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November 2009

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# MEDICA<sup>®</sup> Connections

A monthly publication for Medica and SelectCare<sup>SM</sup> network providers



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## General Information

### 2009 'Raising the Bar' innovation award winners recognized

Medica is pleased to announce the winners and finalists for its second-annual "Raising the Bar" innovation awards for providers. Award winners received \$25,000 and an award plaque to recognize their achievement. Finalists also received a plaque.

Beyond planning, implementation and measurement, this year's provider innovation awards required a demonstration of value. With "Raising the Bar: Rewarding Innovation in Healthcare Value," Medica recognized the work of provider organizations undertaking significant changes to improve health while decreasing healthcare costs.

The following groups implemented programs that not only improved patient care and quality of life, but prevented future complications and hospitalization, ultimately reducing costs to the healthcare system.

#### Winners

|   |   |
|---|---|
|   | <p><b>Apple Valley Medical Clinic</b> began a systemic focus on optimal diabetes care two years ago, bringing about more efficient and effective care of this at-risk patient population. By devoting staff and technology resources to this end, it was able to improve its community standing on this measure by 110 percent in its first year of operation---The number of the clinic's diabetic patients "at goal" for optimal diabetes care, as reported to Minnesota Community Measurement, moved up 23 percentage points in one year.</p>  |
|  | <p><b>Family HealthServices Minnesota, P.A.</b>, implemented a system-wide Safety Improvement Initiative across 13 clinics for nearly 400 employees that constantly reminded all of its clinical staff to keep safety in mind. This unique clinic-based model included error reporting, a blame-free culture, and investigation and analysis allowing staff members to learn from mistakes and share best practices. Key areas of focus for reducing medical errors were lab tests, immunizations, and medication labeling. In addition to reducing patient harm, this safety program brought about efficiencies by reducing or preventing repeat lab tests, immunization errors, and unnecessary patient visits.</p> |

#### Finalists



**Wayzata Children's Clinic** launched a program aimed at reducing childhood obesity through improved diet and increased exercise. "Operation Get F.I.T." tackled a difficult problem that often hinges on lifestyle choices, and focused on the most obese children needing the most help: those with a BMI above 85 percent. Over 6-9 months, the clinic was able to achieve an average BMI reduction in program participants. While reducing BMI was a goal, simply slowing the trend of BMI increase was progress for some of these patients who were severely overweight.



**Allina Medical Clinic** implemented a provider-coaching program across 19 clinic sites in which diabetes educators helped provider clinical staffs learn about optimal diabetes care and thereby improve patient outcomes. In one year, this program cut the staff education gap in half through such intervention, resulting in optimal diabetes control that increased by at least 63 percent for staff providers who went through the program as well as better care for 87 percent more patients. This unique quality improvement program meant fewer health complications such as heart attack and stroke, and thus a reduction in related procedures that will be needed in the future.

With its "Raising the Bar" innovation awards, Medica seeks to recognize the work of provider groups---from single-site practices to healthcare systems---that are undergoing unique changes to improve patient care and that have proven results. Medica launched its provider innovation awards in 2008. With the awards, Medica hopes to recognize and highlight the provider community's work in defining healthcare excellence.

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**Billing for the administration of H1N1 flu immunization**

*New codes recently created for H1N1 billing*

The Medica immunization benefit includes the administration of H1N1 flu immunization consistent with a member's coverage document. Therefore, Medica members who have coverage for the seasonal flu immunization are also covered for the H1N1 flu immunization.

**Coding for H1N1 immunizations**

The following new and revised codes are now available to submit to Medica related to H1N1 vaccine and administration. The American Medical Association recently released a new Current Procedural Terminology (CPT®) code for the administration of H1N1 immunization as well as a revised code for H1N1 vaccine. CPT codes effective as of September 29, 2009, are:

- 90470 H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [new code]
- 90663 Influenza virus vaccine, pandemic formulation, H1N1 [revised code]

In addition, Healthcare Common Procedure Coding System (HCPCS) codes effective as of September 1, 2009, are:

- G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family) [new code]

## G9142 Influenza A (H1N1) vaccine, any route of administration [new code]

Clinics should use their regular billing methods for H1N1 flu immunizations. Since the H1N1 vaccine itself will be furnished at no cost to providers, only the vaccine administration will be eligible for payment.

Here are additional coding details related to billing for H1N1 immunizations:

- Diagnosis code V04.81 (Influenza) should be reported for encounters involving vaccinations.
- *Providers submitting claims for the H1N1 vaccine itself using codes 90663 or G9142 should submit a charge of \$0.01 (not \$0) to ensure proper claims processing.*
- Claims for codes 90663 or G9142 will be denied with reason code 022 or FG ("Not eligible charge; do not bill patient").
- If the only purpose of a visit is to administer either the seasonal or H1N1 immunization, evaluation and management codes should not be submitted as both of the administration codes include counseling of the patient.

