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GENERAL INFORMATION
Premium Designation current program year winds down

Remaining reconsideration requests due by July 16

The current program year for the Medica Premium Designation Program will soon come to a close, and preparations for the next program-year rollout in 2015 will be underway. The final deadline for physicians to review their current-year Premium Designation data and to make any final reconsideration requests will be July 16, 2014. Medica will evaluate and respond to reconsideration requests within 30 days. After July 16, reconsideration requests will not be accepted until the next reconsideration period expected in March 2015. However, Premium Designation reports will still be available for physicians to review until then.

To submit reconsideration requests using the secure program login, or simply for more program details, refer to the Premium Designation home page.

Providers who have questions about Premium Designation may:
- Refer to the Premium Designation program's Frequently Asked Questions (FAQ)
- Send an e-mail to Medica at premiumdesignation@medica.com.

PCA agencies to receive data-validation reports in August

Medica will soon send an annual data-validation request by e-mail to its personal care assistant (PCA) provider network. By doing so, Medica ensures that it has accurate demographic information for PCAs, which is essential for prompt and accurate claims payment.

While agencies are encouraged to submit data changes to Medica as they occur throughout the year, this data-validation effort allows agencies to verify current Medica information. Having updated information will not only improve Medica members' experience, but it will have the potential to increase referrals for services to PCA agencies. As an example, as part of this annual data-validation project, PCA agencies will be asked to provide information regarding cultural and linguistic services offered by agency staffs, which would obviously appeal to populations of color.

Validation notices should arrive in August 2014, with a two-week deadline for responding. Instructions will be provided for verifying the data and making changes using the Provider Demographic-Update Online Tool (PDOT) available at medica.com in the Providers section under Electronic Transactions (this secure login is available to designated Primary and Secondary Administrators for provider groups). To enter the electronic tools section, a username and password is required. Portal registration questions can be e-mailed to portalregistration@medica.com.

Medica would like to extend a sincere thank-you to PCA agencies for taking the time to help keep these records up-to-date.
Annual notice:

Compliance, FWA trainings required for Medicare providers

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

Medica has training available on medica.com, or providers may take training from another source as long as it meets CMS requirements. Providers can also access the Medica Standards of Conduct and Compliance Reporting Policy on medica.com. To access both the Provider General Compliance Training and Provider FWA Training, scroll to the bottom of the medica.com Providers home page, click on Fraud and Abuse (under Resources), and then click on the Provider Training tab at the top.

Learn more about fraud and abuse and take the trainings.

Training is required at the time of a Medicare provider's initial contract and then annually thereafter by December 31. Providers should maintain records of all training. 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.

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Clinical Information

Effective September 1, 2014

Prior authorization to be required for certain heart devices

Beginning with September 1, 2014 dates of service, Medica will implement the following new utilization management (UM) policy that requires prior authorization. This change applies to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

By instituting prior authorization for the following procedures, Medica aims to support members and providers in making evidence-based decisions about appropriate, medically necessary care.

Mechanical circulatory support devices
As of September 1, 2014, mechanical circulatory support devices, including ventricular assist devices
(VADs) and total artificial hearts, will require prior authorization as outlined below.

For use of a VAD as a bridge to transplant, all of the following criteria must be met:

- The device is approved by the U.S. Food and Drug Administration (FDA)
- The individual is approved and listed as a candidate for a heart transplant
- The individual is not expected to survive until a donor heart can be obtained

For use of a VAD as destination therapy, all of the following criteria must be met:

- The device is FDA-approved
- The individual has been evaluated and determined not to be eligible for a heart transplant
- There is documented Class III or IV New York Heart Association (NYHA) end-stage left ventricular heart failure
- The individual has received optimal medical management (i.e., medication, intra-aortic balloon pump, oxygen) for at least 60 of the last 90 days, or survival is in jeopardy
- There is a life expectancy of less than two years.

