MEDICA

January 2019

MEDICA CONNECTIONS®

For Medica network providers

GENERAL NEWS

Effective January 1, 2019:

Medica launches new IFB 'Quest' product in Oklahoma

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

In addition to three new products for individual and family plan (IFB) members in four states mentioned last month, Medica has introduced "Medica Quest℠" in Oklahoma. As with the other new IFB products, Quest will be effective for coverage beginning January 1, 2019.

'Medica Quest' - Oklahoma
Medica Quest is a new health plan option in Oklahoma for 2019, along with the narrow-network Harmony by Medica℠ product. Offered in Oklahoma counties where Harmony is not available, Quest is a broad open-access product, relying on a leased network of providers through First Health. The plan provides access to most doctors and hospitals throughout Oklahoma as well as parts of bordering states. The Quest network includes more than 11,000 primary and specialty care doctors, more than 130 hospitals, and over 40 online and specialty care doctors. Enrollment in the Quest plan is available both on- and off-exchange in Oklahoma.

Network providers for each IFB product can be found at **medica.com/IndividualPlans**. Fact sheets for all of the new 2019 IFB products are available **at medica.com** (under Individual and Family Products).

(Update to "Medica launches 3 new IFB products in 4 states" article in the **December 2018 edition** of *Medica Connections*.)

MHPS claims, demographics, credentialing: set-up for new providers

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

As a reminder, Medica Health Plan Solutions (MHPS), a division of Medica, will begin administering the provider networks and benefits previously administered by Mayo Clinic Health Solutions (also known as MMSI, Inc.) beginning with January 1, 2019, dates of service. This will include Mayo Medical Plan for Mayo Clinic employees and families. MHPS members will have group numbers beginning with "A" on their member ID cards. To find out more, **see the MHPS product fact sheets**.

Note: MHPS providers need to check member ID cards at time of registration to ensure appropriate routing of claims.

Claim submission
Providers can send MHPS claims electronically via their clearinghouse and can work with their clearinghouse to receive electronic payment. MHPS providers need to register MHPS 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.

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

Administrative activities
MHPS network providers will need to follow Medica's administrative requirements, such as coverage policies and utilization management (UM) policies. **See more on UM, including Medica's Prior Authorization List**.

MHPS providers should have received mailings about preparing to work with Medica, such as registering to use secure electronic transactions like patient eligibility and claim status. **Providers new to Medica can learn about this and more**.

New providers should also be sure to keep their demographic data up-to-date with Medica, and maintain current credentialing as well. Credentialing with Medica will be important when MMSI credentialing expires, for example. Taking such actions by year-end 2018 will help Medica pay MHPS providers properly and promptly beginning January 1. **Learn more**.

(Update to "Electronic claim submission, payment for new MHPS membership" article in the **November 2018 edition** of *Medica Connections*.)

Effective January 1, 2019:

Provider call center phone-menu options to change

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

On January 1, 2019, the phone menu for Medica's Provider Service Center will be changing. The main number, 1-800-458-5512, stays the same, but there will be new options that will route callers based on a member's group or policy number. The member's group or policy number will be categorized into one of the following for options: all alphabetic, all numeric, or alpha-numeric. It is important to listen carefully to the prompts in order to be directed to the appropriate specialist.

CLINICAL NEWS

Effective February 18, 2019:

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 February 18, 2019, unless otherwise noted.

These policies apply to all Medica products including commercial, government, and individual and family plan (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 February 18, 2019, 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 January 2019 for policies that will be changing effective March 21, 2019. These upcoming policy changes will be effective as of that January date unless otherwise noted.

Outreach in December:

Annual ACA chart review for coding integrity underway

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

Each year, Medica undertakes medical record reviews for various types of members, and in December 2018 began reaching out to provider offices regarding Affordable Care Act (ACA) 2018 dates of service for office visits and hospital admissions by Medica commercial members. Medica is committed to improving the quality of care provided to our members and is required by the U.S. Department of Health and Human Services (HHS) to submit complete diagnostic data regarding members enrolled in certain ACA-covered health plans.