### More information

Providers may contact the Minnesota Department of Health (MDH) regarding H1N1 vaccine distribution. Details on H1N1 immunization will be posted online as they become available. [Refer to the MDH web page on H1N1.](#)

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### Effective December 1, 2009:

#### Medica to require referrals for homemaking services

Effective with a December 1, 2009, date of service, *Medica will require administrative referrals for homemaking services* for benefit plans that include homemaking services as an eligible covered benefit. Care system care coordinators will need to submit referrals for affected Medica DUAL Solution® and Medica Choice Care<sup>SM</sup> members. These members are in state programs dually funded by Medicare and the State of Minnesota---i.e., enrollees in Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus. This process change will apply for *all* providers that provide homemaking services for these members.

*It is the responsibility of providers to provide services in accordance with each homemaking referral*, which is expected to be obtained prior to the date of service. As of December 1, if providers fail to obtain a referral for homemaking services, related claims will be denied as provider liability and providers may not bill the member for these denied claims. Such claims would be denied with reason code 022 ("Not eligible charge; do not bill patient").

As a reminder, providers should bill for homemaking services using the following Healthcare Common Procedure Coding System (HCPCS) codes:

- S5130 Homemaker Service NOS; Per 15 M
- S5131 Homemaker Service NOS; Per Diem

Providers who have questions may call the Medica Provider Service Center.

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### Effective October 1, 2009:

#### Medica launches North Dakota individual and family products

On October 1, 2009, Medica introduced products for individuals and families to the North Dakota market. The new North Dakota versions of Medica Direct® Health Savings Account (HSA) and Medica Solo<sup>SM</sup> products have been designed to

provide Medica individual and family health plan alternatives to similar health plans offered by other carriers in North Dakota. Benefit highlights for the new Medica Direct HSA and Medica Solo products in North Dakota include the following.

### **Medica Direct HSA**

- Deductible options are: Single plans at \$2,000, \$3,000 and \$4,000 with 80 percent or 100 percent coverage after deductible, and family plans at \$3,500, \$5,000 and \$6,500 with 80 percent or 100 percent coverage after deductible.
- Deductible applies to most eligible services, including prescription drugs.
- An optional \$300 in first-dollar coverage per calendar year is offered for preventive services.
- Maternity coverage has a 10-month wait (except for complications of pregnancy, as mandated by N.D. state law).
- Occupational and speech therapy are limited to 30 consecutive days per condition.
- Day, hour and visit limits apply to mental health and substance abuse services.
- Durable medical equipment has an annual maximum benefit of \$10,000 (except prosthetic limbs) and eligible hearing aids are limited to \$5,000 every three years.

### **Medica Solo**

- Deductible options are \$3,000, \$6,000 or \$9,000 (many eligible services are covered at 100 percent after deductible).
- Coverage is single only (no family or dependent policies).
- Office visit copayments are offered at varying levels (\$30, \$40 or \$50) for the first three visits, as well as a \$100 urgent care copayment and a \$200 ER copayment for the first visit.
- \$200 in first-dollar coverage per calendar year is offered for preventive services.
- Maternity coverage is excluded (except for complications of pregnancy, as mandated by N.D. state law).
- Copayments for office visits, urgent care and ER do not apply toward deductible or out-of-pocket maximum.
- Occupational and speech therapy are limited to 30 consecutive days per condition.
- Day, hour and visit limits apply to mental health and substance abuse services.
- Durable medical equipment has an annual maximum benefit of \$10,000 (except prosthetic limbs) and eligible hearing aids are limited to \$5,000 every three years.
- The following prescription copayments apply: \$10 for formulary generic drugs, \$50 for formulary brand-name drugs, and \$90 for non-formulary drugs.
- There is a \$2,000 annual maximum benefit for prescription drugs.

The new North Dakota versions of Medica Direct HSA and Medica Solo utilize the Medica Choice® provider network and are handled on the same administrative system as the Minnesota versions of these products.

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### **Medica announces new county-based behavioral health product**

As of September 1, 2009, Medica has established a product called the "Wellness Preferred Integrated Network," which is a partnership between Medica Behavioral Health and Dakota County. Medica is the first health plan in Minnesota to implement a mental health-focused product of this kind. Preferred Integrated Network products were developed as an outcome of the Minnesota governor's mental health initiative.

