

A monthly publication
for Medica and SelectCareSM
network providers

Connections

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May 2007

This Summer, Medica to Enable Electronic Payments and Statements Through Its Web site

Effective as soon as July 2007, Medica will enhance its online transactions to allow providers to see electronic payments and statements for claims processed on the new business platform. This capability will be listed as a new transaction on the [Electronic Transactions Web page](#) on www.medica.com. Signing up for this transaction means providers will be able to receive payments by electronic funds transfer and so will no longer receive paper explanations of benefits (EOBs) or paper check payments.

Note: This functionality will be available for claims processed using the new business platform *only*. As a result, this capability won’t apply for the majority of Medica claims at this time.

This enhancement will allow providers to do two things:

1. set up electronic transfers so Medica can direct deposit funds to a provider’s bank account.
2. see payment records online, such as an Explanation of Benefits (EOB) statement (with claims payment information grouped by tax ID number), or electronic provider remittance advice (EPRA) 835 transactions, which are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To see payment information online, providers will need to enroll online for each of their organization’s tax ID numbers and to delegate viewing status to appropriate staff members (business office manager, etc.). A user’s guide and informational documents will be available online when providers click on an enrollment link. Providers can call the Provider Service Center for details at that time.

Medica plans to also offer claims status inquiry through the Electronic Transactions Web page later in 2007. This capability will allow providers to see pending vs. paid status of claims, to see when claims were paid, and to search claims by patient name or by patient ID number — and it will be available for *all* Medica claims.

Route to:

- Administrator
- Office Manager
- Billing Staff
- Claims/Coding Staff
- Physicians
- Other:
- _____

- Medica’s Provider Service Center is available toll-free at 1-800-458-5512.
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Patients Help Themselves to Healthy Lifestyle Information Using ‘My Health Manager’

Survey Indicates Medica Members Find Web-Based Program Helpful

Medica is in the forefront with employer-focused wellness programs to engage consumers. One such innovation is My Health Manager from MedicaSM, an approach to health improvement programs that involves online resources, gift card rewards for participation, and other mechanisms for consumer engagement.

This online tool has various levels of resources and interactivity, for Medica members who simply wish to glance at nutrition and wellness information (e.g., about a better diet, reducing stress, etc.) or those who have a chronic condition. Resources, regardless of risk level or disease state, help these patients manage healthy living. Incentives are built into the components depending on the level of benefit that employers decide to offer *for* their employees – directly linked to the level of corresponding motivation they want *from* those members. Beyond the tools directly available at its Web site, My Health Manager from Medica provides links and information on all Medica health programs and services.

User demographics, feedback

In 2006, nearly 14,000 members logged on to the site and created a personal profile. More than 68 percent of these members signed up for wellness programs and 97 percent actually earned wellness credits. More than 10,500 members completed a wellness assessment. Based on the assessment, the following risk distribution was identified:

- High risk (4 or more risk factors): 47%
- Moderate risk (2-3 risk factors): 39%
- Low risk (0-1 risk factors): 14%

Most prevalent risk factors	Age range of participants
• Nutrition: 61%	• 18-29: 21%
• Physical activity: 56%	• 30-39: 26%
• Stress: 38%	• 40-49: 27%
	• 50-59: 21%
	• 60+: 5%

Participant surveys from fourth quarter 2006 show:

- 94 percent of participants found the site to be informative or very informative
- 94 percent of participants found the site to be very easy or somewhat easy to use
- 96 percent of participants found the site very helpful or somewhat helpful in developing and maintaining healthy behaviors
- 91 percent of participants are satisfied or very satisfied with the wellness credits program
- 65 percent of participants stated that the wellness credits program helped motivate them to make healthy choices
- 59 percent of participants stated that the links definitely made it easier to use Medica resources
- 96 percent of participants would recommend the site to a friend.

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(My Health Manager, cont.)

Customizing details and furnishing incentives for higher levels of engagement

My Health Manager from Medica is personalized to each member's health situation and interests. The program provides information, interactive tools, encouragement and incentives that help members decide where to start, stay on track and achieve meaningful improvements in their health and well-being. It was implemented by Medica in April 2006 and is available to most commercial members (some self-insured employer groups do not include this program in their benefit package).

My Health Manager from Medica strives to help members adopt healthier lifestyles by providing the right support, encouragement, tools and incentives to keep members motivated. Members are rewarded for healthy behavior by receiving a \$25 gift card to spend with familiar merchants when they earn at least 25 wellness credits per quarter. Wellness credits can be earned by completing various assessments online or participating in the following activities:

- wellness assessment (i.e., health-risk assessment)
- health living programs – six-week interactive online programs
- health challenges – four-week program tracking health activities, such as a walking challenge
- preventive care (e.g., recommendations based on age and gender)
- online seminars – interactive educational programs lasting about 15 minutes
- personal enrichment activities – such as volunteering, spending time with loved ones, etc.
- use of health plan resources and programs – including nurse line, disease management programs, or smoking cessation program
- interest/satisfaction survey – to provide feedback on resources, tools and programs

The more that healthy messages are reinforced, the better the outcome. This is particularly important because 25-30 percent of all medical costs result from unhealthy lifestyles. Physicians and other providers can encourage their patients who are Medica members to use online tools such as My Health Manager from Medica to further facilitate better health and overall well-being for these patients (e.g., so they eat better, exercise more, get sufficient rest, reduce stress, etc.). Furthermore, with the workforce spending a greater number of hours at work, employers want to develop a supportive culture and environment where employees make healthy lifestyle choices, which in turn helps employers mitigate rising health care costs.

