General Information

CaringBridge, Medica team up to promote healthy connections

Connecting family and friends when health matters most'

Medica recently announced a partnership with CaringBridge, a nonprofit organization with a free website that allows patients experiencing a significant health challenge to connect with family and friends, with the goal of making each health journey easier.

The CaringBridge website offers a personal and private space for patients (often those who are hospitalized or undergoing long-term health issues) to communicate and show support, saving time and emotional energy when health matters most. CaringBridge includes a journal to post health news and a guestbook for family and friends to leave messages of support.
In a survey of CaringBridge users, 91 percent of patients agreed that using CaringBridge helped make their health journey easier. In addition, 88 percent of patients felt that CaringBridge had a positive impact on their healing process.

CaringBridge can be an important tool for patients and families to reduce isolation and stress in a difficult time, giving them a much-needed outlet for sharing their feelings and receiving support. Rather than individually contacting each member of their support system, a CaringBridge site allows patients and their caregivers to update everyone concerned with just one journal entry. With the help of CaringBridge, patients are able to expand their support network. "On the first day I created my CaringBridge website, I received 120 hits," said a woman with leukemia in remission. "I never could have communicated with 120 people in one day without this website."

CaringBridge is a resource to recommend to anyone facing a significant health challenge. As part of the Medica Health and Wellness Coaching Program, Medica health coaches have been trained on using the CaringBridge tool and have already started referring members to it with a positive response. Patients who are Medica members can learn more at CaringBridge.org/Medica.

Effective March 1, 2011:

**New Allina Care System created for MSHO members**

As of March 1, 2011, Medica will add a new care system for its Minnesota Senior Health Options (MSHO) members—i.e., as part of the Medica DUAL Solution® product. The Allina Care System will include all Allina, Aspen and Quello clinics.

This change occurs as a result of the relationship between Allina-affiliated clinics and the Evercare Care System that terminated at the end of 2010. Current Evercare Care System members with an Allina primary care provider have been notified about this change, giving them a choice to either move with their primary care provider or stay with the Evercare Care System and choose a new primary care provider.

The Allina Care System is already set up on an interim basis to provide care for affected MSHO members from January 1 to March 1, 2011. Approximately 1,300 Allina members with Evercare are in the process of moving to member group number 07850 as a placeholder, and once the Allina Care System is fully set up, members will be moved to the Allina Care System and assigned a new Allina-specific member ID number if they choose to move along with their primary care provider.

**Note:** Given this transition period in first quarter 2011, provider offices are strongly encouraged to verify member eligibility prior to rendering healthcare services, especially for those patients affiliated with the Evercare Care System and with an Allina clinic as their primary care provider. To ensure accurate and prompt claims processing during this transition, it is important to submit claims using the correct member ID number for these patients for their particular dates of service (i.e., using an
Evercare Care System member ID number vs. an Allina Care System member ID number, depending on their status).

Medica, Evercare and Allina have been working together to assist Medica members with this transition.

Clinical Information

Effective April 1, 2011:

**Medica makes new benefit determinations**

The following benefit determinations will be effective beginning with April 1, 2011, 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.

**Anti-infliximab antibody level testing to monitor infliximab treatment**

Anti-infliximab antibody level testing to monitor infliximab treatment is considered investigative and therefore will not be covered.

Infliximab (Remicade) is a genetically engineered antibody that has been approved by the U.S. Food and Drug Administration (FDA) for a number of auto-immune diseases, including rheumatoid arthritis and Crohns disease. During long-term use, some patients develop anti-infliximab antibodies that neutralize the anti-inflammatory action of infliximab. This response may diminish the potential long-term efficacy of infliximab or may cause infusion reactions in patients. Blood tests to monitor levels of infliximab and anti-infliximab antibodies have been proposed as mechanisms to determine risk for infusion reactions or increased hypersensitivity to infliximab.

**CGH microarray for neurodevelopmental chromosomal imbalances**

Comparative genomic hybridization (CGH) microarray for neurodevelopmental chromosomal imbalances is considered investigative and therefore will not be covered.

Comparative genomic hybridization (CGH) microarray analysis is a laboratory test performed to detect unbalanced variations, such as microdeletions and/or duplications, in a person's genes. The test can be performed on blood, body fluid, or tissue specimens. CGH microarray analysis has been proposed as:

- Targeted array evaluation for:
  - Chromosomal imbalances in patients suspected of having a genetic syndrome (e.g., congenital anomaly, dysmorphic features, developmental delay, intellectual disability)
  - Chromosomal imbalances in miscarried fetuses and stillbirths
  - Prenatal diagnostic evaluation
- Whole-genome prenatal diagnostic evaluation.

**Serological markers for diagnosis and management of IBD or IBS**

Serological markers for diagnosis and management of inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) remain investigative and therefore will not be covered.

