MEDICA®

July 2019

MEDICA CONNECTIONS®

For Medica network providers



# GENERAL NEWS

Reminder:

## Annual Premium Designation notifications mailing in late June

*(This applies to Medica direct-contracted providers only.)*

The annual mailing for the 2019 Premium Designation program is due out to Medica network physicians soon. UnitedHealthcare (UHC) plans to send this year's notice by late June, notifying physicians of their latest Premium evaluation, program changes for this year, and registration instructions to view designation details.

As usual, provider offices are able to request a change to designation results prior to public display. To do so, they need to submit a reconsideration request for their 2019 Premium designation *by July 28, 2019*. Then the new Premium designations will be displayed online later this year, tentatively planned for late August 2019. See more about the 2019 program at **UnitedHealthPremium.UHC.com**.

(Update to "Upcoming timeline, changes for 2019 Premium Designation program" article in the **April 2019 edition** of *Medica Connections*.)

Medica's focus on opioids:

## Tips for improving opioid prescribing practices

"Medica is a leader and partner in addressing the opioid epidemic, forming collaborations with pharmacies, providers and members," said Stacy Ballard, MD, MBA, senior medical director at Medica. "We know that providers desire to have the safest opioid-prescribing practice. We wish to be a resource as you seek alternatives to pain medication and aim to taper your patients' opioid use."

One way Medica can help is by promoting clinical resources for practitioners who prescribe pain medication. This month's featured resource:

- **Sample patient agreement forms**. For use with patients on opioid analgesics or other controlled

substances, these forms contain statements to help ensure that such patients understand their role and responsibilities regarding their treatment — such as how to obtain refills, and conditions of medication use — and the conditions under which their treatment may be terminated. These “patient contracts” can help facilitate communication between patients and their providers, helping to resolve any questions or concerns about treatment with a controlled substance.

An estimated 2 million Americans abuse prescription narcotics or are dependent on them. More than 150 die each day due to opioid overdose, according to the National Institute on Drug Abuse.

# CLINICAL NEWS

Effective August 19, 2019:

## Medical policies and clinical guidelines to be updated

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective August 19, 2019, unless otherwise noted.

These policies apply to all Medica products including commercial, government, and individual and family plan (IFB) products unless other requirements apply due to state or federal mandated coverage, for example, or coverage criteria from the Centers for Medicare and Medicaid Services (CMS).

Monthly update notifications for Medica’s policies are available on an ongoing basis. **Update notifications are posted on medica.com** prior to their effective date. The medical policy update notification for changes effective August 19, 2019, is already posted. Changes to policies are effective as of that date unless otherwise noted.

The medical policies themselves will be available online or as a hard copy:

- **View medical policies and clinical guidelines at medica.com** as of their effective date; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1-800-458-5512, option 1, then option 8, ext. 2-2355.

**Note:** The next policy update notification will be posted in July 2019 for policies that will be changing effective September 16, 2019. These upcoming policy changes will be effective as of that September date unless otherwise noted.

Quality programs:

## Reducing MSHO, SNBC enrollees’ opioid abuse, addiction

*(This applies to Medica direct-contracted providers only.)*

Since January 1, 2018, Medica has been conducting a three-year project to reduce chronic opioid use in its Minnesota Senior Health Options (MSHO) and Special Needs BasicCare (SNBC) populations. The focus is to decrease the rate and number of MSHO and SNBC enrollees that are new chronic users of opioid pain relievers—specifically, to decrease the number of MSHO and SNBC members who reach a 45-day threshold. The Minnesota Department of Human Services (DHS) has identified 45 days of opioid use as a critical timeline for patients who are prescribed opioids, as continued use beyond 45 days can result in chronic use or addiction. DHS also developed “New Chronic User” as a clinical outcome measure to support quality improvement efforts in preventing chronic opioid use.

Medica’s three-year opioid project focusing on MSHO and SNBC is part of a broader collaboration of Minnesota managed care organizations that provide Special Needs Plans in Minnesota. This group includes Blue Plus, HealthPartners, Hennepin Healthcare, South Country Health Alliance and UCare. Stratis Health also provides project development support and assistance for this project.

