MEDICA®

June 2018

Medica Connections®

For Medica network providers

GENERAL NEWS

Reminder:

Record submission available electronically for IFB claim appeals

As a reminder, Medica recently developed a new online capability for providers to electronically submit supplemental documentation related to certain claim appeals. Specifically, this process improvement is a secure submission step for Medica individual and family business (IFB) claims that have been denied. Documentation typically submitted for appeals includes medical records, provider remittance advices (PRAs) and practice management notes. Learn more at an upcoming training.

Providers can also continue to use traditional appeal avenues for Medica IFB claim denials as needed, either by mail or fax. And for all Medica claims other than IFB, providers need to continue using mail or fax to submit documentation related to claim appeals.

(Update to "IFB claim appeals: electronic submission now available" article in the March 2018 edition of *Medica Connections*.)

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.

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.

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.

CLINICAL NEWS

Effective July 16, 2018:

Medical policies and clinical guidelines to be updated

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective July 16, 2018, unless otherwise noted.

These policies apply to all Medica products including commercial, government, and individual and family business (IFB) products unless other requirements apply due to state or federal mandated coverage, for example, or coverage criteria from the Centers for Medicare and Medicaid Services (CMS).

Monthly update notifications for Medica's policies are available on an ongoing basis. Update notifications are posted on medica.com prior to their effective date. The medical policy update notification for changes effective July 16, 2018, is already posted. Changes to policies are effective as of that date unless otherwise noted.

The medical policies themselves will be available online or as a hard copy:

- View medical policies and clinical guidelines at medica.com as of their effective date; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1-800-458-5512, option 1, then option 8, ext. 2-2355.

Note: The next policy update notification will be posted in June 2018 for policies that will be changing effective August 20, 2018. These upcoming policy changes will be effective as of that August date unless otherwise noted.

Coding reminder:

Proper coding for documentation related to hypertension

Hypertension, also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure. The higher the pressure, the harder the heart has to pump. Hypertension can lead to other health conditions such as stroke, heart attack, heart failure and kidney disease.

The hypertension category of ICD-10 diagnosis codes may need one or more diagnoses codes to capture the complexity of the patient's condition. The hypertension codes presume a causal relationship between hypertension and heart involvement and between hypertension and kidney in¬volvement, as the two conditions are linked by the term "with" in the ICD-10 manual's Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For hypertension and conditions not specifically linked by relational terms such as "with," "associated with" or "due to" in the chosen code, the provider's documentation *must link the conditions* in order to code them as related.

Essential or primary hypertension
Additional coding information for essential (primary) hypertension:

- I10 includes high blood pressure
- R03.0 is for elevated blood-pressure reading, without the diagnosis of hypertension

Hypertensive heart disease
Use the following when coding for hypertensive heart disease:

- I11.0 Hypertensive heart disease *with* heart failure
- I11.9 Hypertensive heart disease *without* heart failure

Additional coding information for hypertensive heart disease:

- Includes any condition in I50.1-I50.9 or I51.4-I51.9 due to hypertension.

If coding hypertensive heart disease with heart failure (I11.0), use an additional code to identify the type of heart failure (I50.1-I50.9).

Hypertensive chronic kidney disease (CKD)
Use the following when coding for hypertensive CKD:

- I12.0 Hypertensive CKD with stage 5 CKD or end-stage renal disease
- I12.9 Hypertensive CKD with sate 1 through stage 4 CKD, or unspecified CKD

Additional coding information for hypertensive CKD:

- Include I12.xx, "Hypertensive chronic kidney disease," when both hypertension and CKD are present.
- If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

If coding hypertensive CKD (I12.0, I12.9), use an additional code to identify the stage of CKD (N18.1-N18.6).

Hypertensive heart and CKD
Use the following when coding for hypertensive heart and CKD:

- I13.0 Hypertension heart and CKD *with* heart failure and stage 1 through stage 4 CKD, or unspecified CKD
- I13.10 Hypertensive heart and CKD *without* heart failure, with stage 1 through stage 4 CKD, or unspecified CKD
- I13.11 Hypertensive heart and CKD without heart failure, with stage 5 CKD, or end-stage renal disease
- I13.2 Hypertensive heart and CKD with heart failure and with stage 5 CKD or end-stage renal disease

If a patient has hypertension, heart disease and chronic kidney disease, per the guidelines, a single code from ICD-10 category I13 should be used instead.

Status codes
For a patient with a dialysis or transplant condition along with CKD, providers should always use one of these additional status codes:

- Dialysis status, Z99.2
- Kidney transplant status, Z94.0
- Non-compliance with dialysis (refusal of), Z91.15

PHARMACY NEWS

Effective July 1, 2018:

Medica outlines upcoming changes to drug lists

As noted last month, Medica will be making changes in coverage status to member drug formularies (drug lists) effective July 1, 2018. For certain Medica members, as noted below, these changes would be effective July 1, 2018, for *new* prescriptions, but not effective until August 1, 2018, for *existing* prescriptions. The changes to these formularies are now posted online.

