MEDICA

MEDICA CONNECTIONS®

a monthly publication for Medica network providers

January 2015

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GENERAL INFORMATION

Effective March 1, 2015:

Medica to expand concurrent review with network facilities

Medica previously announced that effective October 1, 2014, Medica would begin concurrent review of inpatient stays at selected Minnesota facilities. Medica will be expanding this program to all facilities on March 1, 2015. Depending on an admitted patient's condition, Medica will contact facilities to request one or more of the following for review:

- discharge dates or status
- daily clinical-progress records

Medica nurse case reviewers will monitor appropriateness of care, the setting, and the progress of discharge plans. Reviewers will use MCG Care Guidelines®, which are national standardized evidence-based criteria for appropriateness of care.

Medica nurses will consult with hospital staff members on cases that no longer meet MCG guidelines for a continued stay. The goal is to work with facilities to assure that members are getting the right care in the right setting based on the best possible evidence and clinical review. Together, Medica nurses and providers will work to ensure that members receive the most cost-effective, evidence-based care, and that they get back home or to the best living situation as efficiently and effectively as possible. More details will be available in the coming months.

Note: Beginning with March 1, 2015, dates of service, Medica will no longer cover hospital-based services that *do not meet* MCG guidelines. As a result, related claims may be denied.

(Update to "Medica begins concurrent review with selected facilities" article in the November 2014 edition of *Medica Connections*. **See November 2014 edition**.)

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Effective September 25, 2014:

Medica covers certified doula services

As a Minnesota legislative change earlier in 2014, certified doula services are to be covered as additional support for pregnant women. This change, effective with September 25, 2014, dates of service, applies for Minnesota Health Care Programs (MHCP) enrollees in Medica Choice Care℠, Medica MinnesotaCare and Medica AccessAbility Solution®. Eligible enrollees can receive doula services from certified providers under the supervision of a physician, nurse practitioner or certified nurse midwife. MHCP covers up to six sessions, one of which must be for labor and delivery.

This change only applies when doula services are *not* already included in obstetrical visits and paid as part of hospital contracted charges. Medica will retroactively adjust and reprocess affected claims for dates of services on or after September 25, 2014.

For further details, including billing, **see the DHS website**.

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Effective January 1, 2015:

Medica to add primary care clinics to MHCP member ID cards

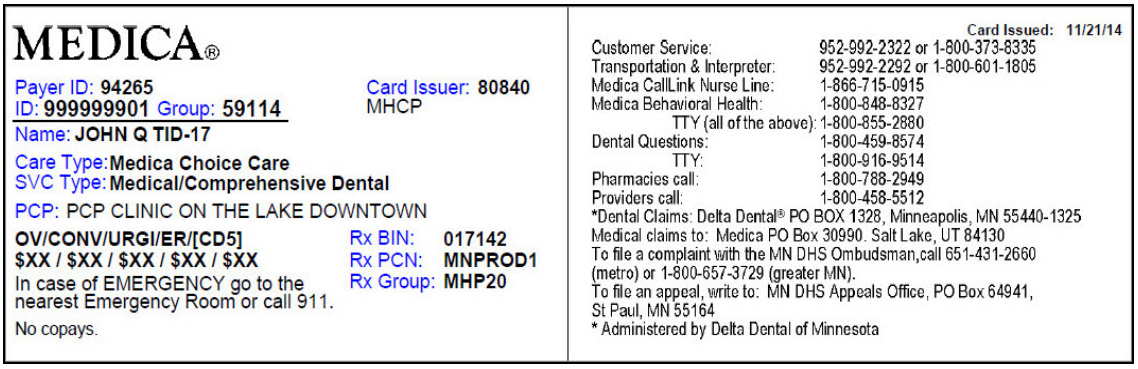
Medica is adding primary care provider (PCP) designations to Minnesota Health Care Programs (MHCP) member ID cards in January 2015. Medica provides enrollees with a choice of PCP as their "home clinic," which is the clinic that should have primary responsibility for coordinating health care services for them. This addition of the PCP to the MHCP member ID card will apply for Medica MinnesotaCare members and Medica Choice Care[SM] members enrolled in the Minnesota Prepaid Medical Assistance Plan (PMAP).

