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April 2024

Medica | MEDICA CONNECTIONS

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General News

Availity update:

Eligibility, benefits functionality now live on Availity portal

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

The eligibility and benefits functionality (270/271 transactions) can now be accessed through the Availity portal. **Previously, providers were notified** that Medica has chosen Availity Essentials as its preferred provider portal for Health Insurance Portability and Accountability Act (HIPAA) electronic data interchange (EDI) functionality.

Availity

Getting started

For those new to Availity Essentials, **visit Availity's Medica microsite** for more information, portal registration instructions, training links, and an FAQ about Medica's transition. Providers who already use Availity Essentials are all set — Medica lines of business should now be payer drop-down options to use for verifying Medica members' eligibility and benefits. Here are the Medica payer IDs, along with their corresponding business names as shown in the Availity portal:

Payer ID	Payer name in Availity
94265	Medica (United Healthcare)
124222	Medica Individual and Family
71890	Medica Health Plan Solutions
MEDM1	Medica Government Programs

(For all payer IDs other than 94265, the 10-digit subscription ID should be submitted as the patient ID.)

Trainings

Looking for a few tips to get started? Once providers get an Availity Essentials account, they can register for a live webinar on how to work with Medica on Availity Essentials. **Register today**. Sessions are recorded and available afterward, **such as this Availity Overview webinar** from December 2023.

What's next

Coming soon: Claim status (HIPAA 276/277 transactions) will be next to move over to Availity's portal. Future functionality will include prior authorizations, appeals, referrals and more. Once all functions are available, provider offices can streamline daily processes from patient to payment. Watch for details as these become available.

The new, secure provider portal from Availity should help provider offices increase efficiency by reducing paperwork and phone calls. This multi-phase migration has been underway and eventually will include the same or even greater functionality than currently available in the Medica.com secure portal.

Coming in May 2024:

Carelon to accept prior authorization requests by mid-April

Submissions will need to go to new UM vendor for select MSK, cardiovascular, radiology services

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

As of April 15, 2024, Carelon will begin accepting prior authorization requests for select services from Medica network providers, for dates of service starting May 1, 2024.

As previously announced , Medica will soon implement prior authorization on select musculoskeletal (MSK), cardiology and radiology services, effective beginning with May 1, 2024, dates of service. Medica is partnering with Carelon, a utilization management (UM) program third-party vendor, to support the provider submission and medical necessity review process for related authorizations. Medica network providers will need to use **Carelon's provider portal**.

To reflect which services will need prior authorization from Carelon, **Medica's prior authorizations lists** will soon be updated. The full details on modalities included for all three types of service will also be coming soon in respective guidelines on the Carelon website, scheduled to be available online in May 2024. **See clinical guidelines currently available from Carelon**.

Pre-service review timeline
For services scheduled to be rendered through April 30, 2024, physician offices must contact Medica to obtain necessary prior authorizations. Any authorizations Medica made prior to the transition date of May 1 will be honored and claims will be processed accordingly.

Beginning April 15, providers will be able to contact Carelon for prior authorization of services that take place on or after May 1, 2024. For most services, authorization reviews will take place *prior* to rendering the service, but where needed, post-service review will be accommodated. Providers are strongly encouraged to verify that an authorization has been obtained before scheduling and performing services, or in some cases after performing services (such as any outpatient cardiovascular services).

Submitting prior authorization requests
Starting April 15, providers can begin submitting requests to Carelon for review or verify order numbers using one of the following methods:

- Use the **Carelon provider portal** which is available 7 days a week, fully interactive, and processes requests in real time using clinical criteria. (Medica network providers can register in advance to use the portal, but Medica won't be a health plan option to select until April 15.)
- Or call Carelon toll-free at 1 (833) 476-1463, Monday through Friday, 8 a.m.-5 p.m. CT.

Excluded services, members
Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis (i.e., those services performed as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are *not included* in the Carelon cardiology and MSK programs. Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are *not included* in the Carelon MSK program.

Submitting prior authorization requests through Carelon is *not required* for Medica members in the following plans: Mayo Medical Plan, Medica Prime Solution® (Medicare Cost) and Medica's Medicare Supplement plans (e.g., Medica Signature Solution℠).

Webinar trainings
Here are upcoming Carelon training dates, open to all Medica network providers:

Service type/topic	Date	Time (CT)	Registration

Radiology/Cardiology	April 1	1-2 p.m.	**Click to register**.
MSK	April 2	Noon-1 p.m.	**Click to register**.
Radiology/Cardiology	April 3	1-2 p.m.	**Click to register**.
MSK	April 4	Noon-1 p.m.	**Click to register**.
MSK (Q&A only)	April 11	Noon-1 p.m.	**Click to register**.
Radiology/Cardiology (Q&A only)	April 24	1-2 p.m.	**Click to register**.
MSK (Q&A only)	April 25	Noon-1 p.m.	**Click to register**.
MSK (Q&A only)	May 9	Noon-1 p.m.	**Click to register**.