For use of a VAD as a bridge to recovery, all of the following criteria must be met:

- The device has been FDA-approved
- The individual has a diagnosis of acute cardiogenic shock or acute myocarditis or cannot be weaned from cardiopulmonary bypass following cardiac surgery.

For use of VAD as a bridge to transplant in pediatric patients, providers should refer to the Medica UM policy on humanitarian device exemptions for details on coverage and criteria relative to a VAD.

For use of a total artificial heart, all of following criteria must be met:

- The total artificial heart device is FDA-approved (currently there is only one FDA-approved device, the SynCardia temporary Total Artificial Heart (TAH-t))
- Diagnosis of biventricular heart failure
- The individual is approved and listed as a candidate for a heart transplant (device used as a bridge to transplant)
- The individual has failed optimal medical therapy
- The individual is not expected to survive until a donor heart can be obtained
- The device is for in-hospital use only.

A new UM policy will address these changes and will replace the Medica coverage policies "Ventricular Assist Devices (VADs)" and "Total Artificial Heart." The complete text of the new UM policy will be available online or on hard copy:

- View UM policies at medica.com as of September 1, 2014; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

As of September 1, 2014, the Medica Prior Authorization List will also be updated to reflect the change above. As a reminder, Medica requires that providers obtain prior authorization before rendering services. If any items on the Medica Prior Authorization List are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability.

View more information about prior authorization requirements on medica.com.
Annual notice:

Medica monitors Quality Improvement program goals for 2014

Medica prepares an annual Quality Improvement Work Plan to outline key quality improvement (QI) activities for the year. The work plan encompasses clinical quality, service quality, provider quality and patient safety, as well as community collaborations and ongoing quality monitoring activities. As of second quarter, the 2014 QI Work Plan features 26 individual quality improvement activities, 19 ongoing quality monitors, and nine community collaborations. More QI activities can potentially be added throughout the year.

Some Work Plan initiatives that may interest medical groups include activities to:

- Improve well-child visit rates for a specific member population.
- Increase colorectal cancer screening rates for a specific member population in targeted clinics through clinic-specific interventions.
- Reduce non-urgent ED use for children age 0-6 by through health literacy interventions.
- Conduct initial audit of interpreter service agencies.
- Pilot provider quality metrics report.

The Medica QI program supports the Medica mission to meet its customers' needs for health plan products and services. The QI program's purpose is to identify and implement activities that will improve:

- Member care, service, access and/or safety;
- Service to providers, employers, brokers and other customers and partners; and
- Medica internal operations.

This program encompasses a wide range of clinical and service quality initiatives affecting Medica members, providers, employers and brokers, as well as internal stakeholders throughout Medica.

Medica evaluates its QI program annually, reviewing the year's QI activities and assessing progress toward goals. Medica also looks at its QI committee structure, program resources, and key challenges and barriers encountered during the year. Each year's program evaluation forms the basis of the next year's work plan.

The Medica Quality Improvement Subcommittee (QIS) of the Medical Committee of the Medica Board of Directors directs and oversees QI program implementation. QIS serves as a peer-review body, receiving and reviewing aggregate data on all aspects of clinical and service quality. QIS approves program activities, recommends policy changes and follows up on improvement opportunities.

For more details about the Medica QI program:

- [Visit the Providers section of medica.com under "Quality and Cost Programs."](URL)
- Call the Medica Provider Literature Request Line for printed copies of documents.

Providers may direct comments or questions about the QI program to the Medica Provider Service Center at 1-800-458-5512.
Effective September 1, 2014:

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 September 1, 2014, unless otherwise noted.