While the PCP is considered the medical home for these members, they will still be able to access other services within the Medica Choice Care network. In addition, MHCP members will be able to change their PCP designation by calling customer service on the back of their ID card.

Note: Designating PCPs on MHCP member ID cards will *not* change the current Medica model of open access within the Medica provider network. Members will still be able to visit any PCP within the network and have those services covered as in-network regardless of the PCP designation on their ID card.

With the addition of a PCP to ID cards, the goal is to emphasize primary care, since the ER can often be used as a first point of contact for basic care needs. **See more about this issue below**.

Here is a sample MHCP member ID card with a PCP indicated on it:



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CLINICAL INFORMATION

Effective February 1, 2015:

Medica to implement new coverage policies

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

Cognitive rehabilitation/remediation

Medica has reviewed cognitive rehabilitation/remediation and has determined that this technology *will be covered* following focal traumatic brain injury when there is reasonable expectation of achieving measureable improvement. Examples include but are not limited to trauma (e.g., traumatic brain injury; brain damage), stroke, brain tumor, and aneurysm.

All other indications — including but not limited to cognitive decline resulting from progression of a chronic disease, coma stimulation, developmental delay disorders, encephalitis, neuropsychiatric disorders, and toxicity — *are investigative and therefore will not be covered*.

Cognitive rehabilitation/remediation is intended to provide retraining in an individual's ability to think, use judgment, and improve decision making skills. It involves the use of therapies, including but not limited to computer-assisted therapies, aimed at improving deficits in memory, concentration, perception, learning, sequencing, judgment, and planning. Intended goals are enhanced ability to process and interpret information and to improve ability to function within community and family relationships. To date, these therapies are not well defined and display a high degree of variation in types of techniques employed.

Laser spine surgeries

Medica has reviewed laser spine surgeries — including but not limited to laser discectomy, laser foraminoplasty/ foraminotomy, laser laminectomy/laminotomy, and facet laser ablation — and has determined that they *are investigative and therefore will not be covered*.

When performing laser spine surgery, a small incision is made and the visual field around the spine remains limited. Under indirect visualization, the laser is used in combination with a small cannula and threading a flexible quartz fiber through a large-bore needle or accessing the site using as endoscope. By ablating the nerve endings and decreasing the size of the disks and surrounding structures, it is theorized that the sources of nerve sensitivity and pain will be eliminated. Lasers have been purported for multiple spine surgery techniques, including ablating bone spurs, herniated and bulging disks, and structures associated with spinal stenosis.

Minimally invasive spine surgeries

The new "Minimally Invasive Spine Surgeries" coverage policy summarizes current Medica clinical coverage policies that address minimally invasive spine surgeries, including alternate names and acronyms for cross-referencing. The policy addresses those procedures that are covered for certain indications, as well as those previously determined investigative and therefore *not* covered for any indication. These policies represent a subset of all available minimally invasive spine procedures, and the procedures represented are subject to change without notice.

Surgical procedures for the treatment of back and neck pain include open surgical approaches as well as multiple alternative minimally invasive techniques. Currently, there is not a standard definition for minimally invasive spine surgery, and there are a variety of minimally invasive surgical techniques purported for use. It is an evolving field using novel techniques and technology to purportedly achieve optimal outcomes. In most cases, a percutaneous or endoscopic approach is used, direct visualization is limited, and surgery is performed using image guidance (e.g., fluoroscopy) and other highly

specialized tools, including specialized tubular retractors, guide wires, endoscopes, and computer-assisted technology. Many minimally invasive procedures are purported for use in the outpatient setting.