- See changes to the 2018 Medica Commercial Large Group Drug List — effective 7/1 for new prescriptions, 8/1 for existing prescriptions.
- See changes to the 2018 Medica Commercial Small Group Drug List.
- See changes to the 2018 Medica Preferred Drug List for individual and family business (IFB).
- See changes to the 2018 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP) — effective 7/1 for new prescriptions, 8/1 for existing prescriptions.

Effective May 25, 2018:

Medica to add new UM policies for medical pharmacy drugs

Medica will soon implement the following new medical pharmacy drug utilization management (UM) policies. These changes will be effective with May 25, 2018, dates of service. Medica implements such policies as soon as possible after conducting a clinical review of these new-to-market drugs and approving them for coverage with UM policies. Prior authorization will be required for the corresponding medical pharmacy drugs.

Medical pharmacy drug UM policies — New
Prior authorization will be required.

Drug code	Drug brand name	Drug generic name
J3490	Akynzeo for injection	fosnetupitant/palonosetron
J3590	Crysvita	burosumab-twza

J3590	Ilumya	tildrakizumab-asmn
A9699, J9999	Lutathera	lutetium lu 177 dotatate
J3590	Trogarzo	ibalizumab-uiyk

These policies will apply to Medica commercial members, individual and family business (IFB) members, Minnesota Health Care Programs (MHCP) members and Medica Medicare members in Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO) and Medica Advantage Solution® (Medicare Advantage). They will *not* apply to Medica Prime Solution® (Medicare Cost) members. The drugs will be subject to pre-payment claims edit policies as well.

The new medical pharmacy drug UM policies above will be available online or on hard copy:

- View drug management policies as of May 25; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective August 1, 2018:

Upcoming changes to Medica Part D drug formularies

Medica posts changes to its Part D drug formularies on medica.com 60 days prior to the effective date of change. The latest lists will 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 August 1, 2018. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of June 1, 2018, view the latest Medicare Part D drug formulary changes.

Medica periodically makes changes to its Medicare Part D formularies: the Medica Prime Solution® Part D closed formulary (4-tier + specialty tier) and the Medica DUAL Solution® Part D closed formulary. The Medica Medicare Part D drug formularies are available online or on paper:

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

Medication request forms
A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information. To request formulary exceptions, providers can submit an exception form or call CVS Caremark.

ADMINISTRATIVE NEWS

Provider College administrative training topics for June

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

Training class topics

"IFB Claim Appeals, Adjustments and Record Submission" (class code: AAR)
This class will discuss the processes that providers should use for submitting claim appeals, claim adjustments and medical records for Medica's individual and family plan (IFB) members. This will include the different submission options available as well as the information required and the best ways to make sure that the submissions are viewed and reviewed as intended. Participants will discuss who reviews appeals and how the adjustment process works and what do to if providers don't agree with the outcome.

"Medica Prime Solution Medicare Product in ND/SD" (class code: PS)
This course will review information to help North Dakota and South Dakota providers better understand the Medica Prime Solution® product. Topics include: when Medica follows Centers for Medicare and Medicaid Services (CMS) guidelines; when to bill Medica as primary payer vs. Medicare; upgraded services offered by the plans; billing requirements; and reimbursement. Time will also be provided for questions and answers as part of this discussion.

Class schedule

Class code	Topic	Date	Time	Notes
AAR-WJ	IFB Claim Appeals, Adjustments and Record Submission	June 19	10-11 am	Class code with "WJ" means offered via webinar in June
PS-WJ	Medica Prime Solution Medicare Product in ND/SD	June 26	10-11 am	

For webinar trainings, login information and class materials are e-mailed close to the class date. To ensure that training materials are received prior to a class, providers should sign up as soon as possible.

The times reflected above allow for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement.

Registration

The registration deadline is one week prior to the class date. Register online for a session above.

Effective August 1, 2018:
All claims with accident diagnosis to require date of accident

Effective with August 1, 2018, dates of claim submission, Medica will require that claims indicating an accident diagnosis also include the corresponding date of the accident. This change, which is consistent with the Health Insurance Portability and Accountability Act (HIPAA), will apply to both physician and facility claims for Medica's commercial, Minnesota Health Care Programs (MHCP) and Medicare products. It will *not* apply for Medica's individual and family business (IFB) products. As part of this new requirement, Medica *will reject* claims without the date of accident when the ICD-10 code indicates an accident occurred. If providers have a claim rejected due to this new claim requirement ("claim edit"), they will need to correct their claim and resubmit it so that the claim can be processed.

SELECTCARE/LABORCARE NEWS

Latest UHC provider bulletin available online

UnitedHealthcare (UHC) has published the latest edition of its *Network Bulletin* (May 2018). Highlights that may be of interest to LaborCare® network providers include:

- Risk Adjustment Data Validation (RADV) audit program — scheduled for June 2018
- New prior authorization requirement for Xgeva, Prolia (denosumab) — scheduled for June 2018
- Luxturna (voretigene neparvovec-rzyl) must be acquired from Accredo Specialty Pharmacy — scheduled for July 2018
- New prior authorization requirement for Crysvita (burosumab) — scheduled for October 2018

View the May 2018 UHC provider bulletin.

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