Quarterly reports are evaluated for trends in participation and health risks of participants. Medica and employer groups implement program decisions based on utilization trends. For example, wellness credit point values were increased in January 2007 to drive more participation in the wellness assessment, healthy living programs and health challenges.

My Health Manager is available through www.medica.com as a link under “Top Member Resources,” where Medica members can access personalized information on nutrition and exercise, trackers, and other tools.

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For MHCP Enrollees, State Covers Psychiatric Consultations by Primary Care Providers With Specialists

As of October 1, 2006, Minnesota Health Care Programs (MHCP) covers consultations between psychiatrists and primary care providers. For Medica, the coverage is limited to its Medica Choice Care, Medica MinnesotaCare and Medica DUAL Solution[®] products. Only the primary care provider may bill the health plan and patient records are maintained by the primary care provider. Psychiatrists are eligible providers for the service, based on a contract between the primary care clinic and the psychiatrist, which would define how the psychiatrist will be paid.

Claims may be billed to Medica in the same manner they are billed to the Minnesota Department of Human Services (DHS). Here is a link to DHS billing instructions: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137000

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Expanded NRT Pharmacy Benefits Help Medica Members Increase Success Rate to Quit Tobacco Use

In 2007, *all* Medica members now have expanded nicotine-replacement therapy (NRT) benefits. Medica's pharmacy benefits now include NRT inhaler and nasal spray as well as Chantix, the pill recently approved by the U.S. Food and Drug Administration (FDA). These forms of NRT join the patch, gum, lozenge and bupropion/Zyban pill. This expanded pharmacy benefit helps members find the best NRT for them to successfully quit.

According to the Archives of Internal Medicine*, NRT plus quit-tobacco counseling may increase a patient's chance of success six-fold. NRT can greatly increase the chances of quitting smoking. In studies, according to the FDA, 24 percent of people who used Chantix to stop smoking were still smoke-free after one year. That compared to 16 percent who used another popular stop-smoking medication and 10 percent who received a placebo. Using tobacco causes the body to become addicted to nicotine. NRT eases the tobacco cravings and other withdrawal symptoms due to nicotine addiction. Using NRT with stop-smoking counseling increases the likelihood of success even more.

Each person's experience of quitting the tobacco habit is as individual as their health needs. Providers are encouraged to help patients find the best course of NRT for quitting tobacco based on their health status – whether the NRT is pill (Chantix, Zyban), gum, patch, inhaler, lozenge, or a combination of these. Along with addressing NRT needs, providers are requested to also encourage their patients who are Medica members to participate in tobacco-cessation counseling through Free & Clear®, Medica's quit-tobacco program. Free & Clear provides telephonic-based cessation counseling, with individualized plans for increased success with quitting. Medica's quit rate through Free & Clear is 36 percent, compared to 3 percent when quitting alone (according to the Centers for Disease Control and Prevention, 2004).

Providers may refer Medica members to call Medica Customer Service to learn about their NRT benefits and other ways Medica can help them quit smoking. For more information about Free & Clear, providers or members may call 1-866-784-8454 (1-866-QUIT-4-LIFE). Free & Clear is offered as a benefit to all Medica members at no cost to them.

* Swan GE, McAfee T, Curry SJ, et. al, 2003: 163: 2337-2344.

High-Performing Clinics Meet Goal for Advance Directives

An ongoing Medica goal is to encourage members to have a written Advance Directive/Health Care Directive so that their wishes about medical treatment will be carried out if they are unable to communicate their decisions themselves. In accordance with the national Patient Self-Determination Act, health care providers are required to educate patients on issues related to Advance Directives. To that end, Medica encourages providers to offer information and answer questions about Advance Directives with their patients.

During 2006, Medica's Clinical & Service Quality Review program examined the performance of 23 clinic groups (103 sites) for their compliance with documentation about Advance Directives for Medica Medicare members.

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(Advance Directives, cont.)

Three groups stood out prominently and were willing to share the methods they use to obtain their high performance level. Following are their scores and methods used. The aggregate percent as well as the percentages cited below refer to positive answers to the measurement question, “Is there evidence in the medical record that the patient does or does not have an advance directive?” By comparison, the aggregate score of all examined groups was 52 percent.

Camden Physicians achieved 93 percent. The support staff prepares charts for each appointment and uses a form called an “Alert Tool” that lists patient care needs. The chart is reviewed and any tests, exams, or other needs that are due for the patient are checked off. If an Advance Directive is needed, it is added to the front of the chart. The provider updates the patient chart with Advance Directive information. It is also updated on a preventive form found in each chart. A quality committee, made up of physicians and staff, meets every other month to review processes. Training is done at individual clinics with the support of a clinical supervisor. Internal audits are conducted by a staff nurse.