The complete text of the policies that apply to the determinations above will be available online or on hard copy:

- **See coverage policies at medica.com** as of February 1, 2015; 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 February 1, 2015:

Medica to make coverage policy changes

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

Virtual colonoscopy and virtual upper GI endoscopy
Medica has reviewed virtual upper gastrointestinal tract endoscopy using computed tomography (CT) imaging and has determined that this technology *is investigative and therefore will not be covered*. Previous Medica determinations related to virtual colonoscopy (CT colonography and MR colonography) *remain unchanged*.

The new determination will be incorporated into the existing coverage policy titled "Virtual Colonoscopy and Virtual Upper GI Endoscopy" (formerly "Virtual Colonoscopy (Computed Tomographic Colonography or Magnetic Resonance Colonography").

Virtual upper gastrointestinal (GI) endoscopy uses 3-D CT to capture detailed pictures of the inside surfaces of the organs of the GI tract. Patients undergoing a virtual upper gastrointestinal endoscopy usually do not need anesthesia or sedation. If a lesion is found, a conventional upper GI endoscopy is necessary for excision or biopsy.

Percutaneous radiofrequency and laser ablation/denervation procedures for facet and SI joints
Medica has reviewed laser ablation/denervation of the facet and sacroiliac (SI) joints and has determined that this technology *is investigative and therefore will not be covered*. The previous determinations for percutaneous radiofrequency ablation/denervation of facet and SI joints *remain unchanged*.

The new determination will be incorporated into the existing coverage policy titled "Percutaneous Radiofrequency and Laser Ablation/Denervation Procedures for Facet and Sacroiliac Joints" (formerly "Percutaneous Radiofrequency Ablation/Denervation of Facet Joint and Sacroiliac Joint").

Laser ablation/denervation is performed using fluoroscopic guidance, whereby a small tube is inserted and a thin wire is passed through to locate the nerve causing the pain. The wire is then removed and a small laser is inserted, which is used to debride the joint and deaden the nerve that supplies the joint.

The complete text of the policies that apply to the determinations above will be available online or on hard copy:

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

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Effective February 1, 2015:

Medica to make UM policy changes

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

Sacral nerve stimulation

Medica will soon implement a new prior authorization requirement. Medica has required prior authorization for *permanent* placement of a sacral nerve stimulation device for both urinary and fecal incontinence since December 1, 2012. In addition, beginning with February 1, 2015 dates of service, Medica *will require prior authorization for both the trial and permanent placement* of the device.

In order for permanent placement to be considered medically necessary, the patient must complete a trial lasting at least one week, demonstrate a 50 percent improvement in symptoms, and provide written documentation of that improvement, including the symptoms that are being measured to define a positive response.

Sacral nerve stimulation involves electrical stimulation of the nerves that control the bladder and bowel. It is a reversible treatment for patients with bladder or bowel-control problems for whom conservative treatments have not worked or have not been tolerated.

Varicose vein and venous insufficiency treatments

Beginning with February 1, 2015 dates of service, Medica *will require high-resolution photographs* documenting skin changes, dermatitis, and/or ulceration *for all prior authorization requests*, unless pain is the only indication for treatment. Digital photographs are the preferred medium, but print copies are acceptable.

In addition, treatment for superficial veins — also referred to as telangiectasia, spider, thread or reticular veins — *is excluded from coverage* in most plans. Therefore, the medical necessity criteria addressing these veins will be removed from the "Varicose Vein and Venous Insufficiency Treatments" utilization management (UM) policy (formerly titled "Varicose Veins and Venous Insufficiency Treatment: Including Ligation/Stripping, Phlebectomy, Endovenous Radiofrequency Ablation, Endovenous Laser Ablation, Sclerotherapy Procedures").

Knee arthroplasty/replacement

Medica has reviewed the criteria for knee arthroplasty and has reduced the requirement for a trial of conservative therapy from 12 months to 3 months. In addition, Medica has removed the requirement for consideration of less invasive surgical procedures prior to total knee arthroplasty for osteoarthritis. All other criteria *remain unchanged*.

