.

Medica has nearly 100,000 members on an antidepressant, and 33,000 of them are overdue in filling their antidepressant medication. Medica's goal — which is aligned with the current Healthcare Effectiveness Data and Information Set (HEDIS) measure for antidepressant use — is to help members be adherent at least 80 percent of the time and encourage them to refill their medications when they have 4 days' worth of medication left. Some common barriers to adherence include:

- Fear of medication
- Lack of motivation
- Cognitive, memory or functional deficits

Skills such as motivational interviewing, shared decision-making and assessing patient's readiness to change when adding antidepressant therapy to a patient's medication regimen can be used to overcome these barriers to adherence.

Medica is committed to improving the mental health of our members through increased antidepressant adherence. The Medica Antidepressant Refill Reminder Program is designed to better understand member barriers to adherence and encourage continuation of antidepressant therapy. The benefits of compliance with antidepressant therapy truly are a benefit to all.

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Due by April 15, 2015:

Quality complaint reports required by State of Minnesota

Medica requires its Minnesota-based network providers to submit first-quarter 2015 quality-of-care complaint reports to Medica *by April 15, 2015*.

The State of Minnesota requires that providers report quality complaints received at the clinic to the enrollee's health plan. All Minnesota-based providers should submit a quarterly report form, even if no Medica members filed quality complaints in the quarter (in which case, providers should note "No complaints in quarter" on the form). Providers may send reports by fax to 952-992-3880 or by mail to:

Medica Quality Improvement
Mail Route CP405
PO Box 9310
Minneapolis, MN 55440-9310

Report forms are available by:

- **Downloading from medica.com**; or
- Calling the Medica Provider Literature Request Line, to obtain paper copies.

Note: Providers submitting a report for multiple clinics should list all the clinics included in the report. Providers who have questions about the complaint reporting process may:

- **Refer to further reporting details online**, or
- Call the Medica Provider Service Center at 1-800-458-5512.

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Effective May 1, 2015:

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 May 1, 2015, unless otherwise noted.

UM policies — Revised

These versions replace all previous versions.

Name	Policy number
Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional Endoskeletal Hip Joint System	III-DEV.17
Mechanical Circulatory Support Devices	III-SUR.38
Genetic Testing for Cardiomyopathies	III-DIA.07
Genetic Testing for Cardiac Channelopathies	III-DIA.05
Transcatheter Heart Valve Replacement and Repair Procedures *(effective 2/18/15)*	III-SUR.36
Real-Time Mobile Cardiac Outpatient Telemetry (RT-MCOT)	III-DIA.08
Human Leukocyte Antigen-DQ (HLA-DQ) Genetic Testing for Diagnosis of Celiac Disease	III-DIA.10
Outpatient Enteral Nutrition Therapy	III-MED.03

UM policies — Inactivated

Name	Policy number
Coronary Artery Calcium Scoring (CACS) *(see new coverage policy below)*	III-DIA.03

Coverage policies — New

Name
Coronary Artery Calcium Scoring (CACS) *(replaces UM policy above)*

Multivariate Biomarker Blood Testing for Predicting Malignancy in Women with Adnexal Mass

Coverage policies — Revised

These versions replace all previous versions.

Name
Electromagnetic Navigation Bronchoscopy
Genetic Testing: TP53 (p53) Testing for Li-Fraumeni Syndrome

ICSI guidelines — Revised

These guidelines are available on medica.com.

Name
Hypertension Diagnosis and Treatment

These documents will be available online or on hard copy:

- **View medical policies and clinical guidelines at medica.com** as of May 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PHARMACY INFORMATION

Effective March 1, 2015:

Medica to update commercial, Marketplace, MHCP drug lists

Medica has reviewed the following products, with their respective coverage status effective March 1, 2015. As indicated in the table below, these changes will apply to the Medica Commercial Preferred Drug List; the new Marketplace Preferred Drug List for individual and family business (IFB) members and small group plan members who purchase health plans on state exchanges; and the Medica List of Preferred Drugs for Minnesota Health Care Programs (MHCP). The Medica MHCP formulary applies to the following products: Medica Choice Care℠ (including Minnesota Senior Care Plus program, or MSC+), Medica MinnesotaCare, Medica AccessAbility Solution® (Special Needs Basic Care program, or SNBC), and Medica DUAL Solution® (Minnesota Senior Health Options program, or MSHO), for non-Part D drugs. These changes will *not* apply to the Medica Medicare Part D formulary.