Fairview Clinics achieved 100 percent. Fairview’s initiative began with first obtaining provider and administrative consensus at its monthly Quality and Informatics Committee (QIC) that advance directive information was a priority. Training of staff regarding the initiative was done through Fairview’s QIC subgroups for each care system. Fairview uses the electronic medical record to capture patient advance directive information.

Quello Clinics achieved 100 percent. Included in the clinics’ problem list is a question to identify whether a patient has an advance directive on file. Once an advance directive is received, it is entered in the chart. Everyone caring for the patient is responsible for getting advance directive information. If the information is not in the record, medical records staff follow up with the provider to ensure that the advance directive question is answered.

Providers interested in learning more about the successful methods of these groups may contact Susan Bierschbach, RN, Medica clinical review program manager, at 952-992-3485 or by e-mail at susan.bierschbach@medica.com.

Medical Policy Manual Updated

Medica’s Medical Policy Manual will be updated to reflect new and revised coverage policies and revised Institute for Clinical Systems Improvement (ICSI) guidelines, as indicated below. The ICSI guidelines are currently available while the coverage policies will be effective June 1, 2007, unless otherwise noted.

As of June 1, these documents may be downloaded at www.medica.com in the “Provider Resources” section, under “Medical Policies” (or directly at this link: <http://provider.medica.com/C9/MedicalPolicies/default.aspx>). For printed copies of documents, providers may call Medica’s Provider Literature Request Line.

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(Medical Policy Manual Updates, cont.)

Coverage Policy – New

Name
Amino Acid-Based Elemental Oral Formulas

Coverage Policies – Revised

These versions replace all previous versions.

Name
Breast Ductal Lavage
Cervicography
Tidal Knee Lavage for Osteoarthritis

ICSI Guidelines – Revised

These guidelines are available by visiting www.medica.com in the “Provider Resources” section.

Name
Chronic Obstructive Pulmonary Disease (released February 2007)
Respiratory Illness in Children and Adults (released February 2007) (This guideline replaces: Viral Upper Respiratory Infection [VURI] in Adults and Children, Acute Pharyngitis, Acute Sinusitis in Adults, and Rhinitis.)

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Effective June 1, 2007:

Changes to Medica's Part D Formulary

Medica previously informed providers about the notification process for changes to Medica's Part D formulary. A list of drugs that will either be removed from the formulary or be subject to a change in preferred or tiered cost-sharing status effective June 1, 2007, will be posted online as of June 1, 2007. The list will be available on www.medica.com in the "Provider Resources" section, under "Drug Formulary" then "Medica Medicare Part D Drug Formulary Changes" (or through this Web link: <http://member.medica.com/C17/PartDDrugFormularyChanges/default.aspx>).

Medica will also notify affected Medica members in their monthly statement, referred to as a Medicare Part D Explanation of Benefits (EOB).

Below is a list of the drugs that will have a change in status effective June 1, 2007.

Open Formulary

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug	Alternative Drug Tier
DURAGESIC 12.5mcg	Move drug to higher cost-share tier	Generic available at lower tier	FENTANYL PATCHES	Tier 1
PAXIL SUSPENSION	Move drug to higher cost-share tier	Generic available at lower tier	PAROXETINE SUSPENSION	Tier 1
WELLBUTRIN XL 300MG	Move drug to higher cost-share tier	Generic available at lower tier	BUDEPRION XL TABLETS	Tier 1
ZOFRAN TABS	Move drug to higher cost-share tier	Generic available at lower tier	ONDANSETRON TABLETS	Tier 1
ZOFRAN ODT	Move drug to higher cost-share tier	Generic available at lower tier	ONDANSETRON ODT TABLETS	Tier 1
ZOFRAN INJECTION	Move drug to higher cost-share tier	Generic available at lower tier	ONDANSETRON INJECTION	Tier 1

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(Part D Formulary, cont.)

Closed Formulary

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug	Alternative Drug Tier
DURAGESIC 12.5mcg	Deletion of drug from formulary	Brand Deletion due to new generic availability	FENTANYL PATCHES	Tier 1
PAXIL SUSPENSION	Deletion of drug from formulary	Brand Deletion due to new generic availability	PAROXETINE SUSPENSION	Tier 1
WELLBUTRIN XL 300MG	Deletion of drug from formulary	Brand Deletion due to new generic availability	BUDEPRION XL TABLETS	Tier 1
ZOFRAN TABS	Deletion of drug from formulary	Brand Deletion due to new generic availability	ONDANSETRON TABLETS	Tier 1
ZOFRAN ODT	Deletion of drug from formulary	Brand Deletion due to new generic availability	ONDANSETRON ODT TABLETS	Tier 1
ZOFRAN INJECTION	Deletion of drug from formulary	Brand Deletion due to new generic availability	ONDANSETRON INJECTION	Tier 1

Medica's Medicare Part D formulary is also available online at www.medica.com, by selecting "Drug Formulary" (or through this Web link: <http://member.medica.com/C15/DrugFormulary/default.aspx>). To request a printed copy, providers may call Medica's Provider Literature Request Line.

Medication Request Forms

A medication request form (MRF) should be used when requesting a formulary exception. This form may be obtained by calling MedImpact at 1-800-788-2949, and is also available on www.medica.com, by selecting "Drug Formulary" then "General Medication Request Form", or directly through this Web link: http://member.medica.com/router/default.pdf?doc=/C15/DrugFormulary/Document%20Library/MRF_General.pdf.