On Medica's behalf, Optum and CiOX Health are conducting the medical record reviews, coordinating record retrieval and reviewing clinical coding. CiOX representatives will contact providers directly to provide retrieval options and a list of the requested member records for services they received in calendar year 2018. Patient records being requested include medical records, notes and reports. Chart collection *must be completed by March 15, 2019*.

This industry-standard commercial chart retrieval request is intended to identify any gaps in coding that are supported in the documentation. Reviewing medical chart documentation will enable Medica to identify conditions that may exist for plan members, but may not have been coded or previously captured. This enables the health plan to assess the health conditions of their members for effective care interventions and to improve health outcomes.

Providers who have questions may contact CiOX at 1-877-445-9293 or at **chartreview@cioxhealth.com**. Or call Medica's Provider Service Center toll-free at 1-800-458-5512.

Survey responses requested by December 31:

Provider offices encouraged to give input on Medica's UM services

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

Medica recently sent providers a survey about utilization management (UM) services, including prior authorization requests and clinical appeals. There's still time to respond. This survey is intended specifically for physicians and office managers who have had experience with Medica's UM program in 2018. Survey responses will be confidential and grouped with other results. **Eligible provider contacts who haven't yet responded can take the survey** up until the end of December.

Provider surveys like this allow Medica to improve services to providers and members. Medica would like to thank physicians and office managers for giving their valuable feedback.

Due by January 15, 2019:

Quality complaint reports required by State of Minnesota

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

Medica requires its Minnesota-based network providers to submit fourth-quarter 2018 quality-of-care complaint reports to Medica by January 15, 2019. *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 can send reports by e-mail to **QualityComplaints@medica.com**, 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.

PHARMACY NEWS

Reminder:

Infusion drug program focuses on cost-effective sites of service

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

As a reminder, Medica commercial and individual and family plan (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. This change will be effective January 1, 2019.

This "Site of Service" program, administered by Magellan Rx, identifies eligible Medica members receiving hospital-based infusion therapies from a list of drugs safe to administer at an alternate site. The care team at Magellan Rx Management works with patients to help them better understand their drug therapy, availability of different infusion sites, infusion benefits and support services. They then work with members as well as their providers to coordinate infusion at more-convenient, lower-cost, alternate treatment sites.

The infusion drugs included in the program require prior authorization through Magellan Rx. If affected members have an existing prior authorization beyond January 1, 2019, 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, beginning January 1. **See the Site of Service policy**.

Providers who have questions about this program can call Magellan Rx at 1-800-424-1845.

Mailing soon:

Opioid outreach for MHCP encourages naloxone prescriptions

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

In addition to responsible prescribing of opioids, it's important to prepare for a potential overdose. Naloxone can quickly reverse the effects of an opioid overdose, and it can be administered by a community member via an intranasal spray or an intramuscular injection using either a prefilled auto injector or a syringe and needle. In 2016, Minnesota passed a law with one of the goals being to increase the availability of naloxone through pharmacies across Minnesota. The law protects prescribers from liability issues related to naloxone prescribing.

Since not every pharmacy is set up to dispense naloxone to whomever requests it, the best way to ensure that a patient has this

drug available is for prescribers to write a prescription for it at the same time as writing one for an opioid. To encourage this proactive approach, Medica will soon reach out to prescribers with Minnesota Health Care Programs (MHCP) patients enrolled with Medica who have at least one opioid prescription. Medica covers both the generic naloxone injection and the Narcan® nasal spray on its MHCP formulary. As covered drugs, they are available to MHCP members for their standard copay, usually $1 to $3.

As required by the Centers for Medicare and Medicaid Services (CMS), Medica manages quality assurance and educational programs designed to provide prescribers with tools and information to help care for patients. Providers are a key to the goal of zero opioid-overdose-related deaths in Minnesota.

