April 2022

Medica | MEDICA CONNECTIONS

NEWS FOR MEDICA NETWORK PROVIDERS

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General News

Due by April 15, 2022:

Annual 'Disclosure of Ownership' forms needed soon

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

Each year, providers must submit an updated "Disclosure of Ownership" form in accordance with regulatory agency requirements. Providers should complete and return their **Disclosure of Ownership Statement** as soon as possible, but no later than April 15, 2022. The form can be sent to Medica by e-mail at **ProviderCertifications@medica.com**.

This requirement is necessary for Medica to comply with contracts it holds with both the Centers for Medicare and Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS). More details about this compliance requirement are available in **the Medica Provider Administrative Manual**.

Medica wishes to thank providers for their prompt response to this obligation.

Billing guidelines and best practices:

Ensuring efficient claim submission for Medica's 2 new MHCP products

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

To help ensure accurate and timely processing of claims for Medica's two new Minnesota Health Care Programs (MHCP) products offered through Minnesota's Families and Children program — Medica Choice Care℠ PMAP (for Prepaid Medical Assistance Program) and Medica MinnesotaCare — providers are encouraged to follow some key guidelines from the Minnesota Department of Human Services (DHS).

The Medica payer ID that applies for Medica's two new MHCP Families and Children products is MEDM1.

Encounter data on claims
Providers should be submitting claims with appropriate encounter data for Families and Children membership, per DHS guidelines. If providers do not take this step, *claims will be denied as provider liability*. The following provider-specific encounter denial codes are used if claims are submitted without necessary information, as required for specific health care services.

For a missing or invalid *rendering* provider:

- Claim Adjustment Reason Code (CARC) CO-16
- Remittance Advice Remark Code (RARC) N289

For a missing or invalid *ordering* provider:

- CARC CO-16
- RARC N264

For a missing or invalid *referring* provider:

- CARC CO-16
- RARC N285

For a missing or invalid *attending* provider:

- CARC CO-16
- RARC N252

Refer to the MHCP Provider Manual for full details of what DHS requires for MHCP claim submission.

Clinical billing edits
Medica also applies DHS clinical and billing guidelines and requirements to Families and Children MHCP claims. Not meeting these DHS requirements *may result in claim denials*. Due to Medica's recent system enhancements, denial messages should be clear about what is needed for a claim appeal or resubmission — remittances include language intended to explain with more specificity.

Some examples of DHS billing guidelines include:

- Requirements for procedure code and modifier appropriateness
- Requirements for procedure code and place of service appropriateness
- Requirements for Medicaid bundling rules

Note: This enhanced edit processing applies for all claims submitted to Medica using payer ID MEDM1.

Refer to DHS for more on billing guidelines.

Clinical News

Effective May 16, 2022:

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 May 16, 2022, unless otherwise noted.

Monthly update notifications for Medica's UM policies, coverage policies and clinical guidelines are available on an ongoing basis. **Update notifications are posted on Medica.com** at least 60 days prior to their effective date. The medical policy update notification for changes effective May 16, 2022, 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.

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).

Note: The next policy update notification will be posted in April 2022 for policies that will be changing effective June 20, 2022. These upcoming policy changes will be effective as of that June 2022 date unless otherwise noted. The affected policies will then be available as noted above.

Highlighting best practices:

Optum primary care training series focuses on behavioral health

The following webcasts are aimed at primary care providers with the theme, "Behavioral Health Identification, Treatment and Referral in Primary Care." This three-part training series will discuss best practices for the integration of behavioral care into a primary care setting. Providers can earn three continuing medical education (CME) credits by completing the courses. These webcasts are offered on-demand by Medica's behavioral health partner, Optum, which administers Medica Behavioral Health.

Part 1: Depression and Follow-up After Higher Levels of Care
Depression significantly impacts both mental and physical health and can result in serious long-term morbidities. Screening tools are routinely used in clinical practice for measurement-based treatment decisions and adjustments.

Healthcare Effectiveness Data and Information Set (HEDIS®), from the National Committee for Quality Assurance (NCQA), serves as a standard measurement tool for comparing performance with a focus on quality improvements. This training will explain HEDIS measures related to the treatment of depression and the referral process for behavioral health treatment.

Part 2: Substance Use Disorders in Primary Care

Substance-use disorders (SUDs) contribute heavily to the burden of disease in the United States. The traditional separation of behavioral health from mainstream health care has created obstacles to successful care coordination. Stigma can also be a barrier to treatment and recovery. This course will focus on the integration of behavioral health services into the clinical primary care setting for SUD and discuss breaking the stigma and setting the stage for collaboration, as well as review HEDIS measures related to SUD.

Part 3: Behavioral Health Treatment for Children and Adolescents
Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders affecting children. The American Academy of Pediatrics (AAP) clinical practice guidelines provide recommendations for the diagnosis and treatment of children with ADHD. This training will focus on the use of screening tools that aid in assessment; treatment modalities, including medication and alternative therapies; strategies for family support; best practices; and the impact of untreated and undertreated ADHD. This course will also review the assessment and treatment of childhood behavioral disturbances with a focus on appropriate antipsychotic medication prescribing.