As part of this Special Needs Plans collaboration, Medica interventions include:

- *Enhanced Safety and Monitoring Program:* Medica offers an Enhanced Safety and Monitoring Program for all Medicare Part D plans including MSHO through its pharmacy benefit manager (PBM). CVS Caremark has a claims review system in place to identify potential high-risk or inappropriate use of medications such as multiple prescribers or pharmacies; multiple or high-dosage opioids prescribed; and high-risk medication combinations.
- *High-Volume Opioid Provider Clinical Review:* Medica's Quality Improvement team conducts targeted and as-needed clinical quality reviews of high-volume opioid prescribers in the Medica network. Centers for Disease Control and Prevention (CDC) guidelines are used in this review program.
- *Medication Disposal Education:* Medica is active in educating members about where to safely dispose of medicine **using Medica's website**.
- *Care Coordinator Education:* Medica members enrolled in a Special Needs Plan each have an assigned care coordinator who works to coordinate access and person-centered delivery of all preventive, primary, specialty, acute, post-acute and long-term-care services among different health and social service professionals and across settings of care. Care coordinators are educated and trained to know what steps they can take if they are concerned about a member's use of opioids.

The Managed Care Organization Opioid Performance Improvement Project Collaborative works together to promote provider education, consistent messaging for community outreach, and care coordinator education. This group has developed an Opioid Prescribers Toolkit containing tools, trainings and resources for clinics and pharmacies related to opioid prescribing. **See the toolkit.**

Limiting initial use of opioids to prevent chronic use and addiction has become a growing national concern and a focus of efforts across health and human services organizations, health plans and health care providers on a national, state and local level. The MSHO and SNBC populations are very complex, often with multiple comorbid medical and behavioral conditions, combined with often-challenging psychosocial situations. These factors can lead to these members being more vulnerable to medication abuse and at high risk for chronic opioid use.

Annual reminder:

## Reviewing medical records for proper diagnosis codes

### *Outreach needed for risk-adjustment data validation*

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

Each year, Medica undertakes a review of medical records to evaluate risk adjustment of patients based on data validation ("RADv"). The Centers for Medicare and Medicaid Services (CMS) requires that health plans validate the ICD-10 diagnosis codes that are submitted for payment, through claims, by conducting a medical record review for documentation that supports these codes.

This retrospective medical record review applies to claims for Medica's Medicare, commercial, and individual and family business (IFB) members. It ensures that ICD-10 codes are reported accurately for payment integrity and accuracy. It also helps health plans like Medica avoid payment "take-backs" from CMS, as well as fines.

As a result of the CMS requirement, Medica reaches out to provider offices to request this review of medical records. Providers have options for different ways to submit their medical records to Medica (options vary depending on the audit). As required by CMS, ICD-10 codes reported on claims must be supported with clear documentation in the medical records, including an evaluation or assessment, treatment plan, and progress note from an in-person appointment (including telemedicine visits) with an acceptable health care provider.

There are two timelines each year for these CMS-required risk-adjustment record reviews:

- Medica's *Medicare* medical record review is currently in progress and concludes in August. The current audit is focused on 2013 dates of service.
- Medica's *commercial/IFB* chart review runs from June 2019-January 2020 this year. This audit is focused on 2018 dates of service.

Medica notifies provider offices when the records are needed, and appreciates providers' prompt assistance in response to these data requests.

**Note:** Medica has additional chart-review periods during the year that are *not* RADv-driven. For instance, Medica has also just begun conducting its annual Medicare chart review separate from RADv audits. The annual Medicare chart review, administered

for Medica by Optum and CiOX Health, ensures that Medica's data submissions to CMS are complete and accurate. This year's review focuses on 2018 dates of service.

