MEDICA

MEDICA CONNECTIONS®

a monthly publication for Medica network providers

May 2015

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GENERAL INFORMATION

ABN form can no longer be used for certain Medicare plans

In accordance with guidance from the Centers for Medicare and Medicaid Services (CMS), the Advance Beneficiary Notice of Noncoverage (ABN) form *cannot be used* for members in Medica Prime Solution® (the Medica Medicare Cost plan) and Medica DUAL Solution® (the Medica Medicare Advantage special needs plan). The form is intended for use with patient care covered under Medicare fee for service, so therefore providers should not use this form for patients receiving care under private Medicare plans.

The following outlines the Medica policy related to non-covered Medicare services, consistent with the most recent CMS guidance:

- If a service is *never* covered, for example, the member has been notified by a clear exclusion in the Medica Evidence of Coverage or the standardized denial notice prior to receipt of an item or service that it is not covered by Medica, then an organization determination (or pre-service determination) is not required. The provider, prior to rendering the service or providing the item, must inform the member in writing and obtain a written authorization from the member that: the member is fully aware that the service or item being provided is not covered by Medica under the member's benefit contract; *and* the member agrees to be financially responsible for the non-covered service or item if it is provided.
- If a provider believes an item or service *may not be covered*, or could be covered only under specific conditions, the provider must advise the member to request a pre-service determination from Medica *or* the provider can make this request on the member's behalf at the request of the member.

To determine if a service is covered:

- Providers should call the Medica Provider Service Center at 1-800-458-5512.
- Medica Prime Solution members should call Medica at 1-800-234-8755.
- Medica DUAL Solution members should call Medica at 1-888-347-3630.

Providers requesting a pre-service determination of coverage can also submit the following information for consideration by faxing it to the Medica Utilization Management department at 952-992-3556:

- all relevant clinical documentation;
- CPT and diagnosis codes;
- member's demographic information, including Medica ID number; and
- provider's name and location where services will be rendered (including facility, if applicable).

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

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CLINICAL INFORMATION

Effective June 1, 2015:

Medica to make coverage policy changes

The following benefit determinations will be effective beginning with June 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.

Expanded carrier testing for genetic diseases

Medica has reviewed expanded carrier testing for genetic diseases and has expanded the scope of the related coverage policy, formerly titled "Counsyl Universal Genetic Test," to include all expanded

carrier testing panels. Medica has determined that:

- Expanded carrier testing for genetic diseases *remains investigative and therefore not covered*. Examples of currently available panels include, but are not limited to, Counsyl Family Prep Screen, GoodStart Select, Inherigen, Inheritest, and Natera Horizon™ Multi-Disease Carrier Screening.
- Carrier screening using a targeted genetic panel for individuals of Ashkenazi Jewish ancestry *will be covered* when screening is done for disorders as recommended by the American College of Medical Genetics and the American College of Obstetricians and Gynecologists. Currently these disorders include: Tay Sachs disease, Canavan disease, cystic fibrosis, familial dysautonomia, Bloom syndrome, Fanconi anemia, Niemann-Pick disease, Gaucher disease, and Mucolipidosis IV.

Traditional carrier testing is done with targeted single gene screening associated with one disease (e.g., the cystic fibrosis transmembrane conductance regulator gene for cystic fibrosis). However, new methodologies have allowed for expanded carrier testing panels intended to identify genes representing multiple and generally unrelated disorders/conditions. This expanded testing is considered a non-targeted approach to carrier testing. Testing is done using buccal swabs, saliva, or blood specimens.

Currently, there is no standardization between similar expanded carrier genetic panels, with tests performed by different laboratories for the same conditions or diseases often testing different sets and combinations of genes. In addition to testing for standard conditions, expanded carrier testing includes many conditions that: are not routinely evaluated; are not addressed in professionally recognized guidelines; have a low prevalence in the general population (i.e., the individual is at very low risk of being a carrier); or has no known treatment.

Serum drug and antibody levels to monitor tumor necrosis factor inhibitors

Medica has reviewed these tests and has expanded the scope of the related coverage policy, formerly titled "Anti-Infliximab Antibody Level Testing to Monitor Infliximab Treatment," from monitoring of infliximab only to include monitoring of all tumor necrosis factor (TNF) inhibitors. Medica has determined that serum drug and antibody level testing to monitor TNF inhibitors *remains investigative and therefore not covered*.

Tumor necrosis factors are drugs used to treat a number of auto-immune system diseases, such as rheumatoid arthritis and Crohn's disease. Some patients develop antibodies to these drugs which may cause reactions and/or reduce its ability to control the disease. Blood tests to measure and monitor both the serum drug level and antibody level to these drugs have been proposed as a way to determine a patient's loss of response to the drug. TNF inhibitors include, but are not limited to, infliximab (Remicade), adalimumab (Humira), etanercept (Enbrel), golimumab (Simponi), and certolizumab pegol (Cimzia).

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 June 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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Help needed to improve colorectal cancer screening rate

Colorectal cancer screening is key in preventing the third most commonly diagnosed cancer in the United States. This cancer kills more men and women than nearly any other cancer — It is second only to lung cancer. However, about one-third of adults 50-75 years of age have *not* been screened. Medica highly encourages screening, and has signed on to the American Cancer Society's goal to have 80 percent of men and women 50-75 years of age screened for colorectal cancer by the year 2018. Providers are vital in achieving this goal.