The complete text of the policies that apply to the determinations above will be available online or on hard copy:

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

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Educating patients on appropriate use of ED, urgent care

How can providers help their patients use the emergency department (ED), urgent care, and retail health clinics more appropriately?

There are patients who frequently use the ED for non-emergency, health-related events. In 2003, the use of EDs rose to 114 million up from 89.8 million in 1992 — a 27 percent increase. According to the Centers for Disease Control and Prevention (CDC), in 2003 about 13 percent of those 114 million ED visits were considered non-urgent. Another survey in 2012 found 44 percent of visits to the ED are for aliments that could be treated by a regular doctor.

Misuse of the ED has a significant impact on health care costs; emergency care is the most expensive form of health care. Some key points that it might be helpful to mention to patients about when to use ED, urgent care, or other clinics:

- There's *a longer wait time* for a service if it's not a true emergency. EDs are triage centers to provide fast, life- or limb-saving care.
- The copay *is often a higher cost* to the patient when using an ED.
- Avoiding the ED *may help keep health care costs down*, which will be reflected in future insurance premiums.

Patients whose condition is life- or limb-threatening should use the ED for symptoms or conditions such as:

- chest pain (signs of heart attack)
- uncontrolled bleeding
- sudden or severe pain
- coughing or vomiting blood, or difficulty with breathing
- sudden dizziness, weakness or change in vision, or signs of a stroke
- loss of consciousness
- poisoning
- suicidal feeling

An urgent care visit may be more appropriate when patients have the following:

- lacerations with controlled bleeding
- sprains, strains or deep bruises
- mild to moderate asthma attack
- ear infection
- urinary tract infection
- sore throat

A retail health clinic may be appropriate when patients have the following:

- bumps, cuts, scrapes
- burning with urination
- ear or sinus pain
- sore throat
- need a vaccination

Remember to remind patients they can call their physician's office, or many health plans have a nurse line to call.

Remind patients that no matter what option they use, based on their condition they should have a list of all medications they take, including dosages and any over-the-counter medications and vitamins. They should keep a list of any allergies they may have, and it is also helpful to know about past operations. Also, let them know if the ED is needed to go immediately.

This topic also has been addressed on the consumer blog "The Good Doctor by Medica." **See more**.

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Due January 15, 2015:

Quality complaint reports required by State of Minnesota

Medica requires its Minnesota-based network providers to submit fourth-quarter 2014 quality-of-care complaint reports to Medica *by January 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 February 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 February 1, 2015, unless otherwise noted.

UM policies — Revised

These versions replace all previous versions.

Name	Policy number
Autologous Cultured Chondrocyte (Carticel®) Transplantation for the Knee	III-SUR.35
Cervical Spine Surgeries	III-SUR.37
Genetic Testing For Hereditary Breast And/Or Ovarian Cancer (BRCA 1 and BRCA 2 Genes and Bracanalysis® Rearrangement Test [BART])	III-DIA.04
Genetic Testing for Susceptibility to Colorectal Cancer (CRC) Syndromes	III-DIA.06
High Frequency Chest Wall Compression (HFCWC) Devices	III-DEV.20
Humanitarian Device Exemption	III-DEV.18
Knee Arthroplasty/Replacement	III-SUR.41
Lumbar Spine Surgeries	III-SUR.34
Positron Emission Tomography (PET) Scan *(administrative update — Coverage Issues section; effective 12/1/2014)*	III-DIA.12
Posterior Tibial Nerve Stimulation for Overactive Bladder	III-MED.07
Sacral Nerve Stimulation (SNS)	III-DEV.22
Varicose Vein And Venous Insufficiency Treatments	III-SUR.26

Coverage policies — New

Name
Cognitive Remediation Therapy
Laser Spine Surgery
Minimally Invasive Spine Surgeries

Coverage policies — Revised

These versions replace all previous versions.