Medica has determined that its coverage policy "Serological Markers for Diagnosis and Management of Inflammatory Bowel Disease (IBD) or Irritable Bowel Syndrome (IBS)—formerly "Serological Testing for Diagnosis and Management of Inflammatory Bowel Disease (pANCA/ASCA)"—will incorporate serological marker testing for both IBD and IBS. Therefore, the number of serological markers considered was expanded beyond pANCA/ASCA to include escherichia coli antibodies (anti-OmpC), pseudomonas fluorescens (Anti-12), and clostridium species antibodies (anti-CBir1). These markers are purported to assist in diagnosis or management of IBD and IBS.

As of April 1, 2011, the complete text of the Medica policies that apply to the above determinations will be available online or on hard copy:

- See coverage policies at medica.com.
- Call the Medica Provider Literature Request Line for printed copies of documents: 952-992-
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 April 1, 2011, unless otherwise noted.

As of April 1, 2011, these documents will be available online or on hard copy:

- View medical policies and clinical guidelines at medica.com;
- Call the Medica Provider Literature Request Line for printed copies of documents.

**Coverage Policies — New**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Anti-Infliximab Antibody Level Testing to Monitor Infliximab Treatment</td>
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<tr>
<td>Comparative Genomic Hybridization (CGH) Microarray Testing for Neurodevelopmental Chromosomal Imbalances</td>
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**Coverage Policies — Revised**

These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Artificial Intervertebral Disc Replacement</td>
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<tr>
<td>Dynamic Stabilization Devices for Chronic Back Pain</td>
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<tr>
<td>Electrothermal Therapy for Treatment of Joint Instability or Laxity of Ligaments</td>
</tr>
<tr>
<td>Serological Markers for Diagnosis and Management of Inflammatory Bowel Disease (IBD) or Irritable Bowel Syndrome (IBS) (formerly Serological Testing for Diagnosis and Management of Inflammatory Bowel Disease [pANCA/ASCA])</td>
</tr>
<tr>
<td>Testing for Neutralizing Antibodies to Interferon beta in the Management of Multiple Sclerosis (formerly Neutralizing Antibody Tests in the Management of Multiple Sclerosis)</td>
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<tr>
<td>Uvulopalatoplasty (UP2, UPP) and Laser-Assisted Uvulopalatoplasty (LAUP or LAUPP) for Sleep-Related Breathing Disorders</td>
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**ICSI Guidelines — Inactivated**

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<tr>
<td>Diagnosis and Treatment of Otitis Media in Children (inactivated February 2011)</td>
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**Note:** Medica will delay the implementation of utilization management (UM) policy III-SUR.26, "Varicose Vein and Venous Insufficiency Treatments: Surgical Procedures (Ligation/ Stripping, Stab Phlebectomy), Endovenous Radiofrequency Ablation, Endovenous Laser Ablation." It was previously published that this policy update would go into effect on February 1, 2011. Existing UM policy "Endovenous Radiofrequency or Laser Ablation for Varicose Veins and Chronic Venous Insufficiency" will continue to be in effect until this update is made.

**Pharmacy Information**

**Effective April 1, 2011:**

**Medica to require prior authorization for 7 more injectables**

Medica will soon expand its list of injectable drugs typically administered in provider offices or outpatient facilities and covered under a member’s medical benefit. Effective April 1, 2011, there will be seven additional drugs added to the list of drugs covered under the medical benefit (vs. the pharmacy benefit) that will require a prior authorization from Medica:

- Actemra
As of October 1, 2010, Medica began requiring prior authorization from providers for 15 such drugs. The prior authorization change above will apply to commercial and Minnesota Health Care Programs (MHCP) members. This change will not have an impact on Medicare members.

**Note:** After April 1, depending on a member's benefits, claims related to the affected medications above may be denied as member liability if the medications are being used for non-covered indications.

Providers will need to request prior authorization before initiating treatment with any of these medications. This requirement also applies to members currently receiving treatment with one of these products as well as to members seeking to initiate therapy. This change will ensure appropriate medication and will allow providers and patients to better understand the extent of Medica coverage for these expensive drugs prior to claims submission.

As of April 1, new or updated drug management policies outlining the above changes will be available online or on hard copy:

- View Drug Management Policies
- Call the Medica Provider Literature Request Line for printed copies of documents.

In the future, Medica will continue to notify providers through *Medica Connections* about additional injectable drugs that require prior authorization.

**Drug prior authorizations are specific to drugs, not classes**

For each new course of treatment involving a new medication, providers need to request prior authorization if the new medication requires it. Prior authorizations are specific to the medication, not to the drug's therapeutic class.

As an example, effective October 1, 2010, prescriptions for immune globulin (intravenous and subcutaneous) began requiring prior authorization. Medica has become aware that some providers desire to switch members with currently approved prior authorizations for Vivaglobin (drug code J1562) to Hizentra (drug code J1559). Although the medication switch is within the same therapeutic class for immune globulin, a new prior authorization approval would be required for coverage of Hizentra.

As a reminder, depending on a member's benefits, claims related to medications that require prior authorization may be denied as member liability if the medications are being used for non-covered indications.