**UM policies — New**

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical Circulatory Support Devices</td>
<td>III-SUR.38</td>
</tr>
</tbody>
</table>

**UM policies — Revised**

These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Implant Removal, Revision, or Reimplantation</td>
<td>III-SUR.11</td>
</tr>
<tr>
<td>Rhinoplasty Procedure with or without Septoplasty</td>
<td>III-SUR.04</td>
</tr>
<tr>
<td>Abdominoplasty/Panniculectomy</td>
<td>III-SUR.13</td>
</tr>
<tr>
<td>Female Breast Reduction Surgery — Reduction Mammoplasty</td>
<td>III-SUR.27</td>
</tr>
<tr>
<td>Otoplasty</td>
<td>III-SUR.33</td>
</tr>
<tr>
<td>Reconstructive Blepharoptosis Repair (Upper or Lower Eyelid),</td>
<td>III-SUR.29</td>
</tr>
<tr>
<td>Blepharoptosis Repair (Upper Eyelid) and Brow Lift</td>
<td></td>
</tr>
<tr>
<td>Male Gynecomastia Surgery</td>
<td>III-SUR.31</td>
</tr>
</tbody>
</table>

**Coverage policies — Revised**

These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast-Specific Gamma Imaging, Scintimammography, and Molecular Breast Imaging</td>
<td></td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy (HBOT)</td>
<td></td>
</tr>
<tr>
<td>Tongue Base Suspension Surgery for Obstructive Sleep Apnea (formerly Repose® System for Obstructive Sleep Apnea)</td>
<td></td>
</tr>
</tbody>
</table>

**Coverage policies — Inactivated**

These versions replace all previous versions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventricular Assist Devices (VAD) (replaced by UM Policy Mechanical Circulatory Support Devices — see above)</td>
<td></td>
</tr>
<tr>
<td>Total Artificial Heart (replaced by UM Policy Mechanical Circulatory Support Devices — see above)</td>
<td></td>
</tr>
</tbody>
</table>
ICSI guidelines — New
*Tese guidelines are available on medica.com.*

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Pain Assessment and Opioid Prescribing Protocol <em>(released January 2014)</em></td>
</tr>
</tbody>
</table>

These documents will be available online or on hard copy:
- View medical policies and clinical guidelines at medica.com as of September 1, 2014; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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PHARMACY INFORMATION

Effective June 1, 2014:
**Medica updates drug coverage and UM policies**

Medica has recently updated the following drug coverage and drug utilization management (UM) policies effective with June 1, 2014, dates of service.

**Coverage policies — Revised**
*Tese versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herpes Zoster Vaccine <em>(Zostavax®)</em></td>
</tr>
<tr>
<td>Human Papillomavirus <em>(HPV)</em> Vaccine</td>
</tr>
</tbody>
</table>

**Drug UM (prior authorization) policies — Revised**
*Tese versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubagio® <em>(teriflunimide)</em></td>
</tr>
<tr>
<td>Signifor® <em>(pasireotide)</em></td>
</tr>
<tr>
<td>Sporanox®, Onmel® <em>(itraconazole)</em></td>
</tr>
<tr>
<td>Subutex®, Suboxone®, Zubsolv® <em>(buprenorphine, buprenorphine/naloxone)</em></td>
</tr>
<tr>
<td>Xolair® <em>(omalizumab)</em></td>
</tr>
</tbody>
</table>

These drug coverage and drug UM policies are available online or on hard copy:
- View drug coverage and UM policies at medica.com; or
- Call the Medica Provider Literature Request Line for printed copies of documents.
Effective July 1, 2014

Medica updates commercial, Marketplace, MHCP formularies

Medica has reviewed the following products, with their respective coverage status effective July 1, 2014, unless otherwise noted. As indicated in the table below, these changes will apply to the Medica Commercial Preferred Drug List; the new Marketplace Preferred Drug List for individual and family business (IFB) members and small group plan members who purchase health plans on state exchanges; and the Medica List of Preferred Drugs for Minnesota Health Care Programs (MHCP). The Medica MHCP formulary applies to the following products: Medica Choice Care SM (including Minnesota Senior Care Plus program, or MSC+), Medica MinnesotaCare, Medica AccessAbility Solution® (Special Needs Basic Care program, or SNBC), and Medica DUAL Solution® (Minnesota Senior Health Options program, or MSHO), for non-Part D drugs. These changes will not apply to the Medica Medicare Part D Formulary.