Generic name (brand name)	Commercial and Marketplace formulary status	Medica MHCP formulary status	Current preferred alternatives	Restrictions and comments	Approved therapeutic indications
naloxone	Commercial	Non-	naloxone,		Emergency

auto injector (Evzio®)	tier 3; Marketplace tier 3	formulary	naltrexone		treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression. Evizio is intended for immediate administration as emergency therapy in settings where opioids may be present. Evizio is not a substitute for emergency medical care.
timothy grass pollen allergen extract (Grastek®)	Commercial tier 3; Marketplace tier 3	Non-formulary	loratadine, levocetrizine (benefit limitations may apply)		Treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 5-65 years of age
ledipasvir/ sofosbuvir (Harvoni®)	Commercial Specialty tier 1; Marketplace tier 5	Formulary Specialty		Specialty drug; prior authorization	Treatment of chronic hepatitis C (-genotype 1)
somatropin (Norditropin®)	Commercial Specialty tier 1; Marketplace tier 5	Formulary Specialty		Specialty drug; prior authorization	Treatment of growth hormone deficiency
simeprevir (Olysio®)	Commercial tier 2; Marketplace tier 6	Non-formulary	Harvoni, Sovaldi	Specialty drug; prior authorization; and current utilizers will be grandfathered until	Treatment of chronic hepatitis C (-genotype 1) in combination with other hepatitis C antivirals

				completion of treatment course	
sweet vernal, orchard, perennial rye, timothy, and kentucky blue grass mixed pollens allergen extract (Oralair®)	Commercial tier 3; Marketplace tier 3	Non-formulary	loratadine, levocetrizine (benefit limitations may apply)		Treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis in patients 10-65 years of age
short ragweed pollen allergen extract (Ragwitek®)	Commercial tier 3; Marketplace tier 3	Non-formulary	loratadine, levocetrizine (benefit limitations may apply)		Treatment of ragweed pollen-induced allergic rhinitis or rhinoconjunctivitis in adult patients (18-65 years of age)
sofosbuvir (Sovaldi®)	Commercial Specialty tier 1; Marketplace tier 5	Formulary Specialty		Specialty drug; prior authorization	Treatment of chronic hepatitis C (-genotypes 1, 2, 3, or 4) as a component of a combination antiviral treatment regimen for those with liver carcinoma or awaiting liver transplantation (-genotype 1) for those who are interferon ineligible as a component of a combination antiviral treatment regimen
ombitasvir/ paritaprevir/ ritonavir/	Commercial Specialty tier 2;	Non-formulary	Harvoni	Specialty drug; prior authorization	Treatment of chronic hepatitis C (-genotype 1)

dasabuvir (Viekira Pak®)	Marketplace tier 6				
testosterone gel (Vogelxo®)	Commercial tier 3; Marketplace tier 3	Non-formulary	Androgel, Axiron		For use in adult males for conditions associated with a deficiency or absence of endogenous testosterone
vorapaxavar sulfate (Zontivity®)	Commercial tier 3; Marketplace tier 3	Non-formulary	clopidogrel, Effient, dipyridamole, cilostazol		Add-on therapy with aspirin and/or clopidogrel for the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or peripheral artery disease (PAD)

Medica drug formularies are available online or on paper:

- **View Medica drug formularies on medica.com**.
- To request a printed copy, providers may call the Medica Provider Literature Request Line.