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.

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Effective June 1, 2007:

Medica to Update Commercial Metro Standard, Commercial Regional, and SelectCare/LaborCare Standard Fee Schedules

Effective June 1, 2007, Medica will implement its annual metro standard commercial physician fee schedule update for rates applicable to providers in the 11-county Twin Cities metro area. In addition, Medica will implement its annual regional commercial physician fee schedule update for rates applicable to providers outside the 11-county Twin Cities metro area. At this time, Medica will also be implementing an annual overall update for the SelectCare and LaborCare standard fee schedules. All of these updates will include an increase in the overall conversion factors.

Changes related to this fee schedule update are expected to result in an increase in overall reimbursement although, as with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

Various fees for services without an assigned CMS RVU will also be updated according to recent fee information. Examples of these services include labs, supplies/durable medical equipment, injectable drugs, immunizations and oral surgery services. This non-RVU update will also have an impact on physician reimbursement that will vary based on specialty and mix of services provided.

The Medica metro and regional standard fee schedules will continue to be aligned with the Centers for Medicare and Medicaid Services (CMS) reimbursement policies that are related to both mid-level practitioner reimbursement (physician assistants, nurse practitioners, and clinical nurse specialists) and reimbursement when services are provided in a facility-based setting. More specifically, the CMS-based reimbursement differential will continue to be applied when the rendering provider is one of the above mid-level provider types. In addition, the CMS-based facility relative value unit (RVU) differential will continue to be applied to the provider's reimbursement when services rendered by the provider are delivered in a facility-based setting (commonly referred to as the "site-of-service differential"). At this time, these adjustments will not be made to the SelectCare and LaborCare standard fee schedules.

Medica will continue to apply 2006 CMS-based RVU methodology for 2007, where applicable. The CMS Medicare physician RVU file (National/Carrier) is available online at <http://www.cms.hhs.gov>. Providers who have questions are encouraged to call their Medica contract manager.

Effective June 1, 2007:

Medica to Update Wisconsin Commercial, SelectCare/LaborCare Fee Schedules

Effective beginning with June 1, 2007, dates of service, Medica will implement a Wisconsin physician fee schedule update for commercial, SelectCareSM and LaborCare[®] products. This fee schedule update will result in an increase in overall reimbursement. As with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided. Providers who have questions about this fee schedule update are encouraged to contact their Medica contract manager.

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Effective June 1, 2007:

Medica to Update Physician MHCP Fee Schedule

Beginning with June 1, 2007, dates of service, Medica will update its fee schedule for Medica's Minnesota Health Care Programs (MHCP) products — Medica Choice CareSM and Medica MinnesotaCare.

The MHCP fee schedule will be modified to align with the Centers for Medicare and Medicaid Services (CMS) reimbursement policies that are related to mid-level practitioner reimbursement (physician assistants, nurse practitioners, and clinical nurse specialists). A CMS-based reimbursement differential will be applied when the rendering provider is one of the above mid-level provider types. This fee schedule change will result in an overall decrease in reimbursement. The level of reduction by clinic will depend on specialty and the mix of services provided.

Various fees for services without an assigned CMS RVU will also be updated according to recent fee information. Examples of these services include labs, supplies/durable medical equipment, injectable drugs, immunizations and oral surgery services. As with the RVU changes referenced above, this non-RVU update will also have an impact on physician reimbursement that will vary based on specialty and mix of services provided.

In addition, there will be a change to Medica's reimbursement policy for developmental and mental health screenings, two components of a Child and Teen Checkups screening. In the past, only developmental screening tests were separately reimbursed for only specified types of screenings and mental health screenings were not separately reimbursed at all. After May 1, developmental testing may be submitted as a separate charge in additional circumstances as well as mental health screenings. (More information on this topic is included on p. 12). The fees for the applicable range of codes will match the Medica Metro Standard fee schedule reimbursement.

Medica will continue to apply 2006 CMS-based RVU methodology for 2007, where applicable. The CMS Medicare physician RVU file (National/Carrier) is available online at <http://www.cms.hhs.gov>. Providers who have questions are encouraged to call their Medica contract manager.

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

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Effective June 1, 2007:

Medica to Make Billing Changes Related to Developmental Screenings for Its MHCP Enrollees

As part of the fee schedule updates to be effective on June 1, 2007, Medica will institute new billing and payment rules regarding developmental and social-emotional/mental health screening for children and teens enrolled in Minnesota Health Care Programs (MHCP). These screenings are required components of a complete Child and Teen Checkups (C&TC) visit for children from birth to 21 years of age.

As of June 1, medical providers who use standardized screening instruments, either observational or parent report, that are normed for the age of the patient and include an interpretation component, can bill for developmental and social-emotional/mental health screenings as separate services completed during a patient visit. A list of recommended screening instruments can be found at the Minnesota Department of Health (MDH) Web site at <http://www.health.state.mn.us/divs/fh/mch/devscrn/instruments.html>. This list will be maintained and updated periodically by MDH.

