MEDICA

November 2018

MEDICA CONNECTIONS®

For Medica network providers

General | Clinical | Pharmacy | Network | Administrative

GENERAL NEWS

Effective January 1, 2019:

Medica launches new Medicare Advantage PPO product

Also, service area of Medicare Advantage HMO-POS to expand

(This applies to Medica direct-contracted providers only.)

Effective January 1, 2019, Medica is introducing Medica Advantage Solution® (PPO), a new Medicare Advantage product offering in 29 Minnesota counties, including two plans in the seven-county Twin Cities metro area, one plan in the six-county Greater Twin Cities metro area, and one plan in 16 counties of southeast Minnesota. Similar to the existing Medica Advantage Solution HMO-POS product (#H6154), the new PPO plans (#H8889) will offer a broad provider network that includes major health care systems such as:

- Allina Health
- Fairview Health Services/HealthEast Care System
- North Memorial Health
- Hennepin Healthcare
- Ridgeview Medical Center & Clinics
- CentraCare Health
- Many other facilities, clinics, primary care and specialists

In addition, plan #H8889-004, with a service area of 16 counties in southeast Minnesota, will include Mayo Clinic Health System in the provider network.

Medica Advantage Solution (PPO) plans include both medical and Part D prescription drug coverage and provide protection from unlimited out-of-pocket costs in- and out-of-network. Plan features include:

- $0 copay for primary care office visits
- Free fitness center membership through SilverSneakers®
- Over-the-counter (OTC) drugs and supplies quarterly benefit allowance
- $0 copay for eVisits through virtuwell®
- Dental and eyewear reimbursements
- Routine eye and hearing exams

- Coverage for hearing aids through EPIC
- Part D deductible does not apply to tiers 1 and 2
- Mail order option includes $0 copays for tiers 1 and 2, and a 3-month supply for only 2 copays for tier 3
- 20% coinsurance for worldwide emergency coverage, worldwide emergency ground transportation

In addition, Medica is expanding its Medica Advantage Solution (HMO-POS) product for next year. Effective January 1, 2019, Medica will offer one HMO-POS plan in the seven-county Twin Cities metro area and one HMO-POS plan in the six-county Greater Twin Cities metro area.

Medica Advantage Solution plans do *not require provider referrals* to see any network provider. However, certain in-network covered services *will require prior authorization*. For a complete list of these services, **refer to Medica's Prior Authorization List**.

A fact sheet for this new plan **will soon be available at medica.com** (under Medicare Products).

Effective January 1, 2019:

Medica offers new Medicare-Medicaid SNBC HMO-SNP product

(This applies to Medica direct-contracted providers only.)

Effective January 1, 2019, Medica is introducing Medica AccessAbility Solution® Enhanced (HMO-SNP), a Special Needs BasicCare (SNBC) product that integrates Medicare and Medical Assistance benefits for eligible Minnesota Health Care Programs (MHCP) enrollees. This new product will be available to residents of Carver, Dakota, Hennepin, Ramsey and Scott counties in the Twin Cities metro area. AccessAbility Solution Enhanced offers a broad provider network in the Twin Cities.

The Medica AccessAbility Solution Enhanced plan includes both medical and prescription and over-the-counter (OTC) drug coverage, plus several supplemental benefits beyond what non-integrated SNBC plans cover. Plan features include:

- No copays for all medical services covered under Medicare or Medical Assistance
- No copays for OTC drugs covered under Medical Assistance
- Reduced copays from Extra Help for prescription Part D drugs
- Free fitness center membership through SilverSneakers®
- Free unlimited public transportation or limited volunteer/taxi transportation to local SilverSneakers fitness centers
- Free oral health education outreach that includes dental health practices, available dental services, and assistance to schedule a dental appointment
- Free restorative dental service of one porcelain over metal crown per year
- Free anti-glare lens coating upgrade on one pair of covered glasses per 24 months

The new Medica AccessAbility Solution Enhanced plan does *not require provider referrals* to see any network provider. However, certain covered services *will require prior authorization*. For a complete list of these services, **refer to Medica's Prior Authorization List**.

A fact sheet for this plan **will soon be available at medica.com** (under Minnesota Health Care Programs).