Name
Blood Coagulation Home Testing Devices
Bone Morphogenic Protein (BMP) for Spine and Orthopedic Applications
Craniosacral Therapy
mild® Procedure (mild® Device Kit) *(12/1/2014 administrative update — title change; formerly Minimally Invasive Lumbar Decompression (MILD))*
Percutaneous Radiofrequency and Laser Ablation/Denervation Procedures for Facet and Sacroiliac

Joints *(formerly Percutaneous Radiofrequency Ablation/Denervation of Facet Joint and Sacroiliac Joint)*
Virtual Colonoscopy and Virtual Upper GI Endoscopy *(formerly Virtual Colonoscopy (Computed Tomographic Colonography or Magnetic Resonance Colonography))*

These documents will be available online or on hard copy:

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

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PHARMACY INFORMATION

Effective January 1, 2015:

Medica to update commercial, Marketplace, MHCP drug lists

Medica has reviewed the following products, with their respective coverage status effective January 1, 2015, *unless otherwise noted*. As indicated in the table below, these changes will apply to the Medica Commercial Preferred Drug List; the 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
umeclidinium and vilanterol inhalation powder (Anoro Ellipta®)	Commercial tier 3; Marketplace tier 3	Non-formulary	Spiriva, Combivent, Serevent, Atrovent HFA		Treatment of chronic obstructive pulmonary disease (COPD)
eslicarbazine (Aptiom®)	Commercial tier 3; Marketplace	Non-formulary	carba-mazepine, oxcarbazepine,	Quantity limit	Adjunct therapy to control partial-onset seizures

	tier 3		gabapentin, lamotrigine, phenytoin, topiramate, Vimpat, Potiga		
testosterone un-decoanoate (Aveed®)	Commercial tier 3; Marketplace tier 3	Non-formulary	testosterone cypionate		For use in adult males for conditions associated with a deficiency or absence of endogenous testosterone
propranolol solution (He-mangeol®)	Commercial tier 3; Marketplace tier 3	Non-formulary	Invokana		Treatment of proliferating infantile hemangioma
tasimelteon (Hetlioz®)	Commercial tier 3; Marketplace tier 3	Non-formulary	zaleplon, zolpidem	Prior authorization	Treatment of non-24-hour sleep-wake disorder
luliconazole (Luzu®)	Commercial tier 3; Marketplace tier 3	Non-formulary	ketoconazole, nystatin, nystatin-triamcinolone, clotrimazole, econazole, ciclopirox		Topical treatment of interdigital tinea pedis, tinea cruris, and tinea corporis
acyclovir buccal tablet (Sitavig®)	Commercial tier 3; Marketplace tier 3	Non-formulary	acyclovir, famciclovir, valacyclovir		Treatment of recurrent herpes labialis (cold sores) in immunocompetent adults
sucroferric oxyhydroxide (Velphoro®)	Commercial tier 3; Marketplace tier 3	Non-formulary	calcium acetate, Renagel, Renvela, sevelamer		Control of serum phosphorus levels in patients with chronic kidney disease on dialysis
oxycodone/ acetamino-phen (Xartemis XR®)	Commercial tier 3; Marketplace tier 3	Non-formulary	oxycodone, oxycodone/ acetamino-phen, Oxycontin		Management of acute pain severe enough to require opioid treatment and for which alternative

					treatment options are inadequate
dextro-amphetamine sulfate (Zenzedi®)	Commercial tier 3; Marketplace tier 3	Non-formulary	dextro-amphetamine sulfate, dextro-amphetamine sulfate ER		Treatment of narcolepsy and attention deficit hyperactivity disorder (ADHD) in pediatric patients 3-16 years of age
ceritinib (Zykadia®)	Commercial tier 2; Marketplace tier 2	Formulary		Specialty drug; step therapy	Treatment of ALK-positive non-small cell lung cancer (NSCLC) that is not responsive or is resistant to treatment with crizotinib (Xalkori)

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 February 1, 2015:

Medica to update drug coverage and UM policies

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

Coverage policies — Revised

These versions replace all previous versions.