### Due by July 15, 2019:

## Quality complaint reports required by State of Minnesota

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

Medica requires its Minnesota-based network providers to submit second-quarter 2019 quality-of-care complaint reports to Medica by July 15, 2019. *The State of Minnesota requires that providers report quality complaints received at the clinic to the enrollee's health plan*. All Minnesota-based providers should submit a quarterly report form, even if no Medica members filed quality complaints in the quarter (in which case, providers should note "No complaints in quarter" on the form).

Providers can send reports by e-mail to **QualityComplaints@medica.com**, by fax to 952-992-3880 or by mail to:

Medica Quality Improvement
Mail Route CP405
PO Box 9310
Minneapolis, MN 55440-9310

Report forms are available by:

- **Downloading from medica.com**, or
- Calling the Medica Provider Literature Request Line, to obtain paper copies.

**Note:** Providers submitting a report for multiple clinics should list all the clinics included in the report.

Providers who have questions about the complaint reporting process may:

- **Refer to further reporting details online**, or
- Call the Medica Provider Service Center at 1-800-458-5512.

# PHARMACY NEWS

### Effective August 15, 2019:

## Medica to add new UM policies for medical pharmacy drugs

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

Medica will soon implement the following new medical pharmacy drug utilization management (UM) policies. These changes will be effective with August 15, 2019, dates of service. Medica implements such policies as soon as possible after conducting a clinical review of these new-to-market drugs and approving them for coverage with UM policies. Prior authorization will be required for the corresponding medical pharmacy drug.

**Medical pharmacy drug UM policies — New**
*Prior authorization will be required.*

| Drug code | Drug brand name | Drug generic name |
|---|---|---|
| J3590 | Evenity | romosozumab-aqqg |

| | | |
|---|---|---|
| J9356 | Herceptin Hylecta | trastuzumab/hyaluronidase-oysk |
| Q5113 | Herzuma | trastuzumab-pkrb |
| Q5107 | Mvasi | bevacizumab-awwb |
| Q5114 | Ogivri | trastuzumab-dkst |
| Q5112 | Ontruzant | trastuzumab-dttb |
| J9999 | Trazimera | trastuzumab-qyyp |
| Q5115 | Truxima | rituximab-abbs |

These policies will apply to Medica commercial, individual and family plan (IFB), Minnesota Health Care Programs (MHCP) and Medica Health Plan Solutions℠ members and to Medica Medicare members in Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO), Medica Advantage Solution® (HMO-POS) and Medica Advantage Solution (PPO) plans. They will *not* apply to Medica Prime Solution® (Medicare Cost) or Mayo Medical Plan members. The drugs will be subject to pre-payment claims edit policies as well.

The new medical pharmacy drug UM policies above will be available online or on hard copy:

- **View drug management policies** as of August 15; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

### Effective September 1, 2019:

## Upcoming changes to Medica Part D drug formularies

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

Medica posts changes to its Part D drug formularies on medica.com 60 days prior to the effective date of change. The latest lists will notify Medicare enrollees of drugs that will either be removed from the Medica Part D formulary or be subject to a change in preferred or tiered cost-sharing status effective September 1, 2019. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of July 1, 2019, **view the latest Medicare Part D drug formulary changes**.

Medica periodically makes changes to its Medicare Part D formularies: the Medica Prime Solution® Part D closed formulary (4-tier + specialty tier) and the Medica Combined List of Covered Drugs for Medicare and Minnesota Health Care Programs. The Medica Medicare Part D drug formularies are available online or on paper:

- **View Medica formularies**.
- Download formularies for free at **epocrates.com**.
- Call the Medica Provider Literature Request Line for printed copies of documents.

**Medication request forms**
A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less

likelihood of Medica needing to request more information. To request formulary exceptions, providers can submit an exception form or call CVS Caremark.

# NETWORK NEWS

Effective September 1, 2019:

## Medica to update ancillary fee schedule for all products

*(This applies to Medica direct-contracted providers only.)*

Effective September 1, 2019, Medica will implement standard ancillary fee schedule updates for all Medica products. This fee update will have an impact on the following provider types: durable medical equipment (DME), home health care, home infusion therapy, public health, skilled nursing facility (SNF) and transportation.