Medication request forms

A uniform formulary exception 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 an exception form at medica.com**.
- Call MedImpact at 1-800-788-2949.

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Effective March 2, 2015:

Medica updates drug UM policies

Medica has recently updated the following drug utilization management (UM) policies, effective with March 2, 2015, dates of service. Changes to these policies were only administrative in nature.

Drug UM (prior authorization) policies — Revised

These versions replace all previous versions.

Name
tocilizumab subcutaneous (Actemra®)
certolizumab prefilled syringes (Cimzia®)
epoetin alfa (Epogen®, Procrit®)
icatibant (Firazyr®)
abatacept subcutaneous (Orencia®)
ustekinumab (Stelara®)

These updated drug UM policies are available online or on hard copy:

- **View drug management policies at medica.com**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Effective May 1, 2015:

Medica to update drug UM policies

Medica will soon update the following drug utilization management (UM) policies, effective with May 1, 2015, dates of service.

Drug UM (prior authorization) policies — Revised

These versions replace all previous versions.

Name
teriparatide (Forteo®)
efuvirtide (Fuzeon®)
afatinib (Gilotrif®)
corticotropin repository (H.P. Acthar®)
mifepristone (Korlym®)
dronabinol (Marinol®)

peginterferon alfa (Pegasys®, PegIntron®)
eltrombopag (Promacta®)
sildenafil and tadalafil (Revatio®, Adcirca®)
vigabatrin (Sabril®)
bedaquiline (Sirturo®)
somatropin (Omnitrope®)
rifaxamin 550 mg (Xifaxin®)

These updated drug UM policies will be available online or on hard copy:

- **View drug management policies at medica.com** as of May 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Effective May 1, 2015:

Medica changes OxyContin prescription process for MHCP

Medica changed the way it manages OxyContin® prescriptions as of January 1, 2015, for Medica members in Minnesota Health Care Programs (MHCP). New OxyContin prescriptions as of January 1, 2015, require step therapy of an equipotent dose of morphine extended-release. Medica made this policy change for MHCP enrollees as part of a larger Minnesota statewide effort involving the Minnesota Department of Human Services (DHS) and others.

This change requiring step therapy didn't apply to Medica MHCP members who had an OxyContin prescription prior to January 1, 2015, *but it will apply to them beginning May 1, 2015*.

As of May 1, 2015, all MHCP members will be required to try morphine extended-release as a first-line drug. Medica will notify affected members informing them of this change. Where Oxycontin is preferred by the prescriber and member, the provider can submit a prior authorization request for clinical review. Medica appreciates its partnership with prescribers to continue enhancing quality of patient care.

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Effective July 1, 2015:

Changes to Medica Part D drug formulary delayed

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. However, due to a delay from the Centers for Medicare and Medicaid Services (CMS), the next available changes to the Part D formularies *will not be effective until July 1, 2015*. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Medica periodically makes changes to its Medicare Part D formularies: the Part D open formulary (4-tier + specialty tier) and the Part D closed formulary. **View Medicare Part D formulary changes online**.

The Medica Medicare Part D drug formularies are available online or on paper:

- **View formularies at medica.com**.
- **Download formularies for free at epocrates.com**.
- Call the Medica Provider Literature Request Line for printed copies of documents.

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.

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ADMINISTRATIVE INFORMATION

Effective May 1, 2015:

Credentialing to add new provider specialty designation

Effective May 1, 2015, Medica will add a new practitioner specialty to identify practitioners as part of their provider demographics (for instance, available in provider directories for Medica members to use). The new specialty is Hand Surgery. Practitioners with the appropriate training or education who would like to request Hand Surgery as their specialty can do one of the following:

- If already credentialed with Medica, submit a Minnesota Uniform Practitioner Change Form to **demographicchangerequests@medica.com**.
- If a new practitioner, contact the Medica Credentialing department at **credinforequest@medica.com**.