Name
Bio-Identical Hormone Replacement Therapy
Botulinum Toxin Treatment for Non-Cosmetic Indications
Respiratory Syncytial Virus Prophylaxis

Drug UM (prior authorization) policies — Revised

These versions replace all previous versions.

Name
alfecept (Amevive®)
carglumic acid (Carbaglu®)
nabilone (Cesamet®)
certolizumab prefilled syringes (Cimzia®)
tesamorelin (Egrifta®)
etanercept (Enbrel®)
transmucosal fentanyl (Abstral®, Actiq®, Fentora®, Lazanda®, Onsolis®)
crofelemer (Fulyzaq®)
adalimumab (Humira®)
lomitapide and mipomersen (Juxtapid® and Kynamro®)
ivacaftor (Kalydeco®)
anakinra (Kineret®)
glycerol phenylbutyrate (Ravicti®)
golimumab (Simponi®)
trametinib (Mekinist®), dabrafenib (Tafinlar®), vemurafenib (Zelboraf®)

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

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

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NETWORK INFORMATION

Effective October 1, 2014:

Medica updates SNF MSHO payment rate, per DHS

Due to Minnesota state legislative changes, Medica is working to update the skilled nursing facility (SNF) payment rate for Medica DUAL Solution® members (enrolled in Minnesota Senior Health Options, or MSHO). Payments were effective with October 1, 2014, dates of service, as determined by the Minnesota Department of Human Services (DHS). Medica will retroactively adjust and reprocess claims to incorporate the updated SNF fees for dates of services on or after October 1, 2014.

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ADMINISTRATIVE INFORMATION

Effective February 14, 2015:

Medica to implement new reimbursement policy

Medica will soon implement the new reimbursement policy indicated below, effective with February 14, 2015, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Multiple therapy procedure reduction

Medica will align with the Centers for Medicare and Medicaid Services (CMS) and implement a new policy, "Physical Medicine & Rehabilitation: Multiple Therapy Procedure Reduction (MTPR)," effective with February 14, 2015, dates of service.

CMS has established relative value units (RVUs) for each component of a procedure: work expense, practice expense (PE) and malpractice expense. CMS has identified a select list of therapy services that are frequently reported together on the same date of service and applies a reduction to payment on the practice expense component for secondary and subsequent procedures. By reducing payment for secondary and subsequent procedures, payments for elements performed only once during a session are reduced.

Medica will apply multiple procedure reduction to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day by providers who report under the same federal tax identification number (TIN). The primary procedure or unit will be reimbursed at full payment. The PE component of the procedural code for all subsequent units and procedures will be reduced by 50 percent. The policy applies to procedural codes identified in the CMS National Physician Fee Schedule with a Multiple Procedure indicator of 5:

5 = Subject to 50% of the practice expense component for certain therapy services

The CMS Non Facility PE RVU assignment to each code is used to determine ranking of the eligible codes. The code with the highest PE RVU is considered the primary procedure. When procedures share the same practice expense RVU, the Total RVU will be used to further rank those codes.

This policy will *not* be applied to providers contracted at a flat rate per-diem payment methodology.

This new policy will be available online or on hard copy:

- **View reimbursement policies at medica.com** as of February 14, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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Effective February 14, 2015:

Medica to revise reimbursement policies

Medica will soon update the reimbursement policies indicated below, effective with February 14, 2015, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

Codes not intended for reimbursement to health care professionals

To align with correct coding guidelines, Medica will revise the Codes Not Intended for Reimbursement to Health Care Professionals policy with the following changes effective for dates of processing on or after February 14, 2015:

- Modifiers 27, 73 and 74 are to be used for services billed by ambulatory surgery centers (ASCs) and hospitals billing for outpatient services.
- Modifier SE indicates that a service has been funded or a vaccine has been provided free of charge by the state or federal government; therefore, no cost has been incurred that requires reimbursement.
- Services reported with these modifiers by physicians or other health care professionals on a CMS-1500 claim form or its electronic equivalent *will be denied*.

