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GENERAL INFORMATION

Dr. James Hartert joins Medica as senior medical director

James Hartert, MD, has recently joined Medica as senior medical director for health management. Dr. Hartert will be an important physician leader for the development of health management programs at Medica. As part of the Medica Health Management senior leadership team, Dr. Hartert oversees all full-time and part-time medical directors at Medica. He reports to Mark Werner, MD, chief clinical and innovation officer.

"Jim is a distinguished and highly experienced leader who has spent much of his career as a senior physician leader within health plans and health systems," said Dr. Werner. "He will bring critically important insight into our evolution of health management programs with a strong focus on utilization management, prior authorization, the application of evidence-based medicine, and the furthering of a robust medical direction program."

Most recently, Dr. Hartert was senior vice president and chief medical officer at Fairview Range Hospital in Hibbing, Minn. His past roles include chief medical officer for Blue Cross Blue Shield of Wisconsin, for Prime Therapeutics, and for MinuteClinic. Dr. Hartert has served in medical director roles for Humana and HealthPartners. He has also developed joint ventures with providers as well as behavioral health, wellness, and disease management programs.

Reminder:
Medica to reward innovations in care collaboration, integration

'Raising the Bar' awards worth up to $25,000 each

Medica is currently offering its seventh-annual innovation awards for provider groups, called "Raising the Bar: Improving Patient/Population Health Through Broadened Care Collaboration and Integration." Medica wants to recognize the work of provider groups striving for innovative care solutions through new or unconventional care settings and inter-professional collaboration to deliver care better to patients. One or more Medica innovation awards worth up to $25,000 each will be presented in fall 2014.

Any provider group, clinic or facility that administers patient care in the Medica provider network is eligible for this annual award. The deadline for award applications is June 27, 2014. More information, including the award application, is available online at medica.com.

Providers who have questions may contact Aleshia Peña at aleshia.pena@medica.com or 952-992-2406.
Medica Connections - June 2014

Medica Foundation funds Alzheimer's support programs

The Medica Foundation has been closely involved in supporting ACT on Alzheimer's, a volunteer-driven, statewide collaborative preparing Minnesota for the personal, social and budgetary impacts of Alzheimer's disease. ACT efforts are intended to prepare local communities for the growing number of people with Alzheimer's disease and related dementias. The Medica Foundation has contributed $250,000 in 2013-14 to fund community programs that support such statewide grassroots efforts.

"We're pleased to support the work of ACT on Alzheimer's," said Rob Longendyke, executive director of the Medica Foundation and senior vice president at Medica. "This health concern is one we feel strongly needs to be addressed since it will continue to grow. The Medica Foundation has a 10-year track record of funding grants that seek to improve community health, so this project also fits well with our mission."

One of ACT's key strategies is working with communities striving to become "dementia-friendly." To date, seven pilot communities and 12 additional communities along with their lead organizations have been awarded a grant from ACT on Alzheimer's to work toward this goal. The 19 "action communities" are the cities of Bemidji, Brainerd/Baxter, Cambridge, Detroit Lakes, Edina, Forest Lake, Harmony, International Falls, Marshall, Northfield, Roseville, St. Louis Park, St. Paul (with two neighborhood coalitions), Walker, and Willmar, as well as the following nonprofit organizations: Comunidades Latinas Unidas En Servicio (CLUES), the Minnesota Council of Churches, and the Twin Cities Jewish Community.

More than 60 organizations are part of the ACT on Alzheimer's collaboration. ACT community grants are funded through the Medica Foundation as well as Blue Plus and Greater Twin Cities United Way. For more about the ACT on Alzheimer's initiative and community resources, visit the ACT website.

Effective July 1, 2014:

Medica to offer new ACO product in northwestern Wisconsin

Effective July 1, 2014, Medica will offer a new accountable care organization (ACO) health plan option available through My Plan by MedicaSM. The "Medica with Mayo Clinic Health System" ACO will comprise 15 primary care clinics, five urgent care locations and five hospitals in northwestern Wisconsin, in the counties of Barron, Dunn, Chippewa, and Eau Claire. Medica members can see any provider in the Mayo Clinic Health System network without a referral. While Mayo Clinic in Rochester, Minn., will not be part of this new ACO arrangement, it will be available if a Mayo Clinic Health System provider directs a member there for care.

Medica and Mayo are collaborating to improve the quality of care, reduce the total cost of care and optimize the consumer experience. They can integrate information and resources to deliver a more personalized experience at a lower cost.

View the product fact sheet for Medica with Mayo Clinic Health System.
**Annual notice:**

**Provider appeals on behalf of Medica members**

Medica members have the right to appoint representatives, such as their providers, to initiate member appeals. For cases involving 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:
- [View Benefit Appeals in the Provider Administrative Manual](#).
- [View Member Assistance Services in the Provider Administrative Manual](#).

