MEDICA

MEDICA CONNECTIONS®

a monthly publication for Medica network providers

February 2015

GENERAL INFORMATION

Drs. Kircher, Sanchez join Medica as new medical directors

Medica has recently hired two new medical directors: Kyle Kircher, MD, and Alvaro Sanchez, MD.

Dr. Kyle Kircher has joined Medica as medical director for government programs. He is responsible for providing medical direction for Minnesota Health Care Programs and Medicare clinical programs, including Medica care system care coordination, integrated care coordination, high-risk pregnancy,

and complex case management. He also serves as a part-time medical director for utilization management. He reports directly to Dan Trajano, MD, vice president for population health at Medica.

Prior to joining Medica, Dr. Kircher was vice president for Bluestone National, leading a market expansion into Wisconsin. He was a consultant in family medicine at the Mayo Clinic from 1998-2012, where he also served as medical director. Dr. Kircher received his medical degree, family medicine residency, and practice management fellowship from the Mayo Graduate School of Medicine, as well as an MBA degree from the University of St. Thomas.

"Kyle's clinical background and executive leadership experience will be essential in Medica's aim to ensure that health care for Minnesota Health Care Programs and Medicare members is both high-quality and affordable," said Dr. Trajano.

Dr. Alvaro Sanchez has recently joined Medica as medical director for health management. He is a physician leader for the development and administration of health management programs at Medica. Dr. Sanchez actively supports Medica utilization and quality management programs. He reports directly to James Hartert, MD, senior medical director for health management at Medica.

Most recently, Dr. Sanchez was associate medical director for UCare in the Twin Cities. His past roles have included regional medical director of primary care at Park Nicollet Health Services. He is board-certified in internal medicine and completed his residency at the University of Minnesota. Dr. Sanchez also is Division Surgeon for the Red Bull Division of the Minnesota Army National Guard, where he holds the rank of lieutenant colonel.

"Alvaro brings critically important insight into the development of health management through his experience in health plans and the delivery system, with a strong focus on utilization management and promotion of evidence-based medicine," said Dr. Hartert.

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Effective in April 2015:

Medica to add 2 new specialties to Premium program for 2015

Medica will soon be making updates to the Medica Premium Designation Program this year. Effective in April 2015, the Medica provider search tool at medica.com will reflect two new Premium program health care specialties. These physician specialties will be added as part of the Premium program:

- Ear, Nose and Throat (ENT)
- Gastroenterology

Physicians included in the 2015 Premium program will receive a letter notifying them of their latest designation and how to log in to see their reports. This notification is scheduled for early February 2015.

For more details about the Premium program, visit **medica.com/premium**. Providers who have additional questions about this program can e-mail Medica at **premiumdesignation@medica.com**.

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CLINICAL INFORMATION

Effective December 17, 2014:

Medica makes coverage policy change

The following benefit determination was effective beginning with December 17, 2014, 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.

Low-dose computed tomography (LDCT) for lung cancer screening
Medica has reviewed LDCT for lung cancer screening and has determined that this technology *is covered* when all of the following criteria are met:

- The individual is asymptomatic and between 55 and 80 years of age.
- The individual is a current or former smoker with a 30 pack-year smoking history.
- If the individual is a former smoker, he or she has quit within the past 15 years.
- The individual has no health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

LDCT for lung cancer screening for all other indications *remains investigative and therefore not covered*.

Lung cancer screening is a test to look for signs of lung cancer in otherwise healthy people. Low-dose computed tomography (CT), also known as helical or spiral CT, is an imaging procedure that uses special X-ray equipment to create a series of detailed pictures, or scans, of areas inside the body. An LDCT can scan the entire chest quickly, usually in 10 to 20 seconds, during a single breath-hold, while the patient lies on a table and passes through the scanner. The images are then reconstructed into a three-dimensional model of the lungs. The amount of radiation delivered during a LDCT scan is about twice that of a conventional chest X-ray, but less than conventional CT and can be done in either the inpatient or outpatient setting. Therefore, LDCT has been proposed as a means of screening high-risk individuals for early lung cancer before they develop symptoms.