To bill for these screenings, CPT code 96110 should be used for a developmental screening completed with a standardized instrument, and code 96110 with modifier UC should be used for a social-emotional/mental health screening completed with a standardized instrument. Both services may be billed, in addition to the office visit code and complete C&TC visit code (S0302), for the same date of service on the same claim. If standardized instruments are not used, surveillance and subjective screening activities should be included in the Evaluation and Management (E/M) code for the visit. Any provider — such as a physician, nurse, nurse practitioner, physician assistant or medical assistant — may perform and bill for these screenings as long as they meet the instrument-specific qualifications for the particular instrument used.

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Provider College Sets Administrative Training Topics for May 2007



The Medica Provider College offers educational sessions on various administrative topics throughout Medica's service area. The following educational sessions are available for all Medica network providers.

Training session topics

"Life of a Claim" (session code: LC)

This class translates the "Life of a Claim" into three components: submission policies, process and output. Participants will review Medica's submission policies for claims, then learn how Medica processes a claim and examine what information is produced when a claim has finished processing. Submission requirements will be identified for both the new CMS-1500 and UB-04 claim forms, including information on the national provider identifier (NPI). Participants will learn about the referral workflow process, provider remittance advices (PRAs), and claim adjustments and appeals. This class will include information for both the existing and new platform used for claims processing.

"Resources for Helping Yourself" (session code: RH)

Medica is continually updating services and resources available to network providers. This training will walk through self-service options available to providers, including resources on www.medica.com and the Provider Service Center VETSS (self-service telephony) phone system. These services and resources can help providers run their offices more efficiently.

Session schedule

Class code	Topic	Date offered	Time	Site	Phone number for directions
LC-F	Life of a Claim	May 3	8-11 am	Best Western The Falls Inn & Suites 925 Western Avenue Fergus Falls, MN 56537	218-739-2211
LC-H	Life of a Claim	May 10	8-11 am	Best Western Hudson House Inn 1616 Crestview Drive Hudson, WI 54016	715-386-2394
LC-S	Life of a Claim	May 17	8-11 am	Best Western	605-336-0650
RH-S	Resources for Helping Yourself	May 17	1-3 pm	Ramkota Hotel 3200 W Maple I-29 Exit 81 Sioux Falls, SD 57107	

The times reflected above allow for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement. Check-in for each class will begin 15 minutes prior to the start time.

Providers may pass along this invitation to others within their organization as well. Space is limited, so providers should sign up as soon as possible.

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Administrative/Operational Information

(Administrative Training, cont.)

Registration

The registration deadline for all classes is one week prior to the class date. To register for the sessions listed, providers may:

- register online at www.medica.com in the “Provider Resources” section under “Provider College” (or through the link <http://provider.medica.com/C13/ProviderCollege/default.aspx>);
- send an e-mail to providercollege@medica.com with the same details as listed on the registration form;
- fill out a registration form and fax it back to Medica at 952-992-3270; or
- call Medica at 952-992-2290 and include the same details as listed on the registration form.

Medica Provider College Registration Form

PLEASE PRINT CLEARLY

Yes, the following providers will be attending a Provider College training session.

Facility/clinic name: _____

Contact person's name: _____ Phone No.: _____

Address _____

City, State, Zip _____

E-mail: _____ Fax: _____

(Include for receipt confirmation)

Registrant name	Class code(s)			
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

- Medica's Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica's Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the “Provider Resources” section.

CMS Announces Contingency Plan Regarding Use of NPIs

Although the May 23, 2007, compliance date for readiness to use national provider identifier (NPI) numbers has been extended by the Centers for Medicare and Medicaid Services (CMS), Medica strongly encourages providers to continue submitting their information to Medica, if they haven't yet done so. The May 23 date had been the Health Insurance Portability and Accountability Act of 1996 (HIPAA) deadline for NPI-readiness. More information is included below about submitting NPI information to Medica.

Medica's NPI-readiness timeline

In May 2007, Medica still plans to accept and process claims with an NPI-only identifier from providers. Providers may still, however, submit their current seven-digit Medica provider number as well if they choose. Once the new NPI capability has been implemented, providers will be able to begin submitting their NPI on all claims, electronic or paper. However, providers should *not* begin using NPIs on transactions until notified that Medica is actually ready to accept NPI numbers. This notification is expected to go out in May.

Providers will also soon be able to use NPI numbers for secure electronic transactions online on www.medica.com. This NPI enhancement is planned for May 2007.

Providers will continue to be notified about NPI developments through *Medica Connections*[®] and Provider Alert e-mails.

NPI submissions still needed

Providers who haven't already submitted their NPI information to Medica are encouraged to do so. Medica can accept and load the initial NPI update information from providers in electronic file, CD or paper formats. Providers who prefer to send NPI update files via secure file transfer (FTP) should contact David Andersen at 952-992-2038, by e-mail at david.andersen@medica.com, or by fax at 952-992-3270 to exchange file address information. Providers who prefer to send NPI update information via CD or paper should mail the information to:

Medica
c/o David Andersen
Mail Route CP345
PO Box 9310
Minneapolis, MN 55440-9310

If providers have questions regarding Medica's readiness for the NPI initiative or they would like to discuss enumeration strategies, they should contact David Andersen at 952-992-2038 or Paige Hinz at 952-992-2988.

