July 2021

Medica | MEDICA CONNECTIONS

NEWS FOR MEDICA NETWORK PROVIDERS

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General News

Annual reminder:

Reviewing medical records for proper diagnosis codes

Outreach needed for Medicare plan data validation

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

Each year, the Centers for Medicare and Medicaid Services (CMS) requires that health plans validate the diagnosis codes that are submitted for payment, through claims, by conducting a medical record review for documentation that supports these codes. Medica has recently begun conducting its annual Medicare chart review, which focuses on 2020 dates of service for Medica Advantage Solution® and Medica DUAL Solution® plan members. This effort, which will run through the fall, is administered for Medica by Optum and CiOX Health.

CiOX Health notifies provider offices when records are needed, providing a list of requested Medicare members' medical records as well as remote retrieval options that are available. To prevent the spread of COVID-19, CiOX can retrieve charts while practicing social distancing. Medica appreciates providers' prompt assistance with this annual project for CMS.

Clinical News

Effective August 16, 2021:

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 16, 2021, 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 16, 2021, is already posted. Changes to policies are effective as of that date unless otherwise noted. ("Medical policy updates" notifications are available at Medica.com under For Providers, "Policies and Guidelines," then "Updates to Medical Policies.")

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 2021 for policies that will be changing effective September 20, 2021. These upcoming policy changes will be effective as of that September 2021 date unless otherwise noted.

Due by July 15, 2021:

Quality complaint reports required by State of Minnesota

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

Medica requires its Minnesota-based network providers to submit second-quarter 2021 quality-of-care complaint reports to Medica by July 15, 2021. *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).

Medica's quality complaint reporting form has been improved with interactive fields, which should save providers time. See link below.

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 Medica's Provider Administrative Manual**, or
- Call the Medica Provider Service Center at 1-800-458-5512.

Medica nurses offer care management support to members

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

Through Medica's care management programs, nurses and other support staff serve Medica members experiencing complex medical and mental health conditions, advanced illness, transitions of care, and other health care needs. All of these support programs involve completion of a comprehensive member assessment, development of medical and behavioral health interventions, and ultimately, the identification of members who would most benefit from telephonic case management.

Case management involves specially trained nurses, social workers and behavioral health professionals who provide both case management and care coordination services. An interdisciplinary team—including pharmacist, behavioral health specialist, nurse practitioner and medical director—supports the member and case manager and is available for consultation. Medica program nurses provide support to members experiencing acute care needs, such as a high-risk pregnancy or transition in care, as well as ongoing management for those with chronic, complex care needs.

Depending on a member's care needs, there are several support programs Medica offers:

- Complex Case Management
- Medical/Behavioral Case Management
- Behavioral Health Program
- Advanced Illness Program
- Transitions of Care Program
- Transplant Program
- Kidney Care Program
- High-Risk Pregnancy Program

See more details on Medica's care management programs.

Note: Since member eligibility varies for Medica's programs, providers are encouraged to verify eligibility before referring patients. To verify program eligibility, contact Medica at 1-866-905-7430 or **CareSupport@medica.com**.

Pharmacy News

Effective August 1, 2021:

Medica to add new UM policies for 3 new 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 1, 2021, 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 drugs.

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

Drug code	Drug brand name	Drug generic name
J9999	Abecma	idecabtagene vicleucel
J9999	Jemperli	dostarlimab-gxly
J9999	Zynlonta	loncastuximab tesirine-lpyl

These policies will apply to Medica commercial, Individual and Family Business (IFB), Minnesota Health Care Programs (MHCP) and Medica Health Plan Solutions℠ (MHPS) members and to Medica Medicare members in Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO) and all Medica Advantage Solution® 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 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective July 1, 2021:

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 July 1, 2021. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Review upcoming Medicare Part D drug formulary changes.

Medica periodically makes changes to its Medicare Part D formularies: the Medicare Part D Closed Formulary and the Medica DUAL Solution® and Medica AccessAbility Solution® Enhanced List of Covered Drugs. 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 Express Scripts.