For more on Carelon
To learn more about Carelon, visit **carelon.com**. Or see individual **MSK**, **radiology** and **cardiology** microsites from Carelon.

Due by June 1, 2024:

New Minnesota CFSS program requires training for PCA providers

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

The Minnesota Department of Human Services (DHS) has received Centers for Medicare and Medicaid Services (CMS) approval for the transition of the personal care assistance (PCA) program to Community First Services and Supports (CFSS) in Minnesota. With this approval, all CFSS workers are required to **complete an individual PCA and CFSS training** *by June 1, 2024*. Per DHS, this new training will help PCA and CFSS staffs prepare for this transition and will help ensure that there are no delays in reimbursement for CFSS services.

Current individual PCA workers who took the test after April 15, 2020, and have a certificate titled “PCA and CFSS Support Worker Training” *do not* need to retake the training. Current individual PCA workers who took the test before April 15, 2020, and have a certificate titled “Personal Care Assistant Training” *will* need to complete the training.

See more from DHS on the new CFSS program.

Clinical News

Effective May 20, 2024:

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 20, 2024, 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 20, 2024, 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 2024 for policies that will be changing effective June 17, 2024. These upcoming policy changes will be effective as of that June 2024 date unless otherwise noted. The affected policies will then be available as noted above.

Clinical best practices:

Follow-up care for children taking antipsychotic medications

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

Antipsychotic medications are associated with a variety of adverse effects, including metabolic derangements. The rate and severity of these adverse effects vary by agent. Because many antipsychotics are associated with metabolic abnormalities, clinical guidelines recommend regular monitoring for these problems (e.g., weight gain, lipid abnormalities and elevated glucose).[1]

For children/adolescent patients taking an antipsychotic, guidelines recommend the following to assess cholesterol and glucose levels:

- At baseline, screen for high cholesterol and diabetes risk factors, and check a lipid profile and fasting blood glucose levels.
- Check a lipid profile and fasting blood glucose (or hemoglobin A1c) three months after initiating a new treatment and at least annually thereafter.

- More frequent monitoring may be indicated in the presence of weight changes, symptoms of diabetes, an elevated hemoglobin A1c, or a random glucose level greater than 200 mg/dL.

What can providers do for patients
Health care providers are encouraged to determine if child/adolescent patients taking an antipsychotic medication are due for metabolic screening.

Medica Behavioral Health resources
Optum provides administration for Medica Behavioral Health (MBH). Behavioral health clinical tools and information are available on Optum's behavioral health provider website, **providerexpress.com**, under "Behavioral Health Toolkits." Providers can request behavioral health coordination of care and referrals for members by calling MBH at 1 (800) 848-8327.

[1] American Academy of Child and Adolescent Psychiatry. **Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents**, published 2011.

Due by April 15, 2024:

Quality complaint reports required by State of Minnesota

(This applies to Medica network providers in Minnesota only.)

Medica requires its Minnesota-based network providers to submit first-quarter 2024 quality-of-care complaint reports to Medica by April 15, 2024. 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 email 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 March 15, 2024:

Medica updates MHCP member drug list with DHS coverage changes

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

As previously noted , Medica planned to make several changes in coverage status to its 2024 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP), effective March 15, 2024. These changes are determined by the Minnesota Department of Human Services (DHS) since Medica follows the DHS drug list. **See the updated MHCP drug list** now posted online.

Providers need to notify Magellan about continuation of therapy with medical pharmacy drugs for Medica MA members

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

As a reminder, Magellan manages prescriptions for specialty drugs covered under Medica's medical pharmacy benefit. **For Medica Medicare Advantage (MA) members**, providers need to reach out to Magellan to verify eligibility regarding preauthorization for these patients who need specialty drugs administered under their plan's medical pharmacy benefit. In particular, providers need to specify if a preauthorization for these drugs *constitutes continuation of therapy*. The Magellan phone number is 1 (800) 424-8115.

Based on guidance from the Centers for Medicare and Medicaid Services (CMS), providers need to contact Magellan and notify them when they will be administering a drug for MA members that is considered continuation of therapy in order to qualify for "continuation of coverage." As long as providers take this step, claims for these members will be processed for dates of service within the first 90 days of the member's coverage start date with an MA plan. Providers will need to submit requests for prior authorization to Magellan as part of the standard process for coverage of medical pharmacy drugs to continue after the MA member's continuation-of-therapy period ends.