Medica to *not* require taxonomy codes

Once Medica starts accepting NPIs, Medica will *not* require taxonomy codes for either facility claims or physician claims. When providers use an NPI number on facility claims — either paper (UB-04) or electronic (837I) — the use of taxonomy codes *will be optional*. The CMS requirement that providers include taxonomy codes along with their NPI number when submitting facility claims was also recently delayed by CMS.

Taxonomy codes, which are maintained by the National Uniform Claim Committee (NUCC), are 10-digit alphanumeric codes used for standardized classification of health care providers. Taxonomy codes allow health care providers (individual, group, or facility) to identify their specialty category. These codes are reported in Form Locator 81 (Code-Code Field) on the new UB-04 claim form. General information regarding taxonomy codes can be found at http://www.wpc-edi.com/taxonomy/more_information.

- Medica's Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica's Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the "Provider Resources" section.

Two Employer Groups to be Exceptions to COB Policy for New Business Platform

(Update to “COB Policy Different for Claims Administered on New Business Platform” article in the April 2007 edition of *Medica Connections*, on p 19.)

Medica’s policy for coordination of benefits (COB) is different for claims processed on the new business platform, where COB is not pursued until a member claim is submitted for more than \$400. However, there are two employer groups that will soon be exempt from this \$400 COB threshold: As of June 2007, both Medica Health Plans (group number 710668) and Frandsen (group number 710724) are expected to be employers excluded from this policy for the new business platform, and therefore COB information will be pursued with the first claim per member for these groups’ employees, without regard to the \$400 claim level.

Medica Bundled Services Policy

Medica’s Bundled Services Policy provides information related to services that are always considered included in the payment for other services. These services may or may not be provided to a member on the same date of service as the primary procedure. Medica’s Bundled Services Policy is based on, but not limited to, the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File, Medica reimbursement policies and community standards.

The Medicare National Physician Fee Schedule file includes information on more than 10,000 physician services related to relative value units (RVUs), payment policy indicators and code status indicators indicating whether the code is in the fee schedule and whether it is separately payable if the service is covered. Medica’s Bundled Services Policy is based on, but not limited to, codes with a status indicator of “B” identified as a bundled code with the following information:

Payment for covered services is always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no separate payment is made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident.

The Bundled Services Policy is located on www.medica.com in the “Provider Resources” section under “Tools and Forms,” then “Reimbursement/Claim Policies” (available directly at this Web page: <http://provider.medica.com/C14/ClaimPolicies/default.aspx>). There are three associated documents:

- a) Medica Medicare Bundled Services Code List
- b) Medica Commercial and Medicaid Bundled Services Code List
- c) Medica Commercial and Medicaid - Status “B” Codes Eligible for Reimbursement

Note: Effective with June 1, 2007, dates of service, a limited number of additional services will no longer be eligible for separate reimbursement and are identified in the documents.

The following link to the CMS National Physician Fee Schedule is included for convenience:
<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1188616&intNumPerPage=10>.

- Medica’s Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica’s Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the “Provider Resources” section.

For High Volume of Claims Adjustments, Providers Should Seek Special Assistance

If providers have more than 15 hospital or 20 physician claims to adjust, they should not send the requests to Medica at the address for paper claims nor send them electronically through the Medica Web site (i.e., on www.medica.com at “Provider Resources” through “Electronic Transactions”). For these high-volume adjustment requests, providers should call the Medica Provider Service Center to be directed to the appropriate area to request special assistance with such claims handling.

Reminder:

Facility Claim Form to Soon be Replaced

The UB-92 will be replaced by the new UB-04 form effective May 23, 2007. While Medica will accept both the UB-92 and UB-04 forms for a short time, eventually the UB-92 will no longer be accepted.

For information on the UB-04 history and requirements, providers may review the Medica-specific guide to completing the UB-04 as well as the UB-04 FAQ posted on www.medica.com under the “Provider Resources” section, under “Tools and Forms”, then “Claims Tools and Forms” in the “Claim Forms” subsection (or at <http://provider.medica.com/C13/ClaimsToolsForms/default.aspx>). Medica will also address UB-04 changes in “Life of a Claim” training sessions in April (for more information on this class, refer to the April 2007 edition of *Medica Connections*, on pp. 17-18, available at this Web page: <http://provider.medica.com/Connections/default.aspx>).

Guidelines for Submitting Inquiries to ‘Coding Questions’ e-Mailbox

The Medica “Coding Questions” mailbox is to be utilized only for Medica claim denials or inquiries, which are noted below. Medica provides many coding and claim resources on www.medica.com, which should be accessed prior to contacting the Medica coding questions mailbox. Coding questions should be researched internally with providers’ own facility/clinic coding departments *prior* to contacting Medica.

Specific information is required when contacting the Medica coding questions mailbox:

- All e-mails must contain a claim number, which is found on the provider remittance advice (PRA) under the member’s name;
- Detailed question, e.g., “We’re not understanding the 059 denial of the two CPT codes submitted on the claim as the services were performed by different providers, within our facility, and have different diagnoses linked to them. Please explain why Medica is denying one of them as included in the primary procedure.”
- Clinic/facility representative’s name, e-mail address, phone number and name of clinic/facility.

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- Medica’s Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica’s Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the “Provider Resources” section.

Administrative/Operational Information

(‘Coding Questions’ Mailbox, cont.)