The Medica Wellness Preferred Integrated Network is for people through 64 years of age who have significant mental health concerns, for those with serious and persistent mental illness, or for those who are disabled with mental illness or emotional disturbance. This vulnerable population includes members who are new to managed care. Members are enrolled based on age and disability status into the appropriate benefit set. Through the new product, they receive integrated medical and behavioral health care. All members have a care coordinator, referred to as a "Wellness Navigator," who is a mental health professional working with Dakota County or Medica Behavioral Health. Wellness navigators are responsible for coordinating all Medicare and Medicaid services.

Preferred Integrated Network plans include state program enrollees in Special Needs Basic Care (SNBC) and Prepaid Medical Assistance Program (PMAP) who have the following group numbers: 05060, 05061, 59416, 59417, and 59418.

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### **Effective January 1, 2010:**

#### **Patient Choice sets 2010 Insights tiers**

The Patient Choice business segment of Medica has completed its annual tiering process for the Patient Choice Insights<sup>SM</sup> by Medica network. Letters will be sent this month to participating providers notifying them of their 2010 tier assignment. Providers can also look up their 2010 tier placement through the provider search feature available online to Medica members: [See "Find Physicians and Facilities ."](#)

A small percentage of providers in the network will change tiers for 2010. The new provider tier assignments---which become effective January 1, 2010---are based on the performance of provider organizations on various cost, quality and efficiency measures.

Patient Choice Insights by Medica features an open-access network arranged into three tiers. Depending on the type of services delivered, the tiers can affect member benefits. Generally, the lower (or better) the tier, the lower the member's copayment and/or percentage of coinsurance.

Providers who have any questions about the 2010 tier assignments may call the Medica Provider Service Center.

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## **Clinical Information**

### **New forms facilitate prior authorization request process**

Medica is enhancing its process for providers to request prior authorization for certain services. New prior authorization forms---tailored for certain procedures or clinical services requiring authorization---detail exactly what documentation is required by providers for Medica members seeking these particular services. [See the new forms available at medica.com.](#)

Procedures and services for which these new forms are available include:

- Abdominoplasty/panniculectomy
- CT angiography for detection of coronary artery disease
- Electrical bone growth stimulator
- Female breast reduction
- Gastrointestinal surgery for morbid obesity
- Real-time blood glucose monitoring systems
- Referrals to out-of-network providers
- Ultrasound bone growth stimulator
- Uvulopalatopharyngoplasty (UPPP)

The goal of this change is to streamline the prior authorization process and ultimately reduce the amount of documentation providers must submit to Medica Care Management when requesting authorization for a procedure or treatment. The new forms allow physicians to focus on the criteria that must be met before Medica approves a service requiring prior authorization. This change should simplify the process for providers when requesting prior authorization

for covered services:

1. Providers initiate the prior authorization process as usual.
2. Providers can access the prior authorization forms on [medica.com](http://medica.com) or Medica Care Management can provide hard copies if needed.
3. Providers return the necessary prior authorization form to Medica by fax or e-mail.
4. The clinical information returned by providers is then forwarded to the Medica Care Management clinical review staff for evaluation.

For additional related information, providers may:

- [Refer to the full Medica Prior Authorization List.](#)
- Send an e-mail to the Medica Care Management staff at [caremanagement@medica.com](mailto:caremanagement@medica.com)

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### Provider College posts e-learning on flu resources

The Medica Provider College is offering the following clinical e-learning: "Medica Seasonal Flu and Pneumonia Programs." This self-directed, web-based course gives providers a general overview of seasonal flu and pneumonia resources available from Medica. Upon completion of this course, providers will understand:



- the characteristics of the seasonal influenza virus;
- vaccine distribution guidelines; and
- Medica claims submission requirements for vaccine and administration.

For more information:

- [Access the flu e-learning program on the Events and Training web page under "Clinical Staff Training."](#)
- [Refer to the October 2009 edition of \*Medica Connections\* with details on seasonal flu and pneumonia.](#)
- [See article above on the H1N1 flu.](#)

If providers have any questions, they may send an e-mail to [providercollege@medica.com](mailto:providercollege@medica.com) or call Medica at 952-992-2290.

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### Medical policies and clinical guidelines 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 December 1, 2009, unless otherwise noted.

As of December 1, 2009, these documents will be available online or on hard copy:

- [Download medical policies and clinical guidelines at \[medica.com\]\(http://medica.com\);](#)
- Call the Medica Provider Literature Request Line for printed copies of documents.