<table>
<thead>
<tr>
<th>Generic name (brand name)</th>
<th>Commercial and Marketplace formulary status</th>
<th>Medica MHCP formulary status</th>
<th>Current preferred alternatives</th>
<th>Restrictions and comments</th>
<th>Approved therapeutic indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>tocilizumab subcutaneous (Actemra®)</td>
<td>Commercial Specialty tier 2; Marketplace tier 6</td>
<td>Non-formulary</td>
<td>Enbrel and Humira</td>
<td>Prior authorization required; specialty drug</td>
<td>Treatment of adults with moderately to severely active rheumatoid arthritis who have hand an inadequate response to one or more DMARDS</td>
</tr>
<tr>
<td>riociguat (Adempas®)</td>
<td>Commercial Specialty tier 1; Marketplace tier 5</td>
<td>Formulary Specialty</td>
<td>Specialty drug</td>
<td>Treatment of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class; and Pulmonary Arterial Hypertension</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>Formulary Details</td>
<td>Mechanism of Action</td>
<td></td>
<td></td>
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<td>----------------------------------------------</td>
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<tr>
<td>Flunisolide (Aerospan®) – effective 10/1/14</td>
<td>Commercial tier 3; Marketplace tier 3</td>
<td>Improved exercise capacity, delayed clinical worsening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mometasone (Asmanex®) – effective 10/1/14</td>
<td>Commercial tier 3; Marketplace tier 3 Non-formulary (for members 6 years of age and older)</td>
<td>Maintenance treatment of asthma in adults and children 6 years of age and older; reduction in use of systemic corticosteroids</td>
<td></td>
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</tr>
<tr>
<td>Tacrolimus extended-release (Astagraf XL®)</td>
<td>Commercial tier 3; Marketplace Tier 3 Non-formulary generic tacrolimus</td>
<td>Organ rejection prophylaxis for kidney transplant patients with mycophenolate and steroid treatment, with or without basiliximab injection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobramycin nebulized solution (Bethkis®)</td>
<td>Commercial Specialty tier 2; Marketplace tier 6 Non-formulary generic tobramycin nebulized solution</td>
<td>Management of cystic fibrosis in patients with P. aeruginosa</td>
<td></td>
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<tr>
<td>Vortioxetine (Brintellix®)</td>
<td>Commercial tier 2; Marketplace tier 2 Formulary</td>
<td>Step therapy Treatment of major depressive disorder</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Paroxetine mesylate (Brisdelle®)</td>
<td>Commercial tier 3; Marketplace tier 3 Non-formulary generic paroxetine, estradiol, Vivelle-Dot, Premarin, Prempro</td>
<td>Treatment of moderate to severe vasomotor symptoms associated with menopause</td>
<td></td>
<td></td>
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<tr>
<td>Estrogens,</td>
<td>Commercial Non-estradiol,</td>
<td>Treatment of...</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Conjugated/bazedoxifene (Duavee®)</td>
<td>Tier 2; Marketplace tier 2</td>
<td>Formulary</td>
<td>Vivelle-Dot, Premarin, Prempro</td>