Effective April 1, 2024:

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, 2024. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of April 1, **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

Effective June 1, 2024:

Medica to implement new reimbursement policy

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

Medica will soon implement the new reimbursement policy indicated below, effective on or after June 1, 2024, dates of service.

Emergency Department Evaluation & Management Codes – Facility

Medica will implement a new facility policy to provide reimbursement guidelines for the reporting of Emergency Department evaluation and management (E/M) codes. These codes are eligible for reimbursement when billed at the appropriate level. Medica follows interpretive guidelines sourced to Centers for Medicare and Medicaid Services (CMS) coding guidelines, American Medical Association (AMA) Current Procedural Terminology (CPT®) code descriptors, and specialty society guidelines for the reimbursement of Emergency Department E/M codes. This new policy will apply to outpatient facility claims reported on a UB-04 claim form or its electronic equivalent for all Medica members.

Medica will review level 4 and level 5 Emergency Department E/M codes using the Optum Emergency Department Claim (EDC) Analyzer tool. The Optum EDC Analyzer™ tool determines E/M coding based on data received from the claim. The Optum EDC Analyzer will use the following claim data to recommend the appropriate level:

- Patient's presented health issues
- Diagnostic services performed during the visit
- Any complicating conditions the patient has

If the Optum EDC Analyzer tool determines a lower level of service should be submitted, Medica will deny the claim line, as the information submitted would not support the level of service. Facilities may submit an appeal for reconsideration of payment. **See more about Optum's EDC Analyzer tool**.

This new Medica policy will be available online or on hard copy:

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

Effective June 1, 2024:

Medica to update reimbursement policy

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

Medica will soon update the reimbursement policy indicated below, effective on or after June 1, 2024, dates of service.

Inpatient Hospital Readmissions
This policy addresses the reimbursement of readmissions to the same hospital, billed on a UB-04 claim form or its electronic equivalent. Medica's Inpatient Hospital Readmission reimbursement policy will be expanded to apply to readmissions to the same facility (i.e., same provider number) within 30 calendar days following discharge to include commercial and Individual and Family Business (IFB) plans in the following states: Iowa, Minnesota, North Dakota, South Dakota and Wisconsin.

Medica will not reimburse for more than one admission to the same hospital within 30 calendar days of discharge when the readmission is for the same, similar, or related condition and/or deemed a preventable readmission. The subsequent admissions will be denied and only the initial hospital stay will be reimbursed. This policy applies to all states and all of Medica's products except Medicaid-only plans — Medica's Minnesota Senior Care Plus (MSC+), Special Needs BasicCare (SNBC), Prepaid Medical Assistance Program (PMAP) and MinnesotaCare plans — which follow the Minnesota Department of Human Services (DHS) guideline of 15 calendar days.

This updated Medica policy will be available online or on hard copy:

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

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, uptodate 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 uptodate. 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:

- Telehealth capability, at both practitioner and site level *(this should include whether an individual practitioner exclusively provides telehealth or provides both telehealth and services at a physical location)*
- Office locations where individual practitioners are actively seeing patients for appointments
- Practitioner names and credentials
- Specialties
- Location names

- Addresses, including suite numbers
- Phone numbers
- Clinic hours
- Practitioner status for accepting new patients *(as a reminder, accepting new patients means the practitioner can see the member within Medica's guidelines for appointment access, **outlined here**)*
- Clinic services available
- Cultural competency training
- Compliance with the Americans with Disabilities Act (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.

Reminder:

Providers need to keep national Medicare demographics data current

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

Medica wants to remind providers of the importance to review, update and certify existing provider information in the National Plan & Provider Enumeration System (NPPES). *Providers who see Medicare patients are legally required to keep their NPPES data current*. When reviewing provider data in NPPES, providers should update any inaccurate information in modifiable fields — including provider name, specialty, mailing address, telephone and fax numbers. **Refer to NPPES online**.

Tips & Training

SELF-SERVICE RESOURCES

Featured this month: E-learning on contract rate disputes

The new training "Contract Rate Disputes for Providers" covers the process after a claim is paid but providers don't think it processed according to their contracted rate for the services. This self-guided micro-training includes resources on how to identify the appropriate contracted rates, and who to work with if providers don't think the information is loaded correctly. This new e-learning is posted on Medica.com and available 24/7. **Check it out**!

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 all Medica network providers, at no charge.

Training class topic

"Life of a Claim"

Understanding all three components of a clean claim — submission, process and output — is important to ensure proper payment. This training will review all three claim stages in order to show how they work together to facilitate the proper processing of Medica claims. It will focus on claim submission policies and requirements; 837P and 837I electronic transactions; provider remittance advices (PRAs) and explanations of payment (EOPs); common denial reasons; and how to request claim adjustments and appeals.

Class schedule

Topic	Date	Time
Life of a Claim	April 10	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**.

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