#### **UM Policies - New**

| Name | Policy Number |
|------|---------------|
|------|---------------|

Genetic Testing for Cardiac Channelopathies

III-DIA.05

**UM Policies - Revised***These versions replace all previous versions.*

| Name  | Policy Number |
|---|---------------|
| Extended Hours Home Care (Skilled Nursing Services) for Patients with Medically Complex or Medically Fragile Conditions | III-HOM.01    |
| Home Health Care  | III-HOM.02    |
| Inpatient (Hospital) Level of Care  | III-INP.01    |
| Medicaid Home Health Aide   | III-HOM.04    |
| Real-Time Continuous Glucose Monitoring Systems   | III-DEV.16    |
| Recombinant Coagulation Factor VIIa (NovoSeven®) Therapy  | III-DRU.05    |
| Skilled Nursing Facility  | III-INP.03    |

**Medica Clinical Guidelines - Revised***These versions replace all previous versions.*

| Name   | Policy Number |
|--|---------------|
| Preventive Services for Children & Adolescents Enrolled in Medica Choice Care & Medica MinnesotaCare | VI-PRV.01     |

**Coverage Policies - Revised***These versions replace all previous versions.*

| Name  |
|---|
| Auditory Integration Therapy ( <i>administrative update only; effective 10/1/09</i> ) |

[Return to top](#)**Pharmacy Information****Effective October 1, 2009:****Medica updates standard commercial and MHCP formularies**

Medica has reviewed the following products, with their respective formulary status effective October 1, 2009, unless otherwise noted. Unless otherwise indicated, these changes apply to *both* the Medica standard commercial drug formulary and the Medica Choice Care<sup>SM</sup> and Medica MinnesotaCare drug formulary. Medica Choice Care and Medica MinnesotaCare members are enrolled in Minnesota Health Care Programs (MHCP). These changes do *not* apply to the Medica Medicare Part D formulary.

| generic name<br>(Brand name),<br>dosage form | Medica<br>formulary<br>status | Current formulary<br>alternatives | Restrictions<br>and comments | Approved therapeutic<br>indications             |
|--|-------------------------------|-----------------------------------|------------------------------|---|
| febuxostat<br>(Uloric®),<br>tablets          | Remains non-<br>formulary     | allopurinol                       | Step therapy                 | Treatment of elevated serum<br>uric acid levels |

|   |                       |  |                          |  |
|---|-----------------------|--|--------------------------|--|
| calcitriol (Vectical®), ointment                  | Remains non-formulary | Dovonex® cream, calcipotriene solution   | Quantity limits          | Treatment of mild to moderate plaque psoriasis   |
| fesoterodine (Toviaz®), tablets                   | Remains non-formulary | oxybutynin, oxybutynin XL, Detrol®, Detrol LA®   | Quantity limits          | Treatment of symptoms related to overactive bladder  |
| silodosin (Rapaflo®), capsules                    | Remains non-formulary | doxazosin, finasteride, terazosin, Flomax, Uroxatral   | Restricted to males only | Treatment of benign prostatic hyperplasia  |
| voriconazole (Vfend®), tablets, solution          | Added to formulary    | N/A  | Prior authorization      | Treatment of invasive aspergillosis, candidemia, candidiasis of esophagus, and other serious fungal infections |
| mesalamine ER (Apriso®), capsules                 | Remains non-formulary | Asacol®/Asacol HD®, balsalazide, Canasa®, Dipentum®, Entocort EC®, sulfasalazine, sulfasalazine delayed-release  |                          | Treatment of ulcerative colitis  |
| adapalene/benzoyl peroxide (Epiduo®), topical gel | Remains non-formulary | benzoyl peroxide, clindamycin 1%, Differin®, erythromycin topical, Finacea®/Finacea Plus®, metronidazole 0.75%, Retin-A Micro®, sulfacetamide/sulfur tretinoin, Benzacilin®, Duac®/Duac CS®, erythromycin/benzoyl peroxide |                          | Treatment of acne  |
| dexlansoprazole (Kapidex®), capsules              | Remains non-formulary | omeprazole, pantoprazole ( <i>for commercial formulary only</i> ), Prevacid®   | Step therapy             | Treatment of erosive esophagitis and gastroesophageal reflux disease (GERD)                                    |
| bupropion (Aplenzin®), delayed-release tablets    | Remains non-formulary | bupropion, bupropion SR, bupropion XL  |                          | Treatment of major depressive disorder (MDD)   |

|   |                           |   |  |                                      |
|---|---------------------------|---|--|--------------------------------------|
| clindamycin/<br>benzoyl peroxide<br>(Acanya®),<br>topical gel       | Remains non-<br>formulary | benzoyl peroxide,<br>clindamycin 1%,<br>Differin®,<br>erythromycin topical,<br>Finacea®/Finacea<br>Plus®,<br>metronidazole 0.75%,<br>Retin-A Micro®,<br>sulfacetamide/sulfur<br>tretinoin,<br>Benzacilin®,<br>Duac®/Duac CS®,<br>erythromycin/benzoyl<br>peroxide |  | Treatment of acne                    |
| ethinyl estradiol/<br>Levonorgestrel<br>(LoSeasonique®),<br>tablets | Remains non-<br>formulary | generic extended-<br>cycle oral<br>contraceptives   |  | Oral contraceptive                   |
| amoxicillin ER<br>(Moxatag®),<br>tablets                            | Remains non-<br>formulary | amoxicillin   |  | Treatment of bacterial<br>infections |