<td>Moderate-severe vasomotor symptoms associated with menopause in women with a uterus and prevention of post-menopausal osteoporosis in women with a uterus</td>
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<tr>
<td>Enalapril maleate liquid (Epaned®)</td>
<td>Commercial tier 3; Marketplace tier 3</td>
<td>Non-formulary</td>
<td>Enalapril tablets</td>
<td>Treatment of hypertension in adults and children older than 1 month of age</td>
<td></td>
</tr>
<tr>
<td>Fluticasone (Flovent® Diskus and HFA) – effective 10/1/14</td>
<td>Commercial tier 2; Marketplace tier 2</td>
<td>Non-formulary</td>
<td>MHCP: Aerospan</td>
<td>Maintenance treatment of asthma in adults and children 4 years of age and older; reduction in use of systemic corticosteroids</td>
<td></td>
</tr>
<tr>
<td>Desvenlafaxine extended-release (Khedezla®)</td>
<td>Commercial tier 3; Marketplace tier 3</td>
<td>Non-formulary</td>
<td>Citalopram, Escitalopram, Fluoxetine, Paroxetine, Sertraline, Duloxetine, Bupropion, Venlafaxine</td>
<td>Treatment of major depressive disorder (MDD) in adults</td>
<td></td>
</tr>
<tr>
<td>Brimonidine tartrate (Mirvaso®)</td>
<td>Commercial tier 3; Marketplace tier 3</td>
<td>Non-formulary</td>
<td>Metronidazole, Finacea, Sulfacetamide/Sulfur</td>
<td>Topical treatment of persistent facial erythema of rosacea in adults</td>
<td></td>
</tr>
<tr>
<td>Macitentan (Opsumit®)</td>
<td>Commercial Specialty tier 1; Marketplace tier 5</td>
<td>Formulary Specialty</td>
<td>Specialty drug</td>
<td>Treatment of pulmonary arterial hypertension to delay disease progression</td>
<td></td>
</tr>
<tr>
<td>Modafinil (Provigil®)</td>
<td>Both brand and generic: Commercial tier 3;</td>
<td>Both brand and generic: Non-</td>
<td>Step therapy</td>
<td>Treatment of obstructive sleep apnea, narcolepsy, and shift work disorder</td>
<td></td>
</tr>
<tr>
<td>Drug Name</td>
<td>Formulary Tier</td>
<td>Formulary</td>
<td>IFB/MHCP</td>
<td>Comments</td>
<td></td>
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<td>-----------------------------------------------</td>
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<td>-------------------</td>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>budesonide (Pulmicort Flexhaler®)</td>
<td>Commercial</td>
<td>Non-formulary</td>
<td>Commercial/IFB: Flovent and Qvar; MHCP: Aerospan</td>
<td>Maintenance treatment of asthma in adults and children 6 years of age and older</td>
<td></td>
</tr>
<tr>
<td>pasireotide (Signafor®)</td>
<td>Specialty</td>
<td>Non-formulary</td>
<td>Ketoconazole, Sandostatin LAR, octreotide acetate</td>
<td>Prior authorization required; specialty drug; Treatment of adult patients with Cushing's Disease (for whom pituitary surgery is not an option or has not been curative)</td>
<td></td>
</tr>
<tr>
<td>mechlorethamine gel (Valchlor®)</td>
<td>Specialty</td>
<td>Formulary</td>
<td>Specialty drug</td>
<td>Second-line treatment of stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma</td>
<td></td>
</tr>
<tr>
<td>diclofenac submicronized (Zorvolex®)</td>
<td>Commercial</td>
<td>Non-formulary</td>
<td>Ibuprofen, naproxen, diclofenac, meloxicam, Celebrex</td>
<td>Treatment of mild to moderate acute pain in adults</td>
<td></td>
</tr>
</tbody>
</table>

