August 2024

Medica | MEDICA CONNECTIONS

NEWS FOR MEDICA NETWORK PROVIDERS

General News

Carelon update:

Reminder to refer to PA lists for service codes that require prior authorization

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

To verify if services require prior authorization and to determine if

authorization is required for a given code through Medica or through Carelon, **refer to Medica's prior authorization lists**. When a service requires authorization, send the request to Medica or Carelon as indicated.

If a request is for muskoskeletal (MSK), cardiovascular or radiology services managed through Carelon, **submit the request directly to Carelon** . Medica is partnering with Carelon, a utilization management (UM) program third-party vendor, to support the provider submission and medical necessity review process for this new prior authorization program. For reference, MSK, cardiovascular and radiology guidelines are available from Carelon. See Carelon's **MSK policies**, **cardiology policies** and **radiology policies**.

Availity update:

How Availity portal payer names correlate to Medica payer IDs

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

Medica and Availity have made enhancements to the Availity Essentials secure portal to help providers select the appropriate payer for each transaction, using the "Payer" dropdown. When providers use Availity to check member eligibility and benefits, for instance, the corresponding payer ID numbers will be displayed in an alert (at top of screen) for each of these four payer names, along with explanations for each.

Availity portal payer name	Medica payer ID	Explanation displayed at top of screen
Medica Health Plan