

**MEDICA
CONNECTIONS®**
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June 2015



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GENERAL INFORMATION

Effective June 1, 2015:

Medica to modify 'Health Rewards' incentives for MHCP members

Next month, Medica will be updating My Health Rewards by Medica[®] incentives for members enrolled in the following Minnesota Health Care Programs (MHCP) products: Medica MinnesotaCare, Medica Choice CareSM and Medica AccessAbility Solution[®]. My Health Rewards includes various incentives for members to seek services related to health care and safety.

Effective June 1, 2015, changes to this program will include:

- An expanded car seat option, to include booster seats
- A new incentive for diabetes monitoring tests
- An increased incentive for annual Child and Teen Checkups (C&TC) visits, from 15 months of age through 20 years of age
- An increased incentive, up to \$150 total, for prenatal and postpartum checkups
- A discontinued incentive for blood lead testing

For each of these incentives, members need to have their provider sign a voucher so they can receive gift cards from Medica. [See more details about the program.](#)

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Annual notice:

Provider appeals on behalf of Medica members

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

For more details about appeals:

- [See Benefit Appeals in the Provider Administrative Manual.](#)
- [See Member Assistance Services in the Provider Administrative Manual.](#)

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Annual notice:

Member rights and responsibilities, for providers to know

Medica recognizes the importance of a three-way relationship among members, their providers and

their health plan. Medica believes that educating members about their healthcare responsibilities is important because it helps members get the greatest benefit from their health plan. Medica outlines member rights and responsibilities for the Medica physician and provider community in order to improve the health of the members Medica serves.

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

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Annual notice:

Medica reaffirms its policy regarding utilization management

Utilization Management (UM) is a process Medica uses to evaluate healthcare services for appropriateness and efficacy. Medica UM decisions are based on national and local standards that support the provision of evidence-based care. All decisions also incorporate a member's benefits and Medica coverage policies. Medica does not specifically reward providers, practitioners, staff members or their supervisors who conduct utilization reviews on the behalf of Medica for issuing denials of coverage or service. It is important to note that UM decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the underutilization of services.

Providers who want more information about the UM process may [refer to Medica UM policies at medica.com.](#)

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CLINICAL INFORMATION

Effective July 1, 2015:

Medica to implement new coverage policy

The following benefit determination will be effective beginning with July 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.

Implantable hypoglossal nerve stimulation for obstructive sleep apnea

Medica has reviewed implantable hypoglossal nerve stimulation for the treatment of obstructive sleep apnea and has determined that this technology *is investigative and therefore will not be covered.*

The Inspire[®] II Upper Airway Stimulation therapy is a surgically implanted device designed to stimulate the patient's hypoglossal nerve (cranial nerve XII) at the base of the tongue. A lead in the chest consists of a pressure sensor that detects breathing. Information about respiration rate is relayed to the device, which stimulates the hypoglossal nerve in the tongue. When stimulated, the tongue moves forward, thus opening the airway and purportedly resulting in unobstructed airway. The device is operated by remote control, which the patient activates before going to sleep.

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 July 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 July 1, 2015:

Medica to make UM policy change

Medica will soon revise the following utilization management (UM) policy that requires prior authorization, effective beginning with July 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.

Bone growth stimulators

Medica has reviewed electrical bone growth stimulation following cervical spinal fusion surgery (failed fusion and adjunct use with surgery) and has determined that this technology *is investigative and therefore will not be covered*. This determination will be addressed in the UM policy titled "Bone Growth Stimulators."

Bone growth stimulators are devices that promote bone growth by using either electrical, electromagnetic, or ultrasound stimulation at or above the fracture site, when fracture healing is not progressing as expected, when healing has ceased, or when the patient is at risk for non-healing.

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

- [See UM policies at medica.com](#) as of July 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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The importance of the postpartum care visit

The postpartum period care visit is an important follow-up appointment for a mother to make with her primary care provider, typically an obstetrician-gynecologist or family provider. A mother would typically schedule this checkup for 6 weeks after the birth of her child. It is a time of significant emotional and physical change and a critical transition time for a woman, her newborn and her family.

The postpartum care visit provides an important opportunity to assess the physical and psychosocial well-being of the mother and address a variety of issues facing new mothers, including breastfeeding, nutrition, sexuality, contraception, and emotional health. Providers can identify complications (such as postpartum depression, infections, etc.) and provide necessary interventions and referrals for their patients, as needed.

The postpartum visit is also an opportunity to schedule or review follow-up tests and exams as well as educate patients on the importance of routine preventive health maintenance to support any future pregnancy outcomes.