**Annual notice:**

**Member rights and responsibilities, for providers to know**

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**

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.**

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**CLINICAL INFORMATION**

**Effective April 16, 2014**

**Medica makes UM policy change**

The following benefit determination was effective beginning with April 16, 2014, dates of service. This change applies to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage.

**Real-time mobile cardiac outpatient telemetry**

Medica reviewed real-time mobile cardiac outpatient telemetry (RT-MCOT) and expanded coverage to include two additional indications for medical necessity review. Besides individuals with unexplained syncope, pre-syncope and/or palpitation, RT-MCOT will be reviewed for individuals:

- Requiring medical monitoring/management following cardiac ablation (e.g., antiarrhythmic or anticoagulant drug therapy), or
- Who have a history of cryptogenic stroke or transient ischemic attack (TIA) with suspected unconfirmed occult atrial fibrillation.

All other criteria remain unchanged. For detailed medical necessity criteria, see the Medica utilization management (UM) policy titled "Real-Time Mobile Cardiac Outpatient Telemetry (MCOT)". This policy was formerly titled "Outpatient Mobile Cardiac Real-Time Telemetry."

The complete text of the policy that applies to this determination is available online or on hard copy:

- **View UM policies at medica.com**
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355.
Effective July 1, 2014:

**Medica to require prior authorization for certain procedures**

Medica will soon implement several new utilization management (UM) policies that require prior authorization. These changes apply to all Medica products including government products unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage. For example, these changes will *not* apply to Medica Medicare products, which will continue to follow National Coverage Determinations (NCD) guidelines.

Beginning with July 1, 2014 dates of service, Medica *will require prior authorization* for the following procedures:
- Spinal cord stimulation
- Vagus nerve stimulation
- Positron emission tomography (PET) scan
- Hip arthroplasty/replacement and hip resurfacing
- Knee arthroplasty/replacement

By instituting prior authorization, Medica aims to support members and providers in making evidence-based decisions about appropriate, medically necessary care. Previously, spinal cord stimulation, vagus nerve stimulation, hip resurfacing arthroplasty, and PET scan were addressed in coverage policies.

The complete text of the related UM policies will be available online or on hard copy:
- [View UM policies at medica.com](#) as of July 1, 2014; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

As of July 1, 2014, the Medica Prior Authorization List will also be updated to reflect the changes 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](#).

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**Medica supports preventive care through child vaccinations**

Medica supports immunization efforts throughout the state of Minnesota. Maintaining high vaccination rates by vaccinating on time every time is the key to keeping deadly diseases away from Minnesota communities. These efforts have led to success in preventing diseases so babies can grow up healthy, and the vast majority of parents fully vaccinate their children. The Minnesota Department of Health (MDH) has created multiple materials to assist providers in promoting the use of vaccines to protect children. [See resources at the MDH website](#).
As a reminder, the Minnesota Vaccines for Children (MnVFC) Program provides free or low-cost shots to children who don't have insurance or whose insurance does not cover the cost of vaccines. As of January 1, 2014, MDH no longer provides free vaccines for those 19 years of age or older.

Learn more about how vaccines protect babies:

- [Minnesota Department of Health](#)
- [American Academy of Pediatrics](#)
- [Centers for Disease Control and Prevention](#)
- [Every Child by Two](#)
- [Vaccine Education Center](#)
- [Immunization Action Coalition](#)

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Effective July 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 July 1, 2014, unless otherwise noted.

### UM Policies — New

<table>
<thead>
<tr>
<th>Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee Arthroplasty/Replacement</td>
<td>III-SUR.41</td>
</tr>
<tr>
<td>Positron Emission Tomography (PET) Scan</td>
<td>III-DIA.12</td>
</tr>
<tr>
<td>Spinal Cord Stimulation</td>
<td>III-DEV.23</td>
</tr>
<tr>
<td>Hip Arthroplasty/Replacement and Hip Resurfacing</td>
<td>III-SUR.40</td>
</tr>
<tr>
<td>Vagus Nerve Stimulation</td>
<td>III-DEV.24</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>Bone Growth Stimulators</td>
<td>III-DEV.07</td>
</tr>
<tr>
<td>Comparative Genomic Hybridization Microarray Testing for Neurodevelopmental Chromosomal Imbalance</td>
<td>III-DIA.09</td>
</tr>
<tr>
<td>Gastrointestinal Surgery for Morbid Obesity</td>
<td>III-SUR.30</td>
</tr>
<tr>
<td>Genetic Testing for Cardiac Channelopathies</td>
<td>III-DIA.05</td>
</tr>
<tr>
<td>Genetic Testing for Cardiomyopathies</td>
<td>III-DIA.07</td>
</tr>
<tr>
<td>Human Leukocyte Antigen-DQ Genetic Testing for Diagnosis of Celiac Disease</td>
<td>III-DIA.10</td>
</tr>
<tr>
<td>Implantable Deep Brain Stimulation</td>
<td>III-DEV.19</td>
</tr>
<tr>
<td>Microprocessor Controlled Knee Prostheses, with or without Polycentric</td>
<td>III-DEV.17</td>
</tr>
</tbody>
</table>
Three Dimensional Endoskeletal Hip Joint System
Outpatient Enteral Nutrition Therapy
Real Time Mobile Cardiac Outpatient Telemetry (RT-MCOT) (effective 4/16/2014)
Vacuum-Assisted Negative Pressure Wound Therapy