Medica previously notified providers about this benefit change with a Provider Alert in late December 2014.

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

- **See coverage 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 December 17, 2014:

Medica makes UM policy change

Medica has revised the following utilization management (UM) policy that requires prior authorization, effective beginning with December 17, 2014, 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.

Through prior authorization for procedures, Medica aims to support members and providers in making evidence-based decisions about appropriate, medically necessary care. As a reminder, Medica requires that providers obtain prior authorization before rendering services. If any services requiring prior authorization are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability.

Mechanical circulatory support devices

Medica has reviewed the portable SynCardia Freedom® Driver System for use with the SynCardia total artificial heart and has determined that this portable driver *is no longer investigative and therefore is covered* when used for indications approved by the U.S. Food and Drug Administration (FDA). The FDA has approved this portable driver for use with the SynCardia total artificial heart as a bridge to transplantation in cardiac transplant candidates who are clinically stable.

The complete text of the policy that applies to this determination will be 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.

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Antibiotics for acute bronchitis: risks vs. benefits

Acute bronchitis is one of the most common illnesses seen in primary care. There have been a number of recent studies done on the use of antibiotics with patients who are diagnosed with acute bronchitis. In the United States, more than half of all patients with upper respiratory tract infections and acute bronchitis are treated with antibiotics annually, despite the fact that most cases are viral in etiology and are not responsive to antibiotics.

Providers are encouraged to stop and weigh the options before prescribing antibiotics. As prescribers are well aware, overuse of antibiotics is a public-health concern as it leads to antibiotic-resistant infections. Several recent studies* indicate that antibiotics only reduce coughing slightly (by less than a day), may cause side effects, and more importantly, may contribute to antibiotic resistance, as well as additional cost.

The Centers for Disease Control and Prevention (CDC) states that antibiotic resistance is one of the world's most pressing public health problems. Antibiotic resistance can cause significant danger and suffering for children and adults who have common infections. The use of antibiotics promotes development of antibiotic-resistant bacteria. Repeated use of antibiotics and their improper use are primary causes of the increase in drug-resistant bacteria. Smart use of antibiotics is the key to controlling the spread of resistance.

There is limited evidence that supports the use of antibiotics if the patient is frail, elderly and with multi-morbidity. However, the magnitude of this benefit still needs to be considered in the broader context of potential side effects, medicalization for self-limiting condition, increased resistance to respiratory pathogens and cost of antibiotic treatment.

Providers are often pressured into prescribing antibiotics due to patient's expectations, time pressure and diagnostic uncertainty. But when a patient has no other health problems, experts recommend that antibiotics not be used for acute bronchitis. Antibiotics are almost never helpful for acute bronchitis and they are often harmful. Patients often suffer unnecessary side effects, such as diarrhea and allergic reactions, and unnecessary antibiotics that are not effective for the virus can play a part in the development and spread of germs that no longer respond to over-used antibiotics.

When to prescribe antibiotics and what type to prescribe depend on the type of infection the patient has, age of patient, any other medical conditions, and the risk of complications from acute bronchitis, such as pneumonia. Providers need to stop and think if the antibiotic is really necessary or if more harm will be done long-term for others that may need the antibiotic in the future.

* JAMA, May 2014, November 2013; and The Cochrane Collaboration, 2014.

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Effective March 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 March 1, 2015, unless otherwise noted.

UM policies — Revised

These versions replace all previous versions.

Name	Policy Number
Mechanical Circulatory Support Devices *(effective 12/17/2014)*	III-SUR.38

Coverage policies — New

Name
Allogeneic Pancreatic Islet Cell Transplantation *(previously addressed in the pancreas transplant UM policy)*

Coverage policies — Revised

These versions replace all previous versions.