Tips for providers to improve patient compliance with postpartum visits:

- Stress the importance of postpartum care during prenatal visits.
- Schedule the postpartum visit prior to discharge from the hospital.
- Provide an appointment reminder via a phone call or postcard.
- Encourage patients to schedule a postpartum visit prior to requesting clearance to return to work.
- Encourage patients to schedule a postpartum visit prior to requesting a prescription for contraceptives.
- Follow up on patients who were diagnosed with gestational diabetes.

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Effective July 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 July 1, 2015, unless otherwise noted.

UM policies — Revised

These versions replace all previous versions.

Name	Policy number
Bone Marrow or Stem Cell (Peripheral or Umbilical Cord Blood) Transplantation	III-TRA.01
Liver Transplantation	III-TRA.02
Kidney Transplantation	III-TRA.03
Pancreas Transplantation (Pancreas Alone)	III-TRA.04
Pancreas-Kidney (SPK, PAK) Transplantation	III-TRA.05

Heart/Lung Transplantation	III-TRA.08
Heart Transplantation (Adult and Pediatric)	III-TRA.12
Lung Transplantation (Single or Double)	III-TRA.11
Intestinal Transplantation	III-TRA.13
Bone Growth Stimulators	III-DEV.07
Bariatric Surgery (<i>formerly Gastrointestinal Surgery for Morbid Obesity</i>)	III-SUR.30
Implantable Deep Brain Stimulation	III-DEV.19

Coverage policies — New

Name
Implantable Hypoglossal Nerve Stimulation (Inspire®)

Coverage policies — Revised

These versions replace all previous versions.

Name
Thoracic Electrical Bioimpedance (TEB) for Cardiac Output Measurement
Light Treatment and Laser Therapies for Benign Dermatologic Conditions
Noncontact, Low-frequency Ultrasound Therapy for Healing of Chronic Wounds

These documents will be available online or on hard copy:

- [View medical policies and clinical guidelines at medica.com](#) as of July 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PHARMACY INFORMATION

Reminder:

Upcoming changes to Medica Part D drug formularies

As a reminder, the next available changes to the Part D drug formularies will be effective July 1, 2015. Medica posts changes to its Part D drug formularies on medica.com 60 days prior to the effective date of change. The latest lists notify Medicare enrollees of drugs that will either be removed from the Medica Part D formulary or be subject to a change in preferred or tiered cost-sharing status effective July 1, 2015. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly. [View the latest Medicare Part D drug formulary changes.](#)

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. 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.

(Update to "Changes to Medica Part D drug formulary delayed" article in the April 2015 edition of *Medica Connections*. [See April 2015 edition.](#))

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NETWORK INFORMATION

Effective July 1, 2015:

Medica to revise fee schedule for MHCP products

Effective with July 1, 2015, dates of service, Medica will implement a revised fee schedule for its enrollees in Minnesota Health Care Programs (MHCP), affecting the Medica Choice CareSM, Medica MinnesotaCare and Medica AccessAbility Solution[®] products. The revised Medica MHCP fee schedule will be based on the fee schedule used by the Minnesota Department of Human Services (DHS) to pay providers for services provided to its fee-for-service enrollees. The effect on reimbursement overall for specific clinics will vary by specialty and the mix of services provided.

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

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Effective July 1, 2015:

Medica to update Medicare physician fee schedule

Beginning with July 1, 2015, dates of service, Medica will implement the quarterly update to its Medicare physician fee schedule for applicable Medica products. This fee schedule change will reflect the July 2015 Centers for Medicare and Medicaid Services (CMS) update applicable to reimbursement for injectable drugs and immunizations. The reimbursement impact of this quarterly update will vary based on specialty and mix of services provided. Updates for durable medical equipment (DME) and orthotics and prosthetics (O&P) will not be implemented at this time.

Details on Medicare changes to drug fees [are available online from CMS.](#)

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

ADMINISTRATIVE INFORMATION

Medica requires referral to in-network laboratory providers

Medica requires network providers to refer laboratory tests or other services to laboratory providers within the Medica provider network, rather than refer them outside the network. Referring to network providers whenever possible is a requirement for network providers according to their contract with Medica. This also ensures that Medica members do not pay more for these services than necessary.

Here's a full list of current Medica network laboratory providers, both independent and health system-based.