The effect on reimbursement due to this fee schedule update will vary by provider type and the mix of products or services provided. Providers who have questions or would like a copy of their updated fee schedule may contact their Medica contract manager.

# ADMINISTRATIVE NEWS

## Provider College administrative training topic for July

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

The Medica Provider College offers educational sessions on various administrative topics. The following class is available by webinar for all Medica network providers, at no charge.

**Training class topics**
*"Elderly Waiver Providers"*
Elderly waiver (EW) providers serve an important function in the care of Medica members. The services these providers offer promote community living and independence while giving people the support they need. Working with a health plan can offer a variety of challenges, particularly for EW providers, and this training will walk providers through the requirements as well as the tools and services available to assist. This class will include: getting set up as an EW provider; the role of a care coordinator; obtaining an authorization; the claims submission process; the role of Medica's Provider Service Center; and what to do if a claim does not process as expected.

**Class schedule**

| Topic | Date | Time |
|---|---|---|
| Elderly Waiver Providers | July 9 | 10-11:30 a.m. |

For webinar trainings, login information and class materials are e-mailed close to the class date. To ensure that training materials are received prior to a class, providers should sign up as soon as possible.

The time reflected above allows for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement.

**Registration**
The registration deadline is one week prior to the class date. **Register online for the session above**.

Reminder:

## Up-to-date demographics help members find providers

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

It is important that patients and members have access to accurate, up-to-date information when seeking care in their provider network. To ensure that members have the best experience possible when looking for care, health plans need providers' help to ensure provider details and clinic locations are up-to-date. Information in Medica's provider directories can be reviewed and edited through the secure **provider demographic-update online tool (PDOT)**.

Directory information to regularly review and keep current includes:

- Office locations where members can be seen for appointments
- Provider names and credentials
- Specialties
- Location names
- Addresses, including suite numbers
- Phone numbers
- Clinic hours
- Practitioner status for accepting new patients
- Clinic services available
- Cultural competency training
- ADA-compliant
- Website URL (optional)

As Medica has previously published, providers need to regularly update their demographic data based on Centers for Medicare and Medicaid Services (CMS) rules. These rules require that provider directories be accurate and updated regularly. As a result, providers need to update their practitioner and site-level demographic data, such as the items listed above, in Medica's directories *as soon as they know of a change* to that data, and to regularly review demographic information for accuracy. **See more about this**.

**Note:** Providers who are part of a *leased* network that contracts with Medica, such as a preferred provider organization (PPO), should work with their network's administrative office to update demographics with Medica, rather than make updates individually using Medica's PDOT tool. Doing so could override corrected data.

## Updates to Medica Provider Administrative Manual

*(This applies to Medica leased-network providers as well as direct-contracted providers.)*

To ensure that providers receive information in a timely manner, changes are often announced in *Medica Connections* that are not yet reflected in the Medica Provider Administrative Manual. Every effort is made to keep the manual as current as possible. The table below highlights updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

| Information updated | Location in manual | When posted |
| --- | --- | --- |

| Added clarification that for time-based codes on claims, the amount of time spent must be documented for a claim to be eligible for payment | "Billing and Reimbursement" section, in "Reimbursement Policies" subsection | June 2019 |
|---|---|---|

For the current version, providers may **view the Medica Provider Administrative Manual online**.

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**John Mach, MD**, *Chief Medical Officer and Senior Vice President*
**Rob Geyer**, *Chief Operations Officer*
**Nichole White, RPh, MBA**, *Senior Vice President of Health Services*
**Stacy Ballard, MD, MBA**, *Senior Medical Director*
**John Piatkowski, MD, MBA**, *Senior Medical Director*

## *Medica Connections* editor

**Hugh Curtler III,** *Marketing and Communications*
Phone: (952) 992-3354
Fax: (952) 992-3377
Email: hugh.curtler@medica.com

See Medica points of contact for providers >

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