Name
Low Dose Computed Tomography (LDCT) for Lung Cancer Screening *(effective 12/17/2014 — formerly titled Helical Computed Tomography (CT) for Lung Cancer Screening)*
Pharmacogenetic Testing to Predict Toxicity to 5-Fluorouracil (5-FU)/Capecitabine-Based Chemotherapy
Gene Expression Profiling Assays for Breast Cancer *(formerly titled Gene Expression Profiling Assays for Assessment and Management of Early-Stage Breast Cancer)*

Coverage policies — Inactivated

Name
Coronary Magnetic Resonance Angiography *(effective 12/17/2014)*

ICSI guidelines— Revised

These guidelines are available on medica.com.

Name
Preventive Services for Adults

These documents will be available online or on hard copy:

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

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PHARMACY INFORMATION

Effective March 2, 2015:

Prior authorization process to change for medical benefit drugs

Medica is committed to providing its members with access to high-quality care that is consistent with evidence-based, nationally recognized clinical criteria and guidelines. With this in mind and to ensure affordability for its members, Medica will implement a change to its current process for the review and approval of certain specialty drugs that are administered by providers and fall under the medical benefit (i.e., medical benefit drugs). This will be effective with March 2, 2015, dates of service.

Prior authorization, which will be administered by Magellan Rx Management, will apply to certain medical benefit drugs requiring administration by health care professionals in a physician's office, outpatient hospital, or home infusion setting. Prior authorization for these drugs will be required for Medica commercial, individual and family business (IFB), and Minnesota Health Care Programs (MHCP) members. This requirement *will not apply* for Medicare members, as well as certain Medica Choice Passport groups. Prior authorization by Magellan Rx for these medical benefit drugs also *will*

not be required when these drugs are administered during an inpatient stay, in an emergency room, or in an observation room setting.

If prior authorization is required but providers have not obtained an authorization from Magellan Rx, related claims will be denied. Providers have 60 days from the date of denial to submit a claim appeal.

Upcoming changes

Prior authorization *will be added* for the following drugs (effective March 2, 2015):

HCPCS code	Brand name	Generic name
J9264	Abraxane®	paclitaxel
J9305	Alimta®	pemetrexed
J2469	Aloxi®	palonosetron
J0881	Aranesp®	darbepoetin
J0717	Cimzia®	certolizumab pegol
J0885	Epogen®/Procrit®	epoetin alfa
J9355	Herceptin®	trastuzumab
J9043	Jevtana®	cabazitaxel
J9354	Kadcyla®	ado-trastuzumab emansine
J2505	Neulasta®	pegfilgrastim
J9306	Perjeta®	pertuzumab
J1745	Remicade®	infliximab
J9310	Rituxan®	rituximab
J1602	Simponi Aria®	golimumab
90378	Synagis®	palivizumab
J9033	Treanda®	bendamustine
J2323	Tysabri®	natalizumab
J9303	Vectibix®	panitumumab
J9041	Velcade®	bortezomib
J9228	Yervoy®	ipilimumab

Prior authorization *will continue to be required* for the following drugs:

HCPCS code	Brand name	Generic name
J3262	Actemra®	tocilizumab
J9035	Avastin®	bevacizumab
J0597	Berinert®	C1 esterase inhibitor
J1556	Bivigam®	IVIG
J1566	Carimune NF®	IVIG
J0598	Cinryze®	C1 esterase inhibitor

J9055	Erbitux®	cetuximab
J1744	Firazyr®	icatibant
J1572	Flebogamma®	IVIG
J1569	Gammagard Liquid®	IVIG
J1566	Gammagard S/D®	IVIG
J1561	Gammaked®	IVIG
J1557	Gammaplex®	IVIG
J1561	Gamunex-C®	IVIG
J1559	Hizentra®	IVIG
J1290	Kalbitor®	ecallantide
J2796	Nplate®	romiplostim
J1568	Octagam®	IVIG
J0129	Orencia®	abatacept
J1459	Privigen®	IVIG
Q2043	Provenge®	sipuleucel-T
J3357	Stelara®	ustekinumab
J2357	Xolair®	omalizumab