Network News

Effective September 1, 2021:

Medica to update ancillary fee schedule for all products

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

Effective September 1, 2021, 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), orthotics and prosthetics (O&P), home health care, home infusion therapy, public health 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

SELF-SERVICE RESOURCES

Featured this month: Prior authorization and notification

For certain health care services, Medica requires that providers obtain prior authorization or give notification

before rendering the services, as noted on Medica's **Prior Authorization and Notification Requirements list**. This list contains prior authorization and notification requirements for network providers for inpatient and outpatient services, although prior authorization does not guarantee payment. To assist with billing, the list also includes Current Procedural Terminology (CPT ®) codes related to each service. To request prior authorization or provide notification, the **appropriate form from Medica.com** should be completed and submitted in a timely manner.

Provider administrative training webinar for July

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

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

Training class topic
"Set-up and Billing for Elderly Waiver and Housing Stabilization Providers"
Elderly waiver (EW) and housing stabilization providers serve an important function in the care of Medica members. Since working with a health plan can offer a variety of challenges, this training will walk providers through requirements as well as tools and services available to assist them, including tips for billing. This class will also focus on: an overview of housing stabilization benefits; getting set up as an EW or housing stabilization provider; role of the care coordinator and role of Medica's Provider Service Center; how to obtain an authorization; the claims submission process; and what to do if a claim is not processed as expected.

Class schedule

Topic	Date	Time
Set-up and Billing for Elderly Waiver and Housing Stabilization Providers	July 20	2-3:30 p.m. CT

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 times reflected above allow 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 each class date. **Register online for the session above**.

Effective September 1, 2021:

Medica to implement 2 new facility reimbursement policies

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

Medica will soon adopt the facility reimbursement policies indicated below, effective with September 1, 2021, dates of processing. Such policies define when specific services are reimbursable based on the reported codes submitted by the same facility—i.e., the same federal tax identification number (TIN) and National Provider Identifier (NPI). The

following policies will be applied to Medica's commercial and Individual and Family Business (IFB) claims submitted by outpatient hospitals and critical access hospitals.

Add-on Codes

This policy describes reimbursement of claims submitted with add-on codes, which are only eligible for reimbursement when reported with the appropriate primary service/procedure code by the same facility on the same day or the day before.

CCI Editing

This policy provides reimbursement guidelines for Column One/Column Two code pairs that should not be reported together per National Correct Coding Initiative (NCCI) edits from the Centers for Medicare and Medicaid Services (CMS). When the same facility submits two or more procedure codes for the same member on the same date of service, the codes will be compared. Medica will only reimburse the most comprehensive procedure, unless an appropriate modifier is reported and applicable to the code pair edit. Documentation must clearly support the use of the modifier override but is not required upon claim submission.

These two policies are based on industry-recognized sources including the CMS NCCI, the CMS Facility Outpatient Hospital Services Medically Unlikely Edits (MUE) Table, CMS Outpatient Code Editor (OCE) edits, and Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) coding conventions.

These new policies are applicable to facility claims billed on a UB-04 claim form or its electronic equivalent or its successor form. They will be available online or on hard copy:

- **View Medica's reimbursement policies** as of September 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Admission notification via Medica.com now available for all members

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

Medica has expanded the functionality of its inpatient admission notification transaction available electronically through **Medica's secure provider portal**. This 278N electronic data interchange (EDI) transaction is now available *for all Medica members*. The new functionality with this real-time transaction will help ensure timely notification of patient hospitalizations as well as help ensure accurate payment of inpatient claims for these members.

Reminder:

Up-to-date directories 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
- Compliance with ADA
- Website URL (optional)

It's required that provider directories be accurate and updated regularly, based on federal and state laws such as Centers for Medicare and Medicaid Services (CMS) rules and Qualified Health Plan (QHP) and Federally Facilitated Exchange (FFE) standards, and in accordance with applicable state laws, including Minnesota network adequacy statutes. 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.

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Distributed: 6/23/21

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