The following are types of Medica claim denial reasons that may be submitted to coding.questions@medica.com after following the guidelines below.

- 807 reason code denials (unbundled service)
 - Provider must review the current National Correct Coding Initiative (NCCI) manual to verify if bundling is correct or not;
 - If NCCI does not bundle, submit inquiry to Medica, documenting the resources accessed verifying the bundle does not exist. If this documentation is not in the email, it will be returned to the provider requesting it. (**Note:** Medica generally follows NCCI with some enhancements as NCCI was created for Medicare claims).
- 251 reason code denials (Medica Prime Solution® product)
 - Provider is required to review the respective policies the denied codes are associated with;
 - Policy criteria locations –
 - a) Centers for Medicare and Medicaid Services (CMS) website/manuals for national coverage criteria;
 - b) Wisconsin Physicians Service Insurance Corporation (WPS) website/publications for local medical coverage criteria for MN/WI;
 - c) Noridian Administrative Services (NAS) website/publications for local medical coverage criteria for ND/SD;
 - d) TriCenturion website/publications for local durable medical equipment (DME) coverage criteria for MN/WI;
 - e) Electronic Data Systems Corporation (EDS) website/publications for local DME coverage criteria for ND/SD;
 - f) Statistical Analysis DME Regional Carrier (SADMERC) and/or Durable Medical Equipment Coding Systems (DMECS) Web site/publications for DME code assignments.
 - Provider will be required to document the resources accessed by identifying the policy name/number and the applicable section within the policy criteria validating the denial is incorrect. Failure to provide this documentation will result in the e-mail being returned, requesting the information.
- 106 reason code denials (units greater than normal)
 - Provider will need to supply rationale and supporting documentation for the number of units submitted.
- 067 reason code denials (incorrect procedure code)
 - Provider should consult the current CPT or HCPCS manual for appropriate code *prior* to contacting Medica.
- 479 reason code denials (submit with other code for processing)
 - Usually associated with a CPT Category III code. Medica accepts all CPT Category III codes, although processing may depend on a CPT Category I codes being submitted on the same claim in order to process appropriately. Providers should consult current CPT manual for an appropriate code *prior* to contacting Medica.
- 599 reason code denials (DRG ICD9 procedure code error)
- 824 reason code denials (DRG diagnosis code error)
- Unlisted HCPCS codes claim denials
 - Provider should access the Statistical Analysis DME Regional Carrier (SADMERC) and/or Durable Medical Equipment Coding Systems (DMECS) Web site/publications for DME code assignments *prior* to contacting Medica.

(Continued on page 19)

- Medica’s Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica’s Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the “Provider Resources” section.

(‘Coding Questions’ Mailbox, cont.)

- 059 reason denials (service included in primary service)
 - Typically seen when two evaluation and management (E/Ms) provided on same date by same provider group/tax ID#, even if different diagnoses are linked. Prior to contacting Medica, providers may access the reference of the “Same Day Services Policy” reimbursement policy on www.medica.com (available at <http://provider.medica.com/C14/ClaimPolicies/default.aspx>).

Other types of Medica claim denials/inquiries are to be addressed to the Medica Provider Service Center available toll-free at 1-800-458-5512. The Coding department does not negotiate contractual agreements or assign coverage of services. Some examples of these would be:

- Service did not reimburse per contractual agreement. Providers should have access to their own Medica contract.
- Coverage of procedures and other services. This is governed by the member’s certificate of coverage (i.e., benefit package) and policies documented on www.medica.com.
- Completion of claim forms (e.g., UB-04 and CMS-1500).

It is critical to use the most current coding books to ensure accurate claims submission and reimbursement. Medica strongly encourages all providers to own or have onsite access to coding manuals, resources, and reference tools, such as the following.

CPT-4

Current Procedural Terminology, fourth edition (CPT-4), is updated and published annually by the American Medical Association (AMA). This book of codes may be purchased directly from the AMA at 1-800-621-8335 or through a number of other book vendors (e.g., Ingenix, St. Anthony Publishing/Medicode).

CPT Assistant

The *CPT Assistant* newsletter is the official coding resource for CPT. For information on ordering, providers may call the AMA.

ICD-9-CM

International Classification of Diseases, ninth revision, clinical modification (ICD-9-CM) is updated and published annually. It may be purchased directly from the AMA or through a number of other book vendors (e.g., Ingenix, St. Anthony Publishing/Medicode).

Coding Clinic

The *Coding Clinic* bulletin is the official coding resource for ICD-9-CM and may be purchased directly from the American Hospital Association by calling 1-800-261-6246.

HCPCS manual

The Healthcare Common Procedure Coding System (HCPCS) manual is updated and published annually. It’s available by calling Minnesota’s Bookstore toll-free at 1-800-657-3757. It can also be ordered through a number of book vendors (e.g., Ingenix, St. Anthony Publishing/Medicode).

UB-04 claim form

Medica has a guide on www.medica.com (available directly at <http://provider.medica.com/C13/ClaimsTools/Forms/default.aspx>). Further information can be obtained from the National Uniform Billing Committee (NUBC) web site at www.nubc.org or from CMS at <http://www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf>.

- Medica’s Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica’s Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the “Provider Resources” section.