Medica drug formularies are available online or on paper:
- **View Medica drug formularies on medica.com.**
- To request a printed copy, providers may call the Medica Provider Literature Request Line.

**Medication request forms**
A uniform 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:
- **Download an exception form at medica.com.**
- Call MedImpact at 1-800-788-2949.
Reminder:

Medica to change DAW-1 process for MHCP members

Effective September 1, 2014, pharmacy claims submitted with "DAW-1" will be denied at point-of-sale for Minnesota Health Care Programs (MHCP) members, so that these members will be required to take the generic equivalent. A provider-requested dispense-as-written or DAW prescription (DAW-1) allows members to receive a branded version of a generically available medication. In situations where the multi-source brand is required per the prescriber, a formulary exception request can be submitted for clinical review.

This prescription change will apply for the following Medica MHCP members: Medica Choice Care℠ (including Minnesota Senior Care Plus program, or MSC+), Medica MinnesotaCare, Medica AccessAbility Solution® (Special Needs Basic Care program, or SNBC), and Medica DUAL Solution® (Minnesota Senior Health Options program, or MSHO), for non-Part D drugs. Medica notified MHCP members in early June of the change, asking them to review current prescriptions and options with their prescriber.

This information was previously published in the May 2014 edition of Medica Connections.

Effective September 1, 2014:

Changes to Medica Part D drug formulary

Medica posts changes to its Part D drug formularies on medica.com 60 days prior to the effective date of change. The latest lists 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 September 1, 2014. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Medica periodically makes changes to its Medicare Part D formularies: the Part D open formulary (3-tier + specialty tier) and the Part D closed formulary. View the latest Medicare Part D drug formulary changes.

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

- View formularies at medica.com
- 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:
NETWORK INFORMATION

'Lag,' quarterly PCR checks to be mailed in July, August

Medica plans to mail final 2013 physician contingency reserve (PCR) distribution checks, or "lag" checks, to providers in late July 2014. Medica returned 100 percent of the PCR withhold for the Medica Prime Solution® Medicare product for 2013, including the lag return. The final 2013 distribution will include PCR withheld from claims with dates of service that fell outside the 90-day submission window for each quarter of last year. The July 2014 distribution will include PCR for claims payments processed through June 30, 2014, plus interest.

In addition, the PCR payment for the first quarter of 2014 for the Medica Prime Solution product is expected to be mailed by the end of August 2014. This represents a 100-percent return of the first-quarter 2014 PCR withhold, plus interest. Checks will cover PCR withheld for claims with dates of service of January 1, 2014, through March 31, 2014, and dates paid of January 1, 2014, through June 30, 2014.

Note: Medica began processing claims with a 2 percent payment reduction in April 2013 due to federal sequestration legislation. The 2 percent sequester reduction was in addition to the standard PCR withhold amount for Medica Prime Solution® claims. This 2 percent cut will not be included in PCR returns.

Certain fee schedules now available via medica.com

Medica has recently made certain fee schedules available for network providers to download through the secure provider login on medica.com. Providers can now view their complete contracted fee schedule online if they enter their tax identification number (TIN) and determine that their fee schedule is available this way. Providers have up to five "Fee Schedule Download" options, as applicable: commercial, Medicare, Medicaid, SelectCare, and LaborCare.

Providers need secure provider portal access to see their fee schedule.

- Providers who already have provider portal access can find out if their contracted fee schedule is downloadable: Visit the fee schedule download page
Don't have secure portal access? Visit medica.com for portal registration details.

If one or more fee schedules are not available through the secure provider login, providers should contact their Medica contract manager for copies of them. Providers with portal-access questions may contact the Medica Provider Service Center. For more information about all secure online transactions, providers can refer to the User Guide for Medica Electronic Transactions.

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**ADMINISTRATIVE INFORMATION**

**Effective July 1, 2014:**

**Medica revises reimbursement policies**

Medica has updated the reimbursement policies indicated below, effective with July 1, 2014, dates of processing. Such policies define when specific services are reimbursable based on the reported codes.

**Reimbursement policies — Revised**

*These versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
<th>From-To Date (updated code list)</th>
<th>Global Days (updated code list)</th>
</tr>
</thead>
</table>

These revised policies are available online or on hard copy:

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

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**Clarification on hospital-based clinics reimbursement policy**

As announced in the July 2014 edition of Medica Connections distributed last month, Medica will be implementing a new reimbursement policy regarding hospital-based clinic charges billed with the 051x revenue codes to be effective August 1, 2014. This policy will be effective for all Medica commercial, individual and family business (IFB), and Minnesota Health Care Programs (MHCP) products.

To clarify this policy:
Whenever the 051x revenue code series is billed with an evaluation and management (E&M) code (defined as code series 99201-99499 and G0463), the claim will be denied as provider liability.

When the 051x revenue code series is not billed with an E&M code, the claim will be eligible for reimbursement.

As stated previously, this policy also will not apply to federally qualified health centers (FQHCs) or rural health clinics.