Medica Network Independent Laboratory Providers
Aurora Medical Park Laboratory LLC
Caremark LLC
Esoterix Genetic Laboratories LLC
Genoa Healthcare Clinical Laboratory LLC
Genomic Health Inc.
Heartland Independent Provider Network
Home Healthcare Laboratory of America Inc.
Laboratory Corporation of America Holdings
Medtox Laboratories
MGA Lab Inc.
Myriad Genetic Laboratories Inc.
Pediatric Lab Services Inc.
PerkinElmer Laboratories Inc.
PrimeCare Health Group
Quest Diagnostics Inc.
Sequenom Center for Molecular Medicine LLC
Transgenomic Inc.

Medica Network System-Based Laboratory Providers
Allina Health System
Avera Health
CentraCare Health System
Children's Health Care
Douglas County Hospital
Fairview Health Services

HealthPartners Medical Group
Huron Clinic Foundation
HealthEast Medical Laboratory LLC
Lake Region HealthCare Corporation
Marshfield Clinic
Mayo Health System
North Memorial Reference Lab
Park Nicollet Health Services
Sanford Medical Center
TLC Advantage LLC
Trinity Health

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CMS offers 'ICD-10: The Road Forward' webinar next week

The Centers for Medicare and Medicaid Services (CMS) is offering a free ICD-10 webinar next week, called "ICD-10: The Road Forward." This webinar will be held on May 19, 2015, and will offer background and strategies on ICD-10 implementation such as:

- Studying the basics, differences, and benefits of ICD-10;
- Exploring common codes, primers for clinical documentation, clinical scenarios; and
- Creating a customized action plan, personalized by specialty and practice details.

This educational session, designed for physicians and practice managers, will cover:

- An overview of ICD-10
- Clinical and business impacts of ICD-10
- Customizable action planning
- Documentation requirements for common health conditions
- Interactive practice clinical scenarios
- Resources

To attend this webinar, [register online](#).

For more ICD-10 resources:

- [See roadto10.org](#)
- [See medica.com](#)

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Effective July 1, 2015:

Medica to revise reimbursement policies

Medica will soon update the reimbursement policies indicated below, effective with July 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
Bundled Services (<i>updated code list</i>)
Maximum Frequency per Day (Units) (<i>updated code list</i>)

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

- [View reimbursement policies at medica.com](#) as of July 1, 2015; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PPO INFORMATION

MHCP eligibility should be verified for DOC inpatient claims

A person incarcerated in a state or local correctional facility may qualify for Medical Assistance payments for inpatient hospital services. As a result, for health care services provided to Minnesota Department of Corrections (DOC) prisoners, Medica SelectCareSM network providers should verify whether or not the patients are enrolled in Minnesota Health Care Programs (MHCP) before submitting inpatient claims to Centurion of Minnesota, LLC. Where DOC patients *are* eligible for MHCP, providers should submit the inpatient claims to MHCP for processing *before* sending them to Centurion. Even in cases where an inmate has an application for MHCP in process, Centurion *cannot* pay related claims and *will deny them* for other coverage.

Refer to the Minnesota Department of Human Services website to learn more about:

- [Verifying MHCP eligibility and submitting claims](#), and
- [MHCP coverage, including for "Incarcerated Recipients."](#)

Also, as a reminder, the inmate ID number *is required* for Centurion to process DOC patient claims. The Minnesota DOC provides an offender search tool for providers to use if they do not capture the offender ID at the time of service: [Access the DOC search tool](#).

Centurion was selected by the State of Minnesota to manage the medical needs of offenders at Minnesota DOC prisons, beginning last year. As a result, providers in the SelectCare network treat

offenders in the custody of DOC.

(Update to "Centurion added as SelectCare payer for DOC patients" article in the August 2014 edition of *Medica Connections*. [See August 2014 edition.](#))

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Aetna ICD-10 approach consistent with Medica

Aetna is approaching the imminent ICD-10 transition in a manner consistent with Medica. All SelectCare 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 only be accepted through September 30, 2015, dates of service (or dates of discharge).

It is important to note that *the current timely-filing process will continue to apply* for SelectCare claims submitted to Medica, *and no extensions will be granted*.

For more details on ICD-10 preparations, [providers can refer to the ICD-10 webpage at medica.com](#).

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Latest UHC provider bulletin available online

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

- Reminder that UHC no longer permits reimbursement of multiple units submitted for single date of service for procedure codes which state "per diem" or "per day" within code description — effective in first quarter 2015
- 2015 UnitedHealthcare Administrative Guide updated and online — effective in April 2015
- Providers will need to submit clinical data, including lab test results, to UHC to support federal and state data collection and reporting requirements — effective in July 2015

[View the April 2015 UHC provider bulletin.](#)

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[View the *Medica Connections* archive.](#)

Health and Network Management leadership at Medica:

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*

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