Modifier	Description
27	Multiple outpatient hospital E/M encounters on the same date
73	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
74	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia
SE	State and/or federally-funded programs/services

To accurately reflect this policy's intent, the name of this policy will change from "Codes Not Intended for Reimbursement to Health Care Professionals" to "Services and Modifiers Not Reimbursable to Health Care Professionals."

Preventive medicine and screening

Preventive medicine services are comprehensive in nature; reflect an age- and gender-appropriate history and examination; and include counseling, anticipatory guidance, and risk-factor-reduction interventions. If an abnormality is encountered or a pre-existing problem is addressed during the preventive visit that requires significant additional work, then the appropriate problem-oriented code, 99201-99215, should also be reported with modifier 25.

Effective for dates of processing on or after February 14, 2015, the following revisions to this policy will apply:

- Medica will reimburse the preventive medicine evaluation and management (E/M) code at the contracted rate. The problem-oriented E/M code will be reimbursed at 75 percent of the contracted rate.
- The following codes will *not* be separately reimbursed when billed with a preventive medicine E/M code:
    - 96110 (Developmental screening)*
    - G0442, G0444 (Screening Services)
    - 97802-97804, G0270-G0271 (Medical Nutrition Therapy)
    - 99354-99355 (Prolonged Services)
    - G0246, G0443, G0445, G0446, G0447, S0265, S9470 (Counseling Services)

***Note:** Current Procedural Terminology (CPT®) code 96110 will continue to be eligible for reimbursement for all Minnesota Health Care Programs (MHCP) members.

See a comprehensive list of codes not separately reimbursed, to be effective February 14, 2015.

These revised policies will be available online or on hard copy:

- **View reimbursement policies at medica.com** as of February 14, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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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.

Location in manual	Information updated	When posted online in manual
Found in 3 locations: • "Health Management and Quality Improvement" section, in "Provider Responsibilities" subsection, under "Medical Records" • "Health Management and Quality Improvement" section, in "Medical Record Review" subsection, under "Provider Responsibility Policy" • "Administrative Policies and	Updated to clarify what information Medica needs from providers to comply with regulatory and accreditation requirements	November 2014

Procedures" section, in "Medical Record Requests" subsection		

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

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PPO INFORMATION

Aetna offers ongoing provider education

Aetna offers live educational webinars at no cost to providers throughout the year. These may be helpful for Medica SelectCare℠ providers in dealing with Aetna. **Learn more at the Aetna provider-education portal**.

Aetna offers monthly webinar topics such as:

- Doing Business with Aetna
- Account Management Tools
- Precertification Tools
- NaviNet Basics
- Aetna Voice Advantage

Be sure to look for upcoming dates for first quarter 2015.

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Latest UHC provider bulletin available online

UnitedHealthcare (UHC) has published the latest edition of its *Network Bulletin* (November 2014). Highlights that may be of interest to LaborCare® network providers include:

- Anesthesia Policy revision — scheduled for first quarter 2015
- Maximum Frequency Per Day Policy revision — scheduled for first quarter 2015
- Procedure to Modifier Policy revision — scheduled for first quarter 2015
- New Pediatric and Neonatal Critical and Intensive Care Services Policy — scheduled for March 2015
- Prior authorization requirement for outpatient injectable chemotherapy — delayed until spring 2015

View the November 2014 UHC provider newsletter.

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Know of colleagues who should get this regularly? **Have them sign up**.

Medica Connections is published monthly by Medica and can be accessed online.
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Health and Network Management leadership at Medica:
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Ted Loftness, MD, *Vice President and Medical Director*
James Hartert, MD, *Senior Medical Director for Health Management*

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