Medica drug formularies are available online or on paper:

- [View Medica formularies at medica.com under "Pharmacy."](#)
- 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 under "Pharmacy."](#)
- Call MedImpact at 1-800-788-2949.

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### Effective January 1, 2010:

#### Medica makes annual updates to drug formularies for 2010

Medica has reviewed the following products, with their respective formulary status effective January 1, 2010, unless otherwise noted. Unless otherwise indicated, these changes apply to *both* the Medica standard commercial drug formulary and the Medica Choice Care and Medica MinnesotaCare drug formulary. Medica Choice Care and Medica MinnesotaCare members are enrolled in Minnesota Health Care Programs (MHCP). These changes do *not* apply to the Medica Medicare Part D formulary.

**Note:** Changes to Lexapro® and Advicor® apply *only* to the Medica standard commercial drug formulary. Lexapro and Advicor were removed from the Medica Choice Care and Medica MinnesotaCare drug formulary as of December 1, 2008.

| generic name,<br>(Brand name)   | Formulary status<br>as of January 1 | Formulary<br>alternatives  | Approved<br>therapeutic<br>indications  | Detail of change and<br>additional information   |
|---|-------------------------------------|--|---|--|
| peginterferon alfa<br>2b (Pegasys®)   | Formulary                           | N/A  | Treatment of<br>hepatitis C   | Effective January 1, 2010, prior<br>authorization will be required.<br>Members currently using these<br>medications will not be<br>affected.   |
| interferon beta-1a<br>(Rebif®),<br>glatiramer<br>(Copaxone®),<br>interferon beta-1b<br>(Betaseron®),<br>interferon beta-1a<br>(Avonex®) | Formulary                           | N/A  | Treatment of<br>multiple sclerosis  | Effective January 1, 2010, step<br>therapy will be required. A trial<br>of Copaxone and Rebif will be<br>required before receiving<br>Betaseron or Avonex.   |
| sumatriptan,<br>rizatriptan (Maxalt®,<br>Maxalt MLT®)   | Formulary                           | N/A  | Treatment of<br>migraine headache   | Effective January 1, 2010, step<br>therapy will be required. A trial<br>of generic sumatriptan will be<br>required before receiving<br>Maxalt or Maxalt MLT.<br>Members currently receiving<br>Maxalt or Maxalt MLT will not<br>be affected. |
| adalimumab<br>(Humira®),<br>etanercept<br>(Enbrel®),<br>certolizumab<br>(Cimzia®),<br>alefacept<br>(Kineret®)                           | Formulary                           | N/A  | Treatment of auto-<br>immune diseases<br>including rheumatoid<br>arthritis, psoriasis,<br>and Crohn's disease | Effective January 1, 2010, prior<br>authorization will be required.<br>Members currently using these<br>medications will not be<br>affected.   |
| niacin/lovastatin<br>(Advicor)  | Non-formulary                       | lovastatin,<br>pravastatin,<br>simvastatin,<br>Crestor®,<br>Niaspan® | Treatment of<br>elevated cholesterol  | Effective January 1, 2010,<br>Advicor will be removed from<br>the <i>standard commercial</i> drug<br>formulary (it was previously<br>removed from the MHCP<br>formulary).  |
| albuterol HFA<br>(Ventolin HFA®)  | Non-formulary                       | Proair HFA®  | Treatment of acute<br>episodes of asthma  | Effective January 1, 2010,<br>Ventolin HFA will be removed<br>from the drug formulary.   |

|  |               |   |  |   |
|--|---------------|---|--|---|
| escitalopram (Lexapro)                                   | Non-formulary | citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline | Treatment of depression                          | Effective January 1, 2010, Lexapro will be removed from the <i>standard commercial</i> drug formulary (it was previously removed from the MHCP formulary). Members currently using Lexapro will not be affected, although copayments for some of these members will change after March 31, 2010. Step therapy continues to apply. |
| Lifescan/One Touch® blood glucose meters and test strips | Non-formulary | Accu-Chek, Bayer  | Used for testing and monitoring of blood glucose | Effective January 1, 2010, Lifescan/One Touch blood glucose meters and test strips will be removed from the drug formulary. Step therapy will also be implemented as of January 1, so members will be required to try <i>both</i> Accu-Chek and Bayer meters and strips.  |

Medica drug formularies are available online or on paper:

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- 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 under "Pharmacy."](#)
- Call MedImpact at 1-800-788-2949.

