MEDICA

June 2019

MEDICA CONNECTIONS®

For Medica network providers

General | Clinical | Pharmacy | Administrative

GENERAL NEWS

Annual notice:

Provider appeals on behalf of Medica members

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

Medica members have the right to appoint representatives, such as their providers, to initiate member appeals. When an adverse medical necessity determination results in 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 Care in the Provider Administrative Manual**.

Annual notice:

Member rights and responsibilities, for providers to know

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

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

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

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**.

Ongoing focus on opioids:

More tips for improving opioid prescribing practices

Prescribers are key to reducing opioid dependence, addiction and overdose. In hopes of improving opioid prescribing practices, Medica wishes to work with the provider community to address the opioid crisis and substance use disorders. One way to help is by promoting clinical resources for practitioners who prescribe pain medication. To this end, this newsletter will periodically feature educational tools and tips.

This month's featured resources:

- An "**Opioid Prescribing Improvement Program**" from the State of Minnesota. It offers continuing education credits.
- An Institute for Clinical Systems Improvement **(ICSI) guideline to assess and treat pain**.

The U.S. Centers for Disease Control and Prevention (CDC) estimates that the total economic burden of prescription opioid misuse in the United States is $78.5 billion a year. This includes the costs of health care, lost productivity, addiction treatment and criminal justice involvement.

CLINICAL NEWS

Effective July 15, 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 July 15, 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 July 15, 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 June 2019 for policies that will be changing effective August 19, 2019. These upcoming policy changes will be effective as of that August date unless otherwise noted.

Coding reminder:

Proper coding for documentation related to hypertension

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

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 involvement, 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 (ESRD)
- I12.9 Hypertensive CKD with stage 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 ESRD
- I13.2 Hypertensive heart and CKD *with* heart failure and with stage 5 CKD or ESRD

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, 2019:

Medica outlines upcoming changes to drug lists

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

As noted last month, Medica will be making changes in coverage status to member drug formularies (drug lists) effective July 1, 2019. For certain Medica members, as noted below, these changes would be effective July 1, 2019, for *new* prescriptions, but not effective until August 1, 2019, for *existing* prescriptions. The changes to these formularies are now posted online.

- **See changes** to the Medica Commercial Large Group and NE Farm Bureau Drug List — effective 7/1 for new prescriptions, 8/1 for existing prescriptions.
- **See changes** to the Medica Commercial Small Group Drug List.
- **See changes** to the Medica Individual and Family Plan Drug Lists.
- **See changes** to the Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP).

As a reminder, several sections of the Medica MHCP drug list will be changing to align with the Minnesota Department of Human Services (DHS) drug list, also beginning July 1, 2019. **See more on this change**.

Effective August 1, 2019:

Upcoming changes to Medica Part D drug formularies

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

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, 2019. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of June 1, 2019, **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 Combined List of Covered Drugs for Medicare and Minnesota Health Care Programs. 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 topic for June

(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 class is available by webinar for all Medica network providers, at no charge.

Training class topics
"Medica's Medicare and Medicaid Products"
Medica offers different Medicare and Medicaid plans (in the state of Minnesota) to fit member needs. This course will review information to assist providers in better understanding the Medicare and Minnesota Health Care Programs (MHCP) plans Medica has available. This will include: differences between Medicare Advantage and Cost plans; features of Medica's MHCP plans for Special Needs, MSHO and Senior Care Plus members; product changes for 2019; when Medica follows Centers for Medicare and Medicaid Services (CMS) guidelines; when to bill Medica vs. Medicare as primary payer; upgraded services offered by plans; and billing requirements and reimbursement.

Class schedule

Topic	Date	Time
Medica's Medicare and Medicaid Products	June 11	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 time reflected above allows 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 the session above**.

Effective August 1, 2019:
Medica to revise reimbursement policies

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

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

Professional and technical components
Beginning August 1, 2019, Medica will align with the Centers for Medicare and Medicaid Services (CMS) and remove newborn hearing from the Professional and Technical Components reimbursement policy. Removing Current Procedural Terminology (CPT®) hearing screening code 92586 ("Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system, limited") will eliminate any duplicative reimbursement to both facility and physician.

Laboratory services
Beginning August 1, 2019, the exclusion of codes 82947 and 82948 from the duplicate laboratory logic will be rescinded. Providers can append the 91 modifier for services that are repeated and be reimbursed. *Only one provider* will be reimbursed when multiple providers bill identical services — Medica will reimburse the provider or entity that actually performed the test. (Duplicate laboratory services are defined as identical or equivalent bundled laboratory codes.) This enhancement to the Laboratory Services reimbursement policy aligns with CMS guidelines indicating that only one laboratory service is reimbursable when duplicate laboratory services are submitted from the same group physician or other qualified health care professional.

These policies apply to claims for all Medica members. Both of these revised policies will be available online or on hard copy:

- **View reimbursement policies at medica.com** as of August 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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