Prior authorization *will no longer be required* for the following drugs (effective March 2, 2015):

HCPCS code	Brand name	Generic name
J2793	Arcalyst®	rilonacept
J9302	Arzerra®	ofatumumab
J9307	Folotyn®	pralatrexate
J0638	Ilaris®	canakinumab
J2562	Mozobil®	plerixafor
J9160	Ontak®	denileukin diftitox
J7335	Qutenza®	capsaicin 8%
J1300	Soliris®	eculizumab

Transition-of-care process

Authorizations issued by Medica *before* March 2, 2015, for the drugs listed above requiring prior authorization *as of* March 2, 2015, will be effective until the authorization end date. To continue treatment after the authorized end date, providers must obtain an authorization from Magellan Rx *prior to the expiration date*. Claims for dates of services after the authorized end date *will be denied* if providers have not obtained a continued authorization from Magellan Rx.

How to request prior authorization

Physicians ordering these drugs will be required to obtain a prior authorization online, by phone, or by fax. All of these options *will be available beginning February 23, 2015*.

- Web requests: As of February 23, 2015, providers can get set up for online requests by accessing the Magellan Rx secure provider self-service website, **www.icorehealthcare.com**, clicking on "Providers and Physicians" and then selecting "New User Request ID." It may take up to 2 business days for user access. After access has been granted, providers can submit prior authorization requests by clicking on the "Providers and Physician" icon.
- Phone requests: Magellan Rx will begin taking prior authorization requests for eligible Medica members on February 23, 2015, at 1-800-424-8115 (Monday to Friday, 7 a.m. to 5 p.m.). This number will be used for all future urgent and non-urgent telephone-initiated prior authorization requests.
- Fax requests: Written prior authorization requests may also be received by fax at 1-888-656-3251.

Further details
Providers are welcome to attend upcoming trainings in February 2015. Providers can choose from 12 webinars **as indicated below**.

In addition, providers can **visit medica.com (under "Medical Benefit Applies") for the following**:

- A quick-reference guide
- A frequently-asked-questions (FAQ) document
- The full schedule of upcoming trainings
- The full list of drugs affected by this change
- All related medical benefit drug policies (via link to the Magellan Rx website)
- A printable request form to fax prior authorization requests

Providers who still have questions may call the Medica Provider Service Center at 1-800-458-5512.

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NETWORK INFORMATION

Third-quarter PCR checks to be mailed in January 2015

By the end of January 2015, Medica plans to mail to eligible providers the physician contingency reserve (PCR) payment for the third quarter of 2014. This represents a 100-percent return of the third-quarter 2014 PCR withhold, plus interest, for the Medica Prime Solution® Medicare product. Checks will cover PCR withheld for claims with dates of service of July 1, 2014, through September 30, 2014, and dates paid of July 1, 2014, through December 31, 2014.

Note: Medica began processing claims with a 2 percent payment reduction in April 2013 due to federal sequestration legislation. The 2 percent sequester reduction was in addition to the standard PCR withhold amount for Medica Prime Solution claims. This 2 percent cut *will not be included* in PCR returns.

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ADMINISTRATIVE INFORMATION

Provider College administrative training topic for February

The Medica Provider College offers educational sessions on various administrative topics. The following class is available by webinar for all Medica network providers, at no charge.

Training class topic

"Prior Authorization Changes for Medical Benefit Drugs"

Medica will soon implement a new process for the review and approval of certain specialty drugs that are administered by providers and fall under the medical benefit. Prior authorization requests for these drugs will be handled by Magellan Rx Management. Magellan Rx will conduct webinar trainings so Medica network providers can learn more about this initiative, through which prior authorization will be required beginning with March 2, 2015, dates of service. Providers are encouraged to attend one of the following hour-long web-based training sessions to become familiar with the new program, such as how and when to make prior authorization requests. **Learn more about this initiative**.