UHC Clarifies Its Appeals Process for Non-Notification Denials

The UnitedHealthcare (UHC) policy requiring notification for emergent and scheduled services by network physicians or other network health care providers includes, but is not limited to, inpatient facility admissions, home health care services, selected potentially cosmetic procedures, and transplant services. UHC notification requirements apply for LaborCare® network providers who see UHC enrollees. For further specific requirements, providers may refer to UHC's administrative guide available at www.unitedhealthcareonline.com.

Non-notification escalation process for appeals

If the provider is unable to resolve a non-notification situation using UHC's usual appeals process, additional steps may be taken.

1. The provider should attempt initial resolution via the standard UHC processes.
2. If unable to resolve through standard processes, then providers may escalate to their Medica escalation contact.
3. Providers need to explain to their Medica escalation contact why the notification was not called in and provide any supporting documentation to support their rationale (in the example of a patient providing incorrect insurance information, it would be helpful to include a screen print showing that the patient was initially set up as self-pay or some other insurance).
4. Medica will then escalate the issue to UHC and within 30 days the Medica contact will update the provider on the status and/or about the final resolution.

Note: Providers *should not* send in patient chart records or medical records with the appeal as the claims are not getting denied for medical necessity and medical records do not assist in the appeal.

UHC simplifies online notification process

UHC has improved the capability to submit inpatient emergency room notifications online, striving to make it faster and easier:

1. log in to www.unitedhealthcareonline.com, and select the Notification Submission link
2. select the appropriate member, facility, and physician information
3. search and select the diagnosis code and description
4. enter the dates of service
5. click on Submit and in seconds, users will receive the service reference number and then may print a copy of the completed notification for their records or check the status of the notification by selecting the Notification Status link

- Medica's Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica's Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the "Provider Resources" section.

UHC Requires EPO HCT Details on Related Physician Claims

Effective April 2, 2007, UnitedHealthcare (UHC) requires the hematocrit (HCT) levels listed on all erythropoietin (EPO) claims submitted on a CMS-1500 form. Claims without HCT levels will be pended and UHC will request the value, which must be submitted using a corrected claim — verbal submissions will not be accepted. This UHC policy applies for LaborCare[®] network providers who see UHC enrollees and is consistent with a new Centers for Medicare and Medicaid Services (CMS) requirement.

Erythropoietin (EPO) is a red-cell enhancing anemia treatment drug. Clinical evidence does not support the use of this drug in individuals with an HCT level greater than 36.

Providers may refer to the September 2006 and January 2007 network bulletins from UHC for more details on claims submissions (both electronic and CMS-1500). The 2007-2008 UHC administrative guide also states the need to include the HCT levels on the CMS -1500 form (both paper and electronic). UHC reference materials are available at www.unitedhealthcareonline.com.

Effective June 1, 2007:

Medica to Update SelectCare/LaborCare Standard, Wisconsin Fee Schedules

Effective June 1, 2007, Medica will implement its annual overall update for the SelectCare and LaborCare standard fee schedules, including the Wisconsin physician fee schedule. Changes related to these fee schedule updates are expected to result in an increase in overall reimbursement, although, as with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

More information about these fee schedule updates is on page 10.

- Medica's Provider Service Center is available toll-free at 1-800-458-5512.
- Provider materials may be requested through Medica's Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512, option 1, then option 5, ext. 2-2355, for those calling from outside the Twin Cities metro area.
- Provider information may be accessed at www.medica.com in the "Provider Resources" section.

General Information

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SelectCareSM and Medica Choice CareSM are service marks of Medica Health Plans.

CPT® is a registered trademark of the American Medical Association.

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Resource Box		
Coding Questions	For coding questions related to Medica claims.	E-mail: coding.questions@medica.com Fax: 952-992-2504 (for providers that do not have e-mail access)
Provider Service Center	Responds to questions from Medica providers.	1-800-458-5512
SelectCare Provider Service	Part of Medica's Provider Service Center. Responds to questions from SelectCare and LaborCare providers.	952-992-2500 or 1-800-858-9060
Provider Literature Request Line	Ordering provider directories, provider communications, referral forms, formularies, administrative manuals, chart stickers, adjustment request forms, late claim appeal forms, practitioner change forms and other <i>printed</i> materials.	952-992-2355 or 1-800-458-5512, option 1, then option 5, ext. 2-2355
World Wide Web	Internet contains important resources such as Medica's Provider Administrative Manual, SelectCare and LaborCare Provider Administrative Manual, medical policies, clinical guidelines, credentialing information, <i>Medica Connections</i> ® bulletins, and the Medica formulary.	www.medica.com in the "Provider Resources" section
Fraud Hotline	Confidential phone line to report suspected fraud.	952-992-2237 or 1-800-821-1331
Overpaid Claims	For issues related to overpaid claims and/or accounts, such as multiple payments or excessive payments made in error.	E-mail: claimsanalysisrec@medica.com Phone: 952-992-3039 or 1-800-458-5512, option 1, option 5, ext. 2-3039

Medica's Physician Leadership:

Charles Fazio, MD, Chief Medical Officer and Senior Vice President

Ken Joslyn, MD, MPH, Medical Director for Quality and Population Health

Paul Karazija, MD, Medical Director for Care Management

Jim Guyn, MD, Medical Director for Provider Relations

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