Effective January 1, 2019:

Electronic claim submission, payment for new MHPS membership

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Beginning with January 1, 2019, dates of service, Medica Health Plan Solutions (MHPS), a division of Medica, will begin administering the provider networks and benefits previously administered by MMSI, Inc. (d/b/a Mayo Clinic Health Solutions). This will include Mayo Medical Plan. Providers will need to be aware of new details such as new payer IDs and a new claims address. Medica Health Plan Solutions members will be identifiable by group numbers beginning with "A00" on member ID cards.

For this new membership, electronic claims will need to be submitted to payer ID #71890 or 88090, depending on the group. Providers can still send claims electronically via their clearinghouse and can work with their clearinghouse to continue receiving electronic provider remittance advices (EPRAs). For electronic payment, Medica Health Plan Solutions providers will also need to register the new payer IDs for electronic funds transfer (EFT) using Change Healthcare. For EFT enrollment, **refer to Change Healthcare's website** or call 1-866-506-2830.

As a reminder, providers should check member ID cards at time of registration to ensure appropriate routing of claims.

Medica Health Plan Solutions network providers will follow Medica's administrative requirements, such as coverage policies and utilization management (UM) policies. UM policies outline when services or drugs require prior authorization. **See more on UM, including Medica's Prior Authorization List**.

To learn more about these new products, **see Medica's product fact sheets**.

For claims with 2018 dates of service, providers in the MMSI network should continue to follow their current process.

Annual notice:

Compliance, FWA trainings required for Medicare providers

(This applies to Medica direct-contracted providers only.)

The Centers for Medicare and Medicaid Services (CMS) requires that Medicare providers complete general compliance training and fraud, waste, and abuse (FWA) training. The training requirement applies to all organizations that provide health care services or administrative services for Medicare beneficiaries, and also applies to the organizations' downstream and related entities. Although Medicare-certified (or deemed) providers are exempt from the FWA portion of the training, they are still required to complete general compliance training.

Medica makes the Medica Standards of Conduct, Compliance Reporting Policy, and links to the CMS general compliance training and FWA training available on medica.com. Medica also requires that a compliance officer or equivalent person for a provider group complete and sign a Compliance Program Attestation and return it to Medica. *This is due by November 30, 2018*.

According to federal regulations, providers must use the general compliance and FWA training materials created by CMS. **Learn more and take the trainings**.

As a reminder, training is required at the time of a Medicare provider's initial contract and then annually thereafter. Providers should maintain records of all training for 10 years. Records should include dates and methods of training, materials used for training, and training logs identifying employees who received training. Medica, CMS, or agents of CMS may request such records to verify that training occurred.

Reminder:

Medica conducts concurrent review for hospitalized members

(This applies to Medica leased-network providers as well as direct-contracted providers.)

As a reminder, Medica's concurrent review program includes concurrent review of inpatient hospitalizations at all facilities. Through this program, nurse case reviewers monitor appropriateness of care, the setting, and the progress of discharge plans for Medica members who are inpatients. These nurses use MCG Care Guidelines®, which are national standardized evidence-based criteria, along with individual patient circumstances and clinical information to determine appropriateness of care. MCG guidelines may be used to review medical criteria for all Medica members.

As previously published, Medica does not cover hospital-based services that do not meet medical criteria. Notification of inpatient admission is *required* but prior authorization for inpatient admission is not. Medica may review health services concurrently or retrospectively to determine if medical necessity criteria were met. In either case, after a review of inpatient services, claims may be denied as provider liability if medical criteria were not met. Upon request by Medica, facilities are required to submit inpatient clinical records within one business day. Notification of admissions and timely responses to requests for medical records help ensure a timely review and communication of determinations. More details about concurrent review are included in the " **Inpatient (Hospital) Level of Care**" utilization management (UM) policy, which can be found on medica.com. Or providers can request a printed copy of this policy by calling the Medica Provider Literature Request Line toll-free at 1-800-458-5512, option 1, then option 8, ext. 2-2355.

(Update to "Medica to expand existing concurrent review program" article in the **March 2015 edition** of *Medica Connections*.)