Class schedule

Topic	Date	Time
Prior Authorization Changes for Medical Benefit Drugs	Feb. 10	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 10	1-2 pm
Prior Authorization Changes for Medical Benefit Drugs	Feb. 11	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 11	1-2 pm
Prior Authorization Changes for Medical Benefit Drugs	Feb. 12	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 12	1-2 pm
Prior Authorization Changes for Medical Benefit Drugs	Feb. 17	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 17	1-2 pm
Prior Authorization Changes for Medical Benefit Drugs	Feb. 18	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 18	1-2 pm
Prior Authorization Changes for Medical Benefit Drugs	Feb. 19	9-10 am
Prior Authorization Changes for Medical Benefit Drugs	Feb. 19	1-2 pm

Registration

To register, providers can send the following details by e-mail to **injectablesolutions@icorehealthcare.com**:

- Webinar date and time (from list above)
- Physician name and/or name of group or hospital
- Tax identification number

- Address
- E-mail and phone contact information
- Number of participants (indicate if attendees are clinical and/or administrative)

After registering, providers will receive an e-mail confirmation with instructions on accessing the webinar.

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Reminder:

Reporting requirements for drug codes

For billing and payment consistency, claims should always be submitted with the correct number of units. Medica accepts fractional units, too. Healthcare Common Procedure Coding System (HCPCS) J-codes for drugs should be submitted in units based on the definition of the J-code. For example, with code J0696 ("Injection, ceftriaxone sodium, per 250mg"), the appropriate units to submit for billing would be:

250 mg = 1 unit
500 mg = 2 units
750 mg = 3 units

Another example: For code J1335 ("Injection, ertapenem sodium, 500mg"), if the dosage given is one vial of 1 gram, then the provider should bill for 2 units.

Also, for codes *requiring* the reporting of a national drug code (NDC) number, providers need to submit the following information along with the HCPCS codes and related drug units:

- NDC
- NDC-defined unit of measure
- NDC dispensing quantity

The following information should be included on the electronic claim submission:

Element name	Where located: loop (segment)	Notes
Product or service ID qualifier	2410 (LIN02)	Enter product or NDC qualifier N4
Product or service ID	2410 (LIN03)	Enter the NDC
Quantity	2410 (CTP04)	Enter the quantity billed
Unit of basis for measurement code	2410 (CTP05-1)	Enter the NDC unit of measurement code: • F2: international unit • GR: gram • ML: milliliter • UN: unit

		• ME: milligram

The above-requested reporting is consistent with reporting guidelines from the Minnesota Administrative Uniformity Committee (AUC), the Centers for Medicare and Medicaid Services (CMS), and other payers.

(Update to "Proper billing related to HCPCS codes and units" article in the April 2014 edition of *Medica Connections*. **See April 2014 edition**.)

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Medica postpones change to mid-level provider specialty types

Medica previously announced that it would make a system update to better align mid-level practitioners with the specialty services they perform at their respective clinics. This change to update mid-level provider specialty types was related to the following advanced-practice practitioners: certified nurse practitioners, certified nurse-midwives, and physician's assistants.

However, this system change will take longer to implement than originally planned in order to be applied for benefit sets of all Medica products. As a result, Medica is postponing this change for advanced-practice practitioners who work in specialty clinics. The new effective date is tentatively scheduled for January 1, 2016.

(Update to "Medica to change specialty types for mid-level providers" article in the December 2014 edition of *Medica Connections*. **See December 2014 edition**.)

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Updates 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 updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

Information updated	Location in manual	When posted online in manual
Added a "Review of Communications" provision requiring the review and approval of certain communications intended for Minnesota Health Care	"Special Contracting Requirements" section, in "Government Program Requirements" subsection, under "Provider Requirements for Medicare, Medicaid and	December 2014 (effective 12/1/14)

Programs (MHCP) members	Government Programs"	

For the current version, providers may **view the Medica Provider Administrative Manual online**.

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View the *Medica Connections* archive.

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