There are no fees for participating in or receiving credit for these webcasts. They are free and available for providers to take on their own time. To learn more and take these courses, **visit the OptumHealth Education website**.

Due by April 15, 2022:

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 third-quarter 2021 quality-of-care complaint reports to Medica by April 15, 2022. *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 Medica’s Provider Administrative Manual**, or
- Call the Medica Provider Service Center at 1-800-458-5512.

Pharmacy News

Effective May 1, 2022:

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 May 1, 2022, 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
J3490	Leqvio	inclisiran
J3590	Tezspire	tezepelumab-ekko
J3490	Vyvgart	efgartigimod alfa

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 policy above will be available online or on hard copy:

- **View drug management policies** as of May 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective June 1, 2022:

Medica's Site of Service drug-infusion program to expand

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

Medica will soon expand its Site of Service drug-infusion program to include Nucala®, effective June 1, 2022. Medica commercial and Individual and Family Business (IFB) members receiving Nucala in a hospital outpatient center will be required to move to a more cost-effective site unless medical necessity criteria are met to remain in the hospital outpatient center.

The Site of Service program, administered by Magellan Rx Management, identifies members receiving hospital-based infusion therapies from a list of drugs considered to be safe to administer at an alternate site, such as those used to treat autoimmune diseases or immuno-deficiencies. The Magellan Rx clinical team works with providers and patients to coordinate infusions at convenient, high-quality, alternate treatment sites, including the member's home or physician's office. For more details about this program, **refer to the Medica Site of Service Policy**.

Effective April 1, 2022:

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 April 1, 2022. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of April 1, 2022, **view the latest 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.

Administrative News

SELF-SERVICE RESOURCES

Featured this month: Relying on reimbursement policies

Providers who have coding questions about a denied claim can find valuable details in **Medica's reimbursement policies** . These policies can help confirm correct coding guidelines in order to allow payment, so make sure to consult them before sending in an appeal. Reimbursement policies provide payment methodology guidelines for medical and surgical services that are submitted for payment, and they often work in conjunction with other Medica policies such as coverage policies and drug management policies, as well as applicable participating provider contract, applicable fee schedules, Medica's Provider Administrative Manual and Medica's Credentialing Plan.

Provider administrative training webinar for April

(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

"Claim Appeals, Adjustments and Record Submission"
Claim appeals and adjustments are important options to ensure proper claims payment. This training reviews the process for submitting appeals, adjustments and supporting documentation to Medica. It focuses on the different avenues for submission, and when each is appropriate; when appeals and adjustment requests are needed; where to find the necessary forms on Medica's website; tips for making sure that an appeal or adjustment request contains the information that supports the desired outcome in an accessible format; and the options available if providers disagree with a decision on an appeal or adjustment request.

Class schedule

Topic	Date	Time
Claim Appeals, Adjustments and Record Submission	April 21	Noon-1 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 class above**.

Reminder:

SympliSend now available for secure online record submission

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

As previously published , Medica recently launched a new tool for record submissions related to claims that are submitted to Medica using payer ID 94265. This application, "SympliSend," is now available as an alternative to faxing or mailing claims documentation. SympliSend allows for quicker, more efficient response times with appeals or claim adjustments. Providers can access this tool using Medica's **secure portal for Electronic Transactions** after **signing up online to use SympliSend**.

Again, this new tool isn't for original claim submission, but only for supporting documents, such as those needed for claim appeals.

Recent enhancement
SympliSend also now allows for Word documents (".docx" files) to be attached as record submissions, up to a 500 MB limit in file size per document.

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)
- Termination of individual practitioner, closing of a site or termination of a provider entity

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.

Updates to Medica Provider Administrative Manual

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

Information updated	Location in manual	When posted
Updated "Medica Health Plans Administrative Requirements for Participating Agencies for the Provision of Personal Care Assistance (PCA) Services" regarding PCA Qualified Professional (QP) Care Oversight service changes. Medica aligned PCA QP service timeline requirements with the Minnesota Department of Human Services (DHS), as referenced in the **DHS PCA Manual**. Medica continues to require that all QP visits are conducted in person.	"Supplementary Contracting and Regulatory Requirements" section, under "Personal Care Assistance (PCA)"	February 2022
Added reference to Minnesota Department of Human Services (DHS) claim submission requirements, and the DHS website, for providers who see Minnesota Health Care Programs (MHCP) members.	"Billing and Reimbursement" section, in "Claim Submission Requirements for Facilities" subsection, under "Submission Information"	February 2022
Added reference to Minnesota Department of Human Services (DHS) claim submission requirements, and the DHS website, for providers who see Minnesota Health Care Programs (MHCP) members.	"Billing and Reimbursement" section, in "Claim Submission Requirements for Professional Services" subsection, under "Submission Information"	February 2022

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

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