Medica Foundation publishes latest annual report on giving

The Medica Foundation has released its most recent annual community report detailing grant investments and featuring the outstanding work of organizations that received funding. The Foundation distributed $1.2 million to the community through nearly 90 grants, which were awarded to providers and other nonprofit organizations working to improve health. These programs:

- Supported the aging population by funding programs that help caregivers gain the skills and resources needed to help their loved ones with dementia and Alzheimer's live at home safely throughout the state of Minnesota
- Addressed the shortage of mental health support for Latino immigrants struggling with anxiety and depression by expanding Spanish language group and individual therapy in Minneapolis
- Helped low-income families in northwest Minnesota access preventive and restorative dental care which they otherwise would have foregone

As these efforts and many others illustrate, the dedicated and compassionate people behind these projects are the power behind meaningful change to improve community health. The Foundation funds community-based initiatives and programs that support community needs by improving health and removing barriers to health care services. As the charitable giving arm of Medica, the nonprofit Foundation distributes grants each year based on health-related criteria. Funding opportunities for next year will be announced in February 2019. **Learn more and see the latest annual report**.

CLINICAL NEWS

Effective December 17, 2018:

Medical policies and clinical guidelines to be updated

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective December 17, 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 December 17, 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 November 2018 for policies that will be changing effective January 21, 2019. These upcoming policy changes will be effective as of that December date unless otherwise noted.

Latest changes released for ICD diagnosis codes

(This applies to Medica leased-network providers as well as direct-contracted providers.)

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) recently released code changes for the International Classification of Diseases (ICD) for year 2019. ICD is a system of medical coding for

documenting diagnoses, diseases, signs and symptoms and social circumstances.

The 2019 ICD-10 CM codes are effective October 1, 2018, through September 30, 2019. This latest release includes 279 new codes, 51 deleted codes and 143 revised codes. There are now 71,932 active ICD-10 CM codes as of October 1.

The following ICD-10 CM chapters had the most changes effective October 1:

- Chapter 2: Neoplasms – all 45 new codes in this chapter are related to the upper/lower eyelids of the right or left eye
- Chapter 7: Diseases of the Eye and Adnexa – now specify upper or lower lids
- Chapter 11: Diseases of the Digestive System – 15 new codes, some demonstrating a breakout of generalized vs. localized peritonitis in association with acute appendicitis; plus, five deleted codes and one revised code
- Chapter 14: Diseases of the Genitourinary System – 17 new codes related to urethral strictures to further specify anatomy, underlying cause and patient gender; plus, two deleted codes and one revised code
- Chapter 15: Pregnancy, Childbirth and the Puerperium – 18 new codes covering triplets, quadruplets and other specified multiple gestations
- Chapter 16: Certain Conditions Originating in the Perinatal Period – 25 new codes dealing with newborn complications related to maternal drug use, metabolic disorders in the newborn and newborns affected by the Zika Virus; plus 5 deleted codes to be replaced with more specific new codes
- Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes – 54 new codes; plus, 3 deleted codes and 87 revised codes

Practices should review and be aware of changes that apply to them.

PHARMACY NEWS

Effective January 1, 2019:

Medica plans to update member formularies

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica is reviewing several medications and will be making changes in coverage status to drug formularies (or drug lists) effective January 1, 2019. For certain Medica members, as noted below, these changes would be effective January 1, 2019, for *new* prescriptions, but not effective until February 1, 2019, for *existing* prescriptions.

These upcoming changes may apply to one or more of the following drug formularies:

- 2018 Medica Commercial Large Group Drug List — effective 1/1 for new prescriptions, 2/1 for existing
- 2018 Medica Commercial Small Group Drug List
- 2018 Medica Preferred Drug Lists for individual and family business (IFB)
- 2018 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP) — effective 1/1 for new prescriptions, 2/1 for existing

The Medica MHCP drug list applies to the following products: Medica Choice Care℠ (for Minnesota Senior Care Plus program, or MSC+), Medica AccessAbility Solution® (for Special Needs Basic Care program, or SNBC), and Medica DUAL Solution® (for Minnesota Senior Health Options program, or MSHO), for non-Part D drugs. These changes will not apply to Medica Medicare Part D drug formularies.