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No exceptions to timely filing for ICD-10 claims

203 days until go-live date arrives

Medica, along with other payers and providers, continues to prepare for this year's ICD-10 coding transition, following the Centers for Medicare and Medicaid Services (CMS) guideline for code submission. It is important to note that *the current timely-filing process will continue to apply* for claims submitted to Medica, *and no extensions will be granted*.

All providers must submit ICD-10 diagnosis and inpatient procedure codes beginning with October 1, 2015, dates of service (or dates of discharge). Claims without ICD-10 diagnosis and inpatient procedure codes as of that date *cannot be processed and will not be accepted*. ICD-9 codes will be accepted through September 30, 2015, dates of service (or dates of discharge).

For more details on ICD-10 preparations, **providers can refer to the ICD-10 webpage at medica.com**.

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Effective May 16, 2015:

Medica to update claim processing system for consistency

Medica will update its claim processing system to achieve consistency with claim edits related to the following reimbursement policies, to be effective with May 16, 2015, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

Add-on code

Current Procedural Terminology (CPT®) provides coding guidelines for some add-on codes specifying which add-on code should be reported in conjunction with a given primary procedure or service code. Medica follows these guidelines and will only reimburse an add-on code when it has been reported with the appropriate primary service or procedure code.

CPT contains key phrases to identify add-on codes which include, but are not limited to, the following:

- "list separately in addition to primary procedure"
- "each additional"
- "one at time of other major procedure"

In other instances, CPT does not specifically identify the primary or add-on code relationships. When this occurs, interpretation may be done utilizing CPT, Centers for Medicare and Medicaid Services (CMS), or specialty society guidelines to determine additional primary or add-on code relationships.

CCI editing

Physicians and other qualified health care professionals must report services correctly, according to the CMS National Correct Coding Initiative (NCCI). Medical and surgical procedures are to be reported with the CPT or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed. When the same provider submits two or more procedure codes for the same member on the same date of service, the codes are compared against the code pair edits in the Medica CCI Editing policy. If any of the codes is considered to be a component of or mutually exclusive of the other code, only the most comprehensive procedure code will be reimbursed.

Under certain circumstances a provider may bill for two or more services and append a modifier to the codes indicating that the procedures are indeed distinct and separate, which must be supported by the medical documentation. Medica applies NCCI and other nationally sourced modifier override rules to the CCI Editing policy to align with CMS reimbursement methodology.

These policies are available online or on hard copy:

- **View reimbursement policies at medica.com**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Effective March 1, 2015:

Medica revises reimbursement policy

Medica has recently updated the reimbursement policy indicated below, effective with March 1, 2015, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

Reimbursement policies — Revised

These versions replace all previous versions.

Name
Add-On Code *(updated code list)*

This revised policy is available online or on hard copy:

- **View reimbursement policies at medica.com**; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PPO INFORMATION

Latest UHC provider bulletin available online

UnitedHealthcare (UHC) has published the latest edition of its *Network Bulletin* (February 2015). Highlights that may be of interest to LaborCare® network providers include:

- Prior authorization change for intensity modulated radiation therapy (IMRT) — effective in January 2015
- Enhanced HIPAA claim edits — scheduled for March 2015
- Reimbursement change for modifiers H9, HU-HZ, OJ and TR — scheduled for second quarter 2015
- Prior authorization to be required for injectable chemotherapy — scheduled for June 2015

View the February 2015 UHC provider newsletter.

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Medica Connections is published monthly by Medica and can be accessed online.
View the *Medica Connections* archive.

Health and Network Management leadership at Medica:
Mark Werner, MD, *Senior Vice President and Chief Clinical and Innovation Officer*
Jana Johnson, *Senior Vice President for Health and Provider Services*
Barbara Lynch, *Vice President for Network Management*
Dan Trajano, MD, *Vice President and Medical Director for Population Health*
James Hartert, MD, *Senior Medical Director for Health Management*
Kyle Kircher, MD, *Medical Director for Government Programs*
Alvaro Sanchez, MD, *Medical Director for Health Management*

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