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**Medica posts new formulary exception form online**

*To be used for general Medica formulary exception requests*

The new formulary exception request form required for all Minnesota-based providers is now available online at medica.com. The "Minnesota Uniform Formulary Exception Form" is intended to make it easier for providers in requesting formulary exceptions from any Minnesota health plan, using a single form for all such requests rather than multiple formats for multiple payers. [See the new uniform formulary exception form.](#)

**Note:** This form is to be used for *all* Medica network providers, even those *not* based in Minnesota.

While this new form replaces the previous Medica Medication Request Form, it continues to be used for the same purpose: to allow providers to request exceptions for products not on the Medica drug formularies. Such requests continue to go to Medica via MedImpact Healthcare Systems, which manages Medica pharmacy benefits. MedImpact information is already entered on the form for Medica-specific requests.

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## Network Information

### Second-quarter PCR checks to be mailed in October 2009

By the end of October 2009, Medica plans to mail to eligible providers the physician contingency reserve (PCR) payment for the second quarter of 2009 for fully insured Medica products. This represents a 100-percent return of the second-quarter 2009 PCR withhold, plus interest. Checks will cover PCR withheld for claims with dates of service of April 1, 2009, through June 30, 2009, and dates paid of April 1, 2009, through September 30, 2009.

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## Administrative Information

### Provider College administrative training topics for November

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

"Vision and Eyewear Benefits" (session code: EC)

This seminar provides an overview of how Medica covers vision and eyewear benefits for its various products. Anyone can attend this session, but it is specifically designed for administrators and administrative staffs working in an ophthalmology or optometry office.

"Medica State Government Programs" (session code: Gov)

This training is designed for providers who need in-depth information on Medica state government products, Medica Choice Care<sup>SM</sup> and Medica MinnesotaCare. Medica will walk providers through various designs and administrative requirements and will assist providers in identifying the various requirements of these products.

"Medica Medicare Products" (session code: MC)

This course will provide information on Medica Medicare products including Medica Prime Solution<sup>®</sup>, Medica Advantage Solution<sup>SM</sup>, Medica DUAL Solution<sup>®</sup>, Medica Complete Solution<sup>®</sup>, Medica AccessAbility Solution<sup>®</sup>, and Medica Select Solution<sup>®</sup>. Topics include the various product designs and structures, provider networks, referrals, and prior authorization requirements. This course will assist providers in identification of a patient's product and any requirements associated with that product.

#### Session schedule

| Class code | Topic                            | Date offered | Time       | Site  | Phone number for directions |
|------------|----------------------------------|--------------|------------|---|-----------------------------|
| Gov-St     | Medica State Government Products | Nov. 5       | 8-10 am    | Radisson Hotel<br>404 W. St. Germain St.<br>St. Cloud, MN 56301 | (320) 654-1661              |
| MC-St      | Medica Medicare Products         | Nov. 5       | 10 am-noon |   |                             |
| EC-St      | Vision and Eyewear Benefits      | Nov. 5       | 1-3 pm     |   |                             |

|       |                                  |         |            |  |                |
|-------|----------------------------------|---------|------------|--|----------------|
| Gov-M | Medica State Government Products | Nov. 9  | 8-10 am    | Medica offices<br>401 Carlson Pkwy<br>Minnetonka, MN 55305 | (952) 992-2900 |
| MC-M  | Medica Medicare Products         | Nov. 9  | 10 am-noon |  |                |
| EC-M  | Vision and Eyewear Benefits      | Nov. 9  | 1-3 pm     |  |                |
| Gov-O | Medica State Government Products | Nov. 17 | 8-10 am    | Hilton Garden Inn<br>420 Inwood Ave.<br>Oakdale, MN 55128  | (651) 735-4100 |
| MC-O  | Medica Medicare Products         | Nov. 17 | 10 am-noon |  |                |
| EC-O  | Vision and Eyewear Benefits      | Nov. 17 | 1-3 pm     |  |                |

*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.

### 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 Events and Training](#);
- [Download a registration form](#). Fax a completed form to Medica at 952-992-3270;
- Send an e-mail with the same details as listed on the registration form to [providercollege@medica.com](mailto:providercollege@medica.com);
- Call Medica at 952-992-2290 and include the same details as listed on the registration form.