Effective September 1, 2014:

**Medica to implement new reimbursement policy**

Medica will soon implement the new reimbursement policy indicated below, effective with September 1, 2014, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

**Services incidental to admission**

Medica will be adopting a new policy to address the billing and reimbursement of outpatient hospital services rendered prior to inpatient admission. This policy will apply to all Medica commercial, individual and family business (IFB) and Minnesota Health Care Programs (MHCP) products.

According to the Services Incidental to Admission policy, the following outpatient services will be considered incidental to admission. Therefore, they are not to be separately billed but should be included on the claim for the inpatient hospitalization:

- Emergency services rendered within 24 hours of admission
- Outpatient surgical procedures resulting in inpatient admission
- Observation services preceding inpatient admission
- All diagnostic and admission-related non-diagnostic services provided by the hospital on the date of inpatient admission (excluding critical-access hospitals, ambulance and chronic maintenance renal dialysis services)

Pre-admission services will be subject to post-payment audits and potential retraction of inappropriate payments.

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

- [View reimbursement policies at medica.com](https://medica.com) as of September 1, 2014; or
- Call the Medica Provider Literature Request Line for printed copies of documents.
Updates 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 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>
</thead>
<tbody>
<tr>
<td>&quot;Billing and Reimbursement&quot; section, in &quot;Claim Submission Requirements for Facilities&quot; subsection, under &quot;Submission Info&quot;</td>
<td>Beginning with 9/1/14 dates of service, Medica will require outpatient hospital facility claims to be submitted with CPT or HCPCS codes when specific revenue codes are billed. Absence of the required CPT or HCPCS code may result in a claim denial. See full list of revenue codes.</td>
<td>July 2014</td>
</tr>
</tbody>
</table>

View the current version of the Medica Provider Administrative Manual.

PPO INFORMATION

Reminder:
Centurion added as SelectCare payer for DOC patients

Earlier this year, Medica announced a partnership with Centurion of Minnesota, LLC, which was selected by the State of Minnesota to manage the medical needs of offenders at all 10 Minnesota Department of Corrections (DOC) prisons across the state. As a result, providers in the Medica SelectCareSM network treat correctional facility offenders in the custody of DOC.

Centurion coordinates and schedules all non-emergent care with providers in the SelectCare network. Notification is required if an offender is admitted as a result of an emergency department (ED) visit, in which case SelectCare network providers should call Centurion customer service toll-free at 1-855-475-4395. Providers may also call Centurion customer service for eligibility inquiries or benefit details.

ID cards are not issued to offenders, so SelectCare network providers should file claims using the following information:

- Electronic data interchange (EDI) payer ID: 00014
- Group ID: MN0001
- Offender ID: This ID should be used as the primary patient ID on claims and will be supplied at
Claims billed with a Social Security Number or claims that omit the inmate ID will not be processed for payment. The Minnesota DOC provides an offender search tool for providers to use if they do not capture the offender ID at the time of service. **Access the DOC search tool.**

SelectCare reprices claims when an inmate requires outpatient specialty services through a provider office or facility, and reprices a limited number of claims related to ancillary services. Real-time claims adjudication is also available.

**Health and Network Management leadership at Medica:**
- **Mark Werner, MD, Senior Vice President and Chief Clinical and Innovation Officer**
- **Jana Johnson, Senior Vice President for Health and Provider Services**
- **Barbara Lynch, Vice President for Network Management**
- **Dan Trajano, MD, Vice President and Medical Director for Population Health**
- **Ted Loftness, MD, Vice President and Medical Director**
- **James Hartert, MD, Senior Medical Director for Health Management**
- **Thomas Becker, MD, Medical Director for Care Management and Reimbursement**

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For Medica contact and reference information, see Medica points of contact for providers.
To update your email address, follow this quick two-step process:
1) Click "One-Click Unsubscribe" above to remove your old email.
2) Visit medica.com to re-subscribe with your new email.

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