Medica will post changes to its drug formularies on medica.com prior to their effective date. To see the latest Medica drug list changes as well as full drug formularies for each member type, **refer to medica.com**.

Medication request forms
A 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

submit an exception form or call CVS Caremark.

Reminder:

Infusion drug program to require lower-cost sites of service

(This applies to Medica leased-network providers as well as direct-contracted providers.)

As previously published, effective January 1, 2019, Medica commercial and individual and family business (IFB) members who receive infusion of specialty drugs on Medica's targeted drug list at a hospital outpatient center *will be required* to move to a more cost-effective site unless medical necessity criteria are met to remain in a hospital outpatient center.

Medica's "Site of Service" program, administered by Magellan Rx Management, identifies members receiving hospital-based infusion therapies from a list of drugs safe to administer at an alternate site, such as those used to treat autoimmune diseases or immunodeficiencies. The care team at Magellan Rx Management talks with members to help them better understand their disease, drug therapy, availability of different infusion sites, infusion benefits and support services. They then work with members and their providers to coordinate infusion at these more-convenient, lower-cost, alternate treatment sites.

While it may make sense for infusions take place in some members' homes, a change to a clinic setting might be better for others. Many members are not aware that in-home infusion might be appropriate and available to them, eliminating the need to travel and take off from work. Home infusion appeals especially to members who live in rural areas. Additionally, infusion at home or in a provider office reduces potential exposure to hospital-based pathogens.

The infusion drugs included in the program require prior authorization through Magellan Rx. If affected members have an existing prior authorization beyond January 1, they will be able to continue their current course of treatment through the end of the existing authorization timeline. Providers who do not make a recommended adjustment for eligible Medica members *may see an impact to related claims*, including denial. **See the new Site of Service drug-infusion policy** .

Providers who have questions about this program or would like to begin transitioning members to a preferred site can call Magellan Rx at 1-800-424-1845.

Effective November 5, 2018:

Medica adds new UM policies for 4 medical pharmacy drugs

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the following new medical pharmacy drug utilization management (UM) policies. These changes will be effective with November 5, 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
A9699, J3450	Azedra	iobenguane I 131
J3590	Nivestym	filgrastim-aafi
J3490	Onpattro	patisiran

J9999	Poteligeo	mogamulizumab-kpkc

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 November 5; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective January 1, 2019:

Medica to add new UM policies for 2 medical pharmacy drugs

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the following new medical pharmacy drug utilization management (UM) policies. These changes will be effective with January 1, 2019, 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
J9301	Gazyva	obinutuzuma
J2507	Krystexxa	pegloticase

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 January 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective January 1, 2019:

Medica to make annual update to Part D drug formularies

(This applies to Medica direct-contracted providers only.)

Medica has made annual decisions on drugs that will either be removed from the Medica Medicare Part D drug formularies or be subject to a change in preferred or tiered cost-sharing status effective January 1, 2019. The 2019 Part D formularies for Medica Prime Solution® members and Medica DUAL Solution® members are posted on medica.com. Members are encouraged to review their formulary to see if any of their medications are changing.

Providers can also refer to a comprehensive list of all previous Medica Medicare Part D drug formulary changes. **View Medicare Part D drug formulary changes on medica.com**.

The Medica Medicare Part D drug formularies are available online or on paper:

- **View the Medica Part D formularies at medica.com**.
- **Download the Part D formularies for free at epocrates.com**.
- Call the Medica Provider Literature Request Line to request a printed copy.

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.

NETWORK NEWS

Effective January 1, 2019:

Medica to update Medicare fee schedules

(This applies to Medica direct-contracted providers only.)

Beginning with January 1, 2019, dates of service, Medica will implement the quarterly update to its Medicare fee schedules for applicable Medica products. This fee schedule change will implement updates from the Centers for Medicare and Medicaid Services (CMS) and have an impact on the following provider types: home infusion therapy, home health care and public health agency providers, as well as physicians.

This fee schedule change incorporates CMS relative value units (RVUs) and conversion factor as well as various Medicare non-RVU fee maximums (such as labs, injections, immunizations, etc.). In addition, Medica will update its Medicare fee schedules with rates for codes without a fee maximum established. Overall reimbursement for providers will depend on specialty and mix of services provided.