Coverage Policies — Revised
These versions replace all previous versions.

Name
Cranial Electrotherapy Stimulation
Trigger Point Dry Needling

Coverage Policies — Inactivated
These versions replace all previous versions.

Name
Hip Resurfacing Arthroplasty (replaced by UM Policy — see above)
Implanted Spinal Cord Stimulation for Chronic Intractable Pain (replaced by UM Policy — see above)
Positron Emission Tomography (PET) Scan with or without Computed Tomography (CT) for Oncology, Neurology, and Cardiology Applications (replaced by UM Policy — see above)
Vagus Nerve Stimulation (replaced by UM Policy — see above)

ICSI Guidelines — Revised
These guidelines are available on medica.com.

Name
ADHD, Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents (endorsed April 2014)

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

PHARMACY INFORMATION

Effective July 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 July 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 on 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:
- Download a coverage determination form at medica.com
- Call MedImpact at 1-800-788-2949.

Effective July 1, 2014

Effective July 1, 2014, Medica will implement standard fee schedule updates for commercial products in both its metro and regional service areas. These updates will result in an overall estimated increase to physician reimbursement. As always, the effect on reimbursement will vary by specialty and the mix of services provided.

Various fees for services without an assigned Centers for Medicare and Medicaid Services (CMS) relative value unit (RVU) will also be updated. Examples of these services include injectable drugs and immunizations. This non-RVU update will also have an impact on physician reimbursement that will vary based on specialty and mix of services provided.

Medica will apply CMS-based RVU methodology where applicable. The CMS Medicare physician RVU file (National/Carrier) is available online at the CMS website.
Effective July 1, 2014

Medica to update Medicare physician fee schedule

Beginning with July 1, 2014, 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 July 2014 Centers for Medicare and Medicaid Services (CMS) update applicable to reimbursement for injectable drugs and immunizations. The reimbursement impact of this quarterly update will vary based on specialty and mix of services provided. Updates for durable medical equipment (DME) and orthotics and prosthetics (O&P) will not be implemented at this time.

Details on Medicare changes to drug fees are available online from CMS.

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

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**ADMINISTRATIVE INFORMATION**

Provider College administrative training topic for June

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 topic**

"Resources for Helping Yourself" (class code: RH-WJ)

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 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-WJ</td>
<td>Resources for Helping Yourself</td>
<td>June 26</td>
<td>10-11 am</td>
<td>Class code with &quot;WJ&quot; means offered via webinar in June</td>
</tr>
</tbody>
</table>
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 for all classes is one week prior to the class date. To register for the session listed, providers may do either of the following:

- **Fill out the Provider College registration form** (available online at medica.com under "News and Training") and e-mail it to providercollege@medica.com.
- Send an e-mail with the same details as listed on the registration form to providercollege@medica.com.

Effective July 1, 2014:
**HIPPS coding to be required on SNF, home health claims**

Medica encourages skilled nursing facilities (SNFs) and home health care facilities to submit Health Insurance Prospective Payment System (HIPPS) codes for Medicare patient encounters. This is consistent with the Centers for Medicare and Medicaid Services (CMS) requirement for Medicare Advantage organizations and other entities. Effective with July 1, 2014, dates of service, Medica will begin denying SNF and home health claims for lack of HIPPS codes.

This timeline is subject to change to be consistent with the CMS timeline for this requirement. Medica contracted rates for SNF and home health providers will continue to apply. Other than the addition of HIPPS codes on a separate line on the claim, these facilities should continue to bill as they currently do. As long as billing is complete, payment will not change. Medica will continue to keep these providers apprised of developments with this HIPPS code requirement as they occur. Medica will also update the Provider Administrative Manual to reflect this change.