A majority of providers believe that colorectal screening is highly important, but only 4 in 10 view it as a top health priority to communicate to their patients. A provider's recommendation is important as studies show that 8 out of 10 patients who participated in colorectal cancer screening chose the particular test they did because their doctor recommended it. Medica appreciates the help of providers in reaching the American Cancer Society's "80 x 18" goal by recommending screening to patients.

After encouraging patients to get screened, there are several testing options for them, such as a colonoscopy or fecal testing. It's important to note that a colonoscopy may be difficult for patients and can be perceived negatively due to the invasiveness of the test or fear of discomfort during the procedure. Fecal testing includes guaiac fecal occult blood test (gFOBT) or fecal immunochemical test (FIT). These tests reduce death from colorectal cancer, are safe, available, and easy to complete. Perhaps most importantly, they are done in the privacy of the patient's home. Evidence indicates these fecal screening tests detect colorectal cancer early when they are completed annually.

Tips for the FOBT or FIT:

- Never use in-office FOBT/FIT as a screening test at the time of a digital rectal exam.
- Perform test only on stool specimens collected by the patients at their home.
- FIT tests need to be billed with Current Procedural Terminology (CPT®) code of 82274.
- gFOBT tests need to billed with CPT code 82270.
- Tests should be billed on the day the test was performed and not on the day when the test was provided to the patient.
- Repeat annually, perhaps offering the test when patients come in for their annual flu shot.
- Be sure to follow up with patients who have a positive test.

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Effective June 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 June 1, 2015, unless otherwise noted.

Coverage policies — Revised

These versions replace all previous versions.

Name
Expanded Carrier Testing for Genetic Diseases *(formerly Counsyl Universal Genetic Test)*
Genetic and Pharmacogenetic Testing *(The following two policies were combined: Genetic Testing and Pharmacogenetic Testing)*
Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) *(formerly Percutaneous Disc Decompression Procedures (Manual, Automated or Laser Discectomy, and Plasma Disc Decompression [PDD]))*
Serum Drug Levels and Antibody Levels to Monitor Tumor Necrosis Factor (TNF) Inhibitors *(formerly Anti-Infliximab Antibody Level Testing to Monitor Infliximab)*
Topographic Genotyping (PathFinder TG®) for Diagnosis of Cancer

These documents will be available online or on hard copy:

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

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PHARMACY INFORMATION

Effective June 1, 2015:

Medica to expand oral oncology split-fill program

Medica is expanding its current specialty-drug split-fill program effective June 1, 2015. The oral oncology drugs being added to the split-fill program are:

- Bosulif
- Erivedge
- Inlyta
- Jakafi
- Tafinlar
- Xalkori
- Xtandi
- Zelboraf
- Zykadia
- Zytiga

This is in addition to nine drugs already included: Afinitor, Nexavar, Sprycel, Sutent, Tarceva, Targretin, Tasigna, Votrient, and Zolinza.

This program exists due to the fact that a patient may need to try multiple medications to find one that works for cancer treatment. By splitting the prescription fill, a specialty pharmacy can monitor the medication and determine if it is effective after the first 14 days before dispensing additional medication. Doing so avoids medication waste, saving costs for patients as well as payers. If an adverse event is noted, the specialty team can respond according to established protocols and can contact the physician as necessary.

Once the patient is tolerating therapy, the remainder of the month's supply of medication is shipped. The partial fill of a medication continues for the initial 3 months of treatment. The member pays 50 percent of a copayment on the first partial fill and then would pay the remaining 50 percent upon the completion fill. If side effects or problems are identified during an assessment, the medication would be held, thus preventing waste.

This program applies to Medica commercial and individual and family business (IFB) members. As a reminder, the main specialty-drug vendor for Medica is Fairview Specialty Pharmacy (Walgreens Specialty Pharmacy continues to handle certain medications).

(Update to "Medica to modify oral oncology split-fill program" article in the July 2014 edition of Medica Connections. **See July 2014 edition**.)

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NETWORK INFORMATION

Fourth-quarter PCR checks to be mailed in April 2015

By the end of April 2015, Medica plans to mail to eligible providers the physician contingency reserve (PCR) payment for the fourth quarter of 2014. This represents a 100-percent return of the fourth-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 October 1, 2014, through December 31, 2014, and dates paid of October 1, 2014, through March 31, 2015.

Note: Medica began processing claims with a 2 percent payment reduction in April 2013 due to federal sequestration. 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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Effective June 15, 2015

Medica to update anesthesia reimbursement for all products

Effective June 15, 2015, Medica will update anesthesia reimbursement, increasing standard anesthesia conversion factors for all Medica products in both metro and regional service areas. The effect on reimbursement will vary by specialty and the mix of services provided. This update will not affect providers with custom anesthesia reimbursement.

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

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ADMINISTRATIVE INFORMATION

Effective April 5, 2015:

Medica revises reimbursement policy

Medica has recently updated the reimbursement policy indicated below, effective with April 5, 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
Ambulance *(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* (March 2015). Highlights that may be of interest to LaborCare® network providers include:

- Reminder on prior authorization requirement for more orthopedic procedures— effective in April 2015
- Reminder on prior authorization requirement for injectable chemotherapy — scheduled for June 2015
- Laboratory Services Policy to be revised — scheduled for June 2015

View the March 2015 UHC provider newsletter

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View the *Medica Connections* archive.

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