**Network Information**

**Effective April 1, 2011:**

**Medica to update Medicare physician fee schedule**

Beginning with April 1, 2011, dates of service, Medica will implement the quarterly update to its Medicare physician fee schedule for applicable Medica products. This fee schedule change will reflect the April 2011 Centers for Medicare and Medicaid Services (CMS) update applicable to reimbursement for injectable drugs, immunizations, durable medical equipment (DME), and orthotics and prosthetics (O&P). The reimbursement impact of this quarterly update will vary based on specialty.
and mix of services provided.

Details on Medicare changes to drug, DME and O&P fees are available online from CMS.

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

Provider College administrative trainings for March

The Medica Provider College offers educational sessions on various administrative topics throughout the Medica service area. The following class is available by webinar for all Medica network providers.

Training class topics
"Resources for Helping Yourself" (class code: RH-W)
Medica is continually updating services and resources available to network providers. This webinar will walk through self-service options available to providers, including resources on medica.com and the automated phone system. These services and resources should assist providers in running their offices more efficiently.

Class schedule

<table>
<thead>
<tr>
<th>Class Code</th>
<th>Topic</th>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH-WM</td>
<td>Resources for Helping Yourself</td>
<td>Mar. 16</td>
<td>10-11 am</td>
<td>Class code with &quot;WM&quot; means offered via webinar in March</td>
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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.

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 for all classes is one week prior to the class date. To register for the sessions listed, providers may do either of the following:

- Fill out the Provider College registration form (available online at medica.com under "Events and Training"). Fax the completed form to Medica at 952-992-3270.
- Send an e-mail with the same details as listed on the registration form to providercollege@medica.com.

Reminder:

Notifying Medica about terminating care for Medica members

Sometimes a provider-patient relationship is no longer effective if, for example, patients don't pay their copayments, have outstanding bills, exhibit uncooperative or abusive behavior toward the staff, or frequently miss appointments. As a result of this, providers may wish to terminate health services for such patients. To do so for a Medica member, providers need to notify Medica of this intention so that Medica can verify that attempts were made to resolve any problems and then can assist the member in finding another provider, as needed.

Before a provider can refuse to furnish healthcare services to a member, the member must be informed of the problem and be given at least 30 days to resolve it. All parties need to cooperate to ensure continuity of care for the Medica member. Also, providers may not terminate a Medica member from their organization if there is no suitable alternative provider in the patient's geographic...
proximity. All parties will comply with applicable provisions of the Medica Participation Agreement and Medica agreements with the Centers for Medicare and Medicaid Services (CMS) and the Minnesota Department of Human Services.

The Medica Provider Administrative Manual contains more details about the termination-of-care process for providers to follow, including the Authorization for Termination of Health Services Form to submit to Medica in this situation. Read more about the termination-of-care process.

Update to Medica Provider Administrative Manual

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 the updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

<table>
<thead>
<tr>
<th>Location in manual</th>
<th>Information updated</th>
<th>When posted online in manual</th>
</tr>
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<tbody>
<tr>
<td>&quot;Billing and Reimbursement&quot; section, in &quot;Claim Submission Requirements for Professional Services&quot; and &quot;Claim Submission Requirements for Facilities&quot; subsections</td>
<td>Updated claims processing information regarding change in timeframe for adjustments to paid claims</td>
<td>January 2011 (continued from December)</td>
</tr>
<tr>
<td>&quot;Special Contracting Requirements&quot; section, in &quot;Government Program Requirements&quot; subsection (under &quot;Provider Requirements for Medicare, Medicaid and Government Programs&quot;)</td>
<td>Updated member protection provisions and lobbying disclosure provisions</td>
<td>January 2011</td>
</tr>
</tbody>
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For the current version, providers may:

- View the Medica Provider Administrative Manual online or
- Call the Medica Provider Literature Request Line for a hard copy.

PPO Information

Reminder:

Filling out provider details on PPO paper claims

As a reminder, it is important for providers to completely fill in box 31 on a CMS-1500 claim form for billing physician charges, when applicable—Box 31 should contain both the provider's name and the provider's credentials. The information in this field helps determine if providers are contracted with the Medica SelectCare℠ or LaborCare® preferred provider organization (PPO). Filling in box 31 will help ensure correct and prompt processing of these claims.

The mailing address for paper PPO claims is:

SelectCare/LaborCare
PO Box 830489
Birmingham, Al 35283-0489

Note: When submitting SelectCare and LaborCare claims, providers should not use the number 00014 as the group number or as a member ID number, since 00014 is the EDI payer ID number that should be used for submitting SelectCare and LaborCare claims electronically. If it is used as a group number or member ID number on a claim, the claim cannot be processed and will be returned.
Latest UHC provider bulletin available online

UnitedHealthcare (UHC) has published the latest edition of its Network Bulletin (January 2011). Highlights that may be of interest to LaborCare® network providers include:

- New One or More Sessions Policy — delayed until second quarter 2011
- New Procedure to Modifier Policy — scheduled for second quarter 2011
- Revised Anesthesia Policy — scheduled for second quarter 2011
- Revised Global Days Policy — scheduled for second quarter 2011
- Revised Prolonged Services Policy — scheduled for second quarter 2011
- Retired Interventional Radiology Policy — scheduled for second quarter 2011

View the January 2011 UHC provider newsletter.

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