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### Instructions for billing multiple units and repeat services

The following information updates and clarifies previously published details from Medica about coding standards that apply for billing multiple units and repeat services. These guidelines apply for all electronic claims submission.

- The guidelines for reporting "units" of a service are based on code descriptions.
- If the code *does not* contain a measurement such as "per" or "each" in the description of the code, providers should report one unit for all services.
- If a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code description *does not* contain "per" or "each," and multiples of that service are provided, providers should bill the code with the appropriate repeat service modifier on *separate lines*.
  - The 76 modifier is used for repeat services.
  - The 91 modifier is used for clinical diagnostic laboratory tests.
- If the CPT or HCPCS code description contains "per" or "each" or another unit of measurement, and multiple services are provided, providers should bill the code on *one line* with the appropriate number of units.
- Codes billed on a single line with multiple units will be paid up to the maximum allowed per day.
- Drugs are billed in multiples of the dosage specified in the HCPCS code long descriptor. If the drug dose is not a multiple of the HCPCS code dosage descriptor, providers should round up to the next highest unit based on the HCPCS long descriptor for the code in order to report the dose provided.
  - If the full dosage of the drug provided *is less than* the dosage for the HCPCS code descriptor specifying the minimum dosage for the drug, providers would report *one unit* of the HCPCS code for the minimum dosage amount.
  - Home infusion providers should bill according to their Medica agreement.

**Note:** Although the above guidelines for units billing are required for Minnesota-based providers as an outcome of the Minnesota Administrative Uniformity Committee (AUC), Medica recommends that *all* network providers use these guidelines for optimal claims processing, resulting in the most efficient turnaround time on related claims submitted to Medica.

The AUC is in the process of developing a best-practices document for units billing to outline consistent billing rules for Minnesota providers. [See more details from the AUC \(in August 25 meeting materials\).](#)

For more information on billing of drugs and biologicals, providers can [refer to the Medicare Claims Processing Manual \(in Chapter 17: Payment Rules for Drugs and Biologicals\).](#)

(Update to "HIPAA coding standards to apply for billing multiple units" article in June 2009 edition of *Medica Connections*. [View June 2009 edition.](#))

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### **Effective by December 15, 2009:**

#### **Payment-posting enhancements to align with new standards**

To conform with guidelines of the Minnesota Administrative Uniformity Committee (AUC), Medica is making several changes to electronic payments involving the Health Insurance Portability and Accountability Act (HIPAA) 835 transaction, to be effective by December 15, 2009. This will allow for a unified transaction experience to simplify provider auto-posting of payments using the 835 transaction. Such updates should also enable quicker posting of payments from Medica.

As a result of the enhancements, Medica will meet the 835 transaction requirements of the Minnesota AUC when reporting payment-related details to providers involving overpayment recovery, manual refunds, and claim adjustments.

Changes having an impact on the majority of claims payments to Medica network providers will include the following.

#### **Authorized return reporting**

When a refund check is received, it is reported in the 835 transaction in the authorized return (PLB 72). An overpayment recovery (PLB WO) will be reported in addition to offset the PLB 72 and balance the payment advice. A reversal and corrected claim will not be reported in the payment advice.

Currently, in some instances corrected and reversal claims are reported and in others just the reversal claim was reported in the payment advice. In either situation, the PLB 72 is reported in the same payment advice but is not being offset with another PLB adjustment.

#### **Underpayment reporting**

When a prior claim has been underpaid, a corrected claim showing the correct processing of the claim and a reversal claim showing the total reversal of the original claim will be reported in the payment advice.

Currently, in some instances corrected and reversal claims are reported and in others just the corrected claim showing the additional payment is reported in the payment advice.

#### **Historical claim adjustment reporting**

An historical claim adjustment is one where claim data have been corrected but there is no impact to prior payment. When this occurs, a reversal of the original claim and corrected claim will be reported in the payment advice.

Currently, in some instances corrected and reversal claims are reported and in others just the reversal claim is reported in the payment advice.

**Overpayment recovery reporting**

When sufficient funds are available in a current payment advice, a reversal to the original claim and a corrected claim are reported in the payment advice.

Currently, in some instances corrected and reversal claims are reported, and in others just the reversal claim is reported in the payment advice.

**Lost or re-issued check reporting**

When a check is reissued, the original check payment amount will be returned as part of the lost or re-issued check reporting (PLB CS). The reference ID for the PLB CS will be the original check number. No claim data from the original transaction are reported in the payment advice.

Currently, when re-issuing a payment, the amount of the check is reported in the PLB 72. A reversal of the original claim and a corrected claim are reported in the payment advice (i.e., the electronic provider remittance advice, or EPRA).