HIPPS codes involve case-mix groups, representing specific patient characteristics used to determine payment. HIPPS codes should be submitted for the following Medica Medicare products: Medica Prime Solution®, Medica Complete Solution®, Medica DUAL Solution® and Medica Clear Solution®.

(Update to “SNF HIPPS coding encouraged; related claim denials delayed” article in the October 2013 edition of Medica Connections. See October 2013 edition.)
Effective April 13, 2014:

**Medica revises reimbursement policy**

Medica has updated the reimbursement policy indicated below, effective with April 13, 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>Add-On Code (updated code list)</th>
</tr>
</thead>
</table>

This revised policy is 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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Effective July 1, 2014:

**Medica to revise reimbursement policies**

Medica will soon update the reimbursement policies indicated below, to be effective with July 1, 2014, dates of processing. Such policies define when specific services are reimbursable based on the reported codes

**Bundled services**

The Bundled Services policy defines services that are not eligible for separate reimbursement and considered to be part of another service. These services may have been provided on the same date of service or another date of service. This policy is based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File. This file contains status indicators for each code. Codes assigned a status indicator of "B" are always bundled into payment for other services not specified.

For commercial and Medicaid products, certain codes with an assigned status indicator of "B" may be allowed for separate reimbursement subject to the member's certificate of coverage and Medica reimbursement policies. These codes are identified on the Commercial and Medicaid — Status "B" Codes Eligible for Reimbursement Code List. Effective July 1, 2014, Status "B" codes 36416, 97602, 99091, and 99288 will be removed from this code list and added to the Commercial and Medicaid Bundled Services Code List and will not be eligible for reimbursement.

**Telehealth**

Medica reimburses telephone services (Current Procedural Terminology (CPT®) codes 99441-99443 and 98966-98968) when used to report a non-face-to-face evaluation and management (E/M) service that is initiated by an established patient, or guardian of an established patient, via the telephone.

If the telephone service ends with a decision to see the patient within 24 hours or at the next available
urgent visit appointment, it should not be reported. The service is considered part of the pre-service work of the subsequent visit.

Telephone services should not be reported when the call refers to an E/M service performed and reported by the physician or other qualified health care professional within the previous 7 days or within the postoperative period of a previously completed procedure. The service would be considered part of the previous E/M service or procedure.

Since the code descriptions clearly indicate that they do not originate from a related E/M service nor lead to an E/M service, they are therefore assigned a status indicator "N" (non-covered services) in the Medicare Physician Fee Schedule. According to CMS, providers may bill beneficiaries directly for these services. Effective July 1, 2014, the phone call codes will be denied member liability for Medicare beneficiaries.

**Other policy updates**
The following reimbursement policy will also be updated effective with July 1, 2014, dates of processing.

*These versions replace all previous versions.*

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlisted Procedure Code <em>(updated unlisted drug reimbursement)</em></td>
</tr>
</tbody>
</table>

These revised policies are available online or on hard copy:
- [View reimbursement policies at medica.com](http://medica.com) as of July 1, 2014; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

**Reminder:**

**Proper Medicare billing related to status 'I' services**

The Centers for Medicare and Medicaid Services (CMS) releases a file on a quarterly basis that provides information on services covered by the Medicare Physician Fee Schedule (MPFS). It provides information on more than 10,000 physician services including the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (e.g., payment of assistant at surgery, team surgery, bilateral surgery). The MPFS status code within the file indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered.

Certain codes are assigned status "I":

"Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)"

**Examples:**

<table>
<thead>
<tr>
<th>Status 'I' codes</th>
<th>Codes to be reported for Medicare beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>44705</td>
<td>G0455</td>
</tr>
<tr>
<td>80101</td>
<td>G0431</td>
</tr>
</tbody>
</table>
Note: Certain status "I" codes do not have replacement codes and are not eligible for reimbursement. The CMS MPFS and a complete listing of the status codes can be accessed at the CMS website.

Medica encourages continued ICD-10 preparations

Despite the recent news from the Centers for Medicare and Medicaid Services (CMS) that the ICD-10 implementation will be delayed, Medica is continuing to work toward an assumed effective date of October 1, 2015. Medica encourages all network providers to continue moving forward with training and other readiness planning as well to ensure a successful coding transition, especially since all stakeholders have additional time to prepare now. While waiting for direction from CMS, Medica is evaluating next steps and continuing its own preparations. As a reminder, Medica has resources available to assist providers with this important initiative.

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;Administrative Policies and Procedures&quot; section, in &quot;Genetic Counselors&quot; subsection</td>
<td>To revise the current explanation of genetic counselors and make the language current with licensing and certification requirements in ND and SD</td>
<td>July 2014</td>
</tr>
</tbody>
</table>

View the current version of the Medica Provider Administrative Manual.