Here are some resources to assist prescribers in managing patient opioid use:

- **U.S. Surgeon General statement on naloxone availability and opioid overdose**
- **Minnesota community initiative on expanding naloxone access**

(Update to "Medica conducts outreach to improve opioid prescribing" article in the **September 2018 edition** of *Medica Connections*.)

Effective January 18, 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 18, 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
J9999	Libtayo	cemiplimab-rwlc
J9999	Lumoxiti	moxetumomab pasudotox-tdfk

These policies will apply to Medica commercial, individual and family plan (IFB), Minnesota Health Care Programs (MHCP) and Medica Health Plan Solutions members and to Medica Medicare members in Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO) and Medica Advantage Solution® (both HMO-POS and PPO plans). They will *not* apply to Medica Prime Solution®(Medicare Cost) or Mayo Medical Plan 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 18; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

ADMINISTRATIVE NEWS

Provider College administrative training topics for January

(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.

"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	Jan. 8	10-11:30 a.m.
Life of a Claim	Jan. 15	10-11:30 a.m.
Resources for Providers	Jan. 22	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 January 1, 2019:

Annual updates scheduled for reimbursement policy code lists

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

Medica will soon update the reimbursement policies indicated below, effective with January 1, 2019, dates of service. Such policies define when specific services are reimbursable based on the reported codes. These changes will apply to all Medica commercial, Medicare, individual and family plan (IFB), Medica Health Plan Solutions and Minnesota Health Care Programs (MHCP) products.

Reimbursement policies — Revised
These versions will replace all previous versions.

Name
Add-On Code (updated code list)
Assistant Surgeon (updated code list)
Ambulance (updated code list)
Bilateral Procedures (updated code list)
Bundled Services (updated code list)
Care Plan (updated code list)
Contrast and Radiopharmaceutical (updated code list)
Co-Surgeon/Team Surgeon (updated code list)
From-To Date (updated code list)
Global Days (updated code lists)
Injection and Infusion Services (updated code lists)
Laboratory Services (updated code list)
Multiple Procedure Reduction (updated code lists)
Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging (updated code list)
Physical Medicine & Rehabilitation: Multiple Therapy Procedure Reduction (updated code list)
Professional and Technical Components (updated code lists)
Prolonged Services (updated code lists)
Same Day Same Service (updated code list)
Supply (updated code list)

Services and Modifiers Not Reimbursable to Health Care Professionals (updated code list)
Telemedicine (updated code list)
Telephone Services (updated code list)
Time Span Codes (updated code list)

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

- **View Medica's reimbursement policies** as of January 1, 2019; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

At the same time, Medica will update related code lists in two reference guides:

- Place of Service (POS) Code Reference Guide
- Reimbursement Policy Modifier Reference Guide

Reminder:

Up-to-date provider directories help members find providers

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

It is important that patients and members have access to accurate, up-to-date information when seeking care in their provider network. Providers need to regularly update their demographic data based on Centers for Medicare and Medicaid Services (CMS) rules. To ensure that members have the best experience possible when looking for care, health plans need providers' help to ensure provider details and clinic locations are up-to-date. Providers should update their practitioner and site-level information regularly or *as soon as they know of a change to that data*. Information in Medica's provider directories can be reviewed and edited through Medica's secure **provider demographic-update online tool (PDOT)**.

Key elements for accuracy in provider directories are for providers to *indicate exactly where* their practitioners see patients, and *their direct phone number* for scheduling appointments. Site-specific practitioner information needs to be accurate so when members call a site and ask for a doctor, they don't find out the doctor doesn't provide services there, or find they cannot get through at all.

Note: Providers who are part of a *leased* network that contracts with Medica, such as a preferred provider organization (PPO), should work with their network's administrative office to update demographics with Medica, rather than make updates individually using Medica's PDOT tool. Doing so could override corrected data.

Learn more about making demographic updates.

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

Separating provider contact information specific to Medica's individual and family plan (IFB) and Medica Health Plan Solutions (MHPS) membership	"Medica Points of Contact" section, under "Other Points of Contact"	December 2018

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

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See Medica points of contact for providers >

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