**Payer check returned by provider reporting**

A payer check returned by the provider will be voided from the claim payment system. The amount of the voided check will be reported in the PLB 72, with the PLB 72 being offset with a PLB WO. A reversal claim will not be reported. The PLB 72 and PLB WO reference ID will be the voided (original) check number.

Currently, when voiding a payer check returned by the provider, the amount of the check is reported in the PLB 72. A reversal of the original claim is reported in the payment advice.

[See more on claim payment electronic transactions from the AUC.](#)

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**Medicare diagnosis-verification process continues**

*Next phase has deadline of January 2010*

Medica is contracted with the Centers for Medicare and Medicaid Services (CMS) to offer coverage plans to Medicare beneficiaries. CMS requires Medicare plans to submit and validate diagnosis codes provided by physicians and other healthcare professionals that are used to assess illness severity. For Medica, this requirement applies to its population enrolled in Medica DUAL Solution®, Medica Advantage Solution<sup>SM</sup>, Medica Complete Solution®, and Medica AccessAbility Solution® products. In an effort to continue to provide CMS with the most accurate data, validate the data, and remain in compliance, Medica implemented a process to validate the diagnoses submitted to CMS as well as assist providers with comprehensive diagnosis-coding practices.

To this end, Medica continues with its diagnosis-verification process for affected Medica Medicare members. This process uses chart reviews and is driven by data submission dates from CMS. Below are upcoming CMS submission deadlines and estimated chart review dates. Medica has recently begun its final review for calendar year 2008, with a submission deadline of January 31, 2010. After January 2010, CMS will no longer accept submissions for 2008 data.

| Dates of service to be reviewed | Chart review timeline       | CMS submission deadline | Current status |
|---------------------------------|-----------------------------|-------------------------|----------------|
| 1/1/07 - 12/31/07               | March 2008 - January 2009   | 1/31/2009               | Completed      |
| 1/1/08 - 12/31/08               | January 2009 - March 2009   | 3/6/2009                | Completed      |
| 7/1/08 - 6/30/09                | June 2009 - September 2009  | 9/4/2009                | Completed      |
| 1/1/08 - 12/31/08               | October 2009 - January 2010 | 1/31/2010               | In progress    |

To assist with this project, Medica has forged a new partnership with Outcomes Health Information Solutions to conduct the review of patient charts on Medica's behalf. Outcomes contracted with Medica as a Business Associate which is covered by the Health Insurance Portability and Accountability Act (HIPAA). Outcomes is ethically and legally bound to protect the confidentiality of any protected health information (PHI) it gathers from clinical records provided by the hospital or medical practice.

Medica appreciates the significant involvement and ongoing cooperation of provider offices with this CMS-driven compliance project. Medica, with the support and cooperation of providers, has successfully completed reviews of dates of service in calendar years 2008 and 2009 for the January, March, and September 2009 submissions to CMS.

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### **Effective October 1, 2009: Medica implements 2010 MS-DRG changes**

The Centers for Medicare and Medicaid Services (CMS) published the fiscal year 2010 Medicare Severity (MS) diagnosis-related group (DRG) changes in the August 27, 2009, edition of the *Federal Register*. [See the final IPPS rule for FY 2010.](#)

As of October 1, 2009, Medica has updated its claim processing system with 2010 MS-DRG changes. Medica claims will be processed in accordance with these changes for discharges on or after October 1, 2009, which is consistent with CMS.

**Note:** *No action is required by providers.* Providers will *not* need to submit claim adjustments as a result of the 2010 DRG update.

Providers who have any questions about this are encouraged to discuss it with their contract manager.

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## **PPO Information**

### **Provider College posts e-learning for PPO products**

The Medica Provider College is offering an e-learning on the following administrative topic: "SelectCare/LaborCare Life of a Claim." This self-directed, web-based course gives providers an overview of Medica SelectCare<sup>SM</sup> and LaborCare<sup>®</sup> products and their claims payment process.



[Access this e-learning on the Events and Training web page under "Business Office Staff Training"](#)

Providers with questions may send an e-mail to [providercollege@medica.com](mailto:providercollege@medica.com) or call Medica at 952-992-2290.

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### **UHC coverage related to H1N1 flu immunization**

UnitedHealthcare is providing coverage for the administration of the H1N1 (swine flu) vaccine for all members covered by UHC-insured plans. This information applies for LaborCare providers. [See more details on this from UHC.](#)

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## Aetna coverage related to H1N1 flu immunization

Aetna is covering administration of the H1N1 flu vaccine for all fully insured medical plan members and self-funded plan members unless a plan sponsor decides otherwise. This information applies for SelectCare providers. [See more details on this from Aetna.](#)

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