Details on Medicare changes to drug fees **are available online from CMS**. Providers who have further questions may contact their Medica contract manager.

Effective January 1, 2019:

Medica to update IFB state-based physician fee schedules

(This applies to Medica direct-contracted providers only.)

Beginning with January 1, 2019, dates of service, Medica will implement the annual update to its Individual and Family Plan (IFB) state-based physician fee schedules for applicable Medica products. This fee schedule change will implement updates from the Centers for Medicare and Medicaid Services (CMS), incorporating CMS relative value units (RVUs) and conversion factor, as well as various CMS non-RVU fee maximums (such as labs, injections, immunizations, etc.). In addition, Medica will update its IFB state-based physician fee schedules with rates for codes without a CMS fee maximum established. Overall reimbursement for providers will depend on specialty and mix of services provided.

For a list of Medica's IFB products, **see medica.com**, under "Individual and Family Products." Providers who have further questions may contact their Medica contract manager.

Effective January 1, 2019:

Medica to make quarterly update to reference lab fee schedule

(This applies to Medica direct-contracted providers only.)

Effective with January 1, 2019, dates of service, or as soon thereafter as the CMS quarterly reference lab fee schedule updates are publicly available, Medica will implement the next quarterly update to its standard reference lab fee schedule, for all Medica products. This quarterly update will reflect any applicable Centers for Medicare and Medicaid Services (CMS) reference lab code or fee schedule updates that are effective January 1, 2019. The reimbursement impact of this CMS quarterly update will vary based on mix of services provided.

Details on Medicare changes to lab fees **are available online from CMS**. Providers who have further questions may contact their Medica contract manager.

Second-quarter PCR checks to be mailed in October 2018

(This applies to Medica direct-contracted providers only.)

By the end of October 2018, Medica plans to mail to eligible providers the physician contingency reserve (PCR) payment for the second quarter of 2018. This represents a 100-percent return of the second-quarter 2018 PCR withhold, plus interest, for the Medica Prime Solution® Medicare product. Checks will cover PCR withheld for claims with dates of service of April 1, 2018, through June 30, 2018, and dates paid of April 1, 2018, through September 30, 2018.

ADMINISTRATIVE NEWS

Provider College administrative training topics for November

(This applies to Medica leased-network providers as well as direct-contracted providers.)

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

"Claim Appeals, Adjustments and Record Submission"

Claim appeals and adjustments are important options to ensure proper claims payment. This webinar will review the process for submitting appeals, adjustments and supporting documentation to Medica. It will focus on the different avenues for submission, and when each is appropriate; when appeals and adjustment requests are appropriate; where to find the necessary forms on Medica's website; tips for making sure that an appeal or adjustment request contains the information that supports the desired outcome in an accessible format; and the options available if providers disagree with a decision on an appeal or adjustment request.

"Medica's Medicare Products"

Medica offers different Medicare plans to fit member needs. This course will review information to assist providers in better understanding the different Medicare plans Medica has available. It will focus on the differences between Medicare Advantage and Cost plans; plan changes for 2019; when Medica follows Centers for Medicare and Medicaid Services (CMS) guidelines; when to bill Medica vs. Medicare as the primary payer; upgraded services offered by plans; and billing requirements and reimbursement.

"Life of a Claim"

Understanding all three components of a clean claim—submission, process and output—is important to ensure proper payment.

This webinar will review all three in order to help providers understand how they work together to facilitate the proper processing of claims. It will focus on claim submission policies and requirements; 837P and 837I electronic transactions; provider remittance advices (PRAs); common denial reasons; and how to request claim adjustments and appeals.

"Resources for Providers"
Having quick and easy resources available is a great way to save time. Medica routinely updates resources available to providers. This webinar will walk providers through Medica's self-service options, including resources on medica.com. It will focus on determining member eligibility; verifying if utilization management and reimbursement policies apply to services being billed; verifying how a claim processed; and next steps for claims (e.g., appeals or adjustments).

Class schedule

Topic	Date	Time
Claim Appeals, Adjustments and Record Submission	Nov. 6	10-11:30 a.m.
Medica's Medicare Products	Nov. 7	10-11:30 a.m.
Life of a Claim	Nov. 13	10-11:30 a.m.
Resources for Providers	Nov. 27	10-11:30 a.m.

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 February 1, 2019:
Medica to implement new reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the new reimbursement policy indicated below, effective on or after February 1, 2019, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

MPPR for diagnostic cardiovascular and ophthalmology procedures
Medica will align with the Centers for Medicare and Medicaid Services (CMS) and implement a new policy, "Multiple Procedure Payment Reduction (MPPR) for Diagnostic Cardiovascular and Ophthalmology Procedures," effective with February 1, 2019, dates of service.

The MPPRs on diagnostic cardiovascular and ophthalmology procedures apply:

- Independently to cardiovascular and ophthalmology services
- To the technical component (TC) *only* and to the TC of global services
- When multiple services are furnished to the *same* patient by the *same* physician or another physician from the *same* group (so, same federal tax identification number, or TIN) on the *same* day

The MPPRs on diagnostic cardiovascular and ophthalmology procedures do *not* apply to professional component (PC) services.

The CMS Non-Facility Relative Value Unit (RVU) will rank services. Services with the highest RVU will be considered primary and services with the lower RVU will be considered secondary and subsequent.

The policy applies to *diagnostic cardiovascular* procedural codes identified in the CMS National Physician Fee Schedule with a multiple procedure indicator of 6, meaning subject to a 25 percent reduction of the second highest and subsequent procedures to the technical component of diagnostic cardiovascular services. This policy applies to *diagnostic ophthalmology* procedural codes identified in the CMS National Physician Fee Schedule with a multiple procedure indicator of 7, meaning subject to a 20 percent reduction of the second highest and subsequent procedures to the technical component of diagnostic ophthalmology services.

This policy will apply to claims for Medica's commercial, Medicare, Minnesota Health Care Programs (MHCP) and individual and family business (IFB) members. It will *not* apply to claims for Medica Health Plan Solutions members.

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

- **View Medica's reimbursement policies** as of February 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective January 1, 2019:

Medica to revise reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon update the reimbursement policy indicated below, effective on or after January 1, 2019, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Laboratory services
Beginning January 1, 2019, only reference laboratories reporting laboratory services appended with a modifier 90 will be eligible for reimbursement. Non-reference laboratory physicians or other health care professionals that report laboratory services with modifier 90 *will no longer be reimbursed* for these services.

This enhancement to the Laboratory Services reimbursement policy aligns with the Centers for Medicare and Medicaid Services (CMS) guidelines that only allow reimbursement of laboratory services to the reference laboratory for the referred laboratory services. Physicians or other health care professionals who own lab equipment and perform laboratory testing will continue to be eligible for reimbursement, as modifier 90 would not be appended to the procedure code for the clinic laboratory service. Reference laboratories may refer to another laboratory and will continue to be reimbursed when the reported laboratory services are appended with modifier 90.

This policy will *not* affect provider reimbursement related to claims for Medica Health Plan Solutions members in all service areas or claims for Medica commercial and individual and family business (IFB) members seeing providers in Minnesota, North Dakota, South Dakota and Wisconsin.

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

- **View Medica's reimbursement policies** as of January 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Updates to Medica Provider Administrative Manual

(This applies to Medica leased-network providers as well as direct-contracted providers.)

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
Consolidating demographic and credentialing pages, adding functionality for new states	"Network Operation and Support Services" section, in new "Credentialing/ Demographics" subsection	November 2018

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

Do you receive *Connections*?
Sign up for regular updates, if you haven't already.

Subscribe

Looking for past issues?
You can access the archive on our website.

View archive

Health Services and Provider Network Leadership

Lori Nelson, *Senior Vice President of Provider Strategy and Network Management*
John Mach, MD, *Chief Medical Officer and Senior Vice President*
Nichole White, RPh, MBA, *Vice President of Health Services*
Stacy Ballard, MD, *Senior Medical Director*
John Piatkowski, MD, MBA, *Senior Medical Director*

Medica Connections editor

Hugh Curtler III, *Medica, Marketing and Communications*
Phone: (952) 992-3354
Fax: (952) 992-3377
Email: **hugh.curtler@medica.com**

See Medica points of contact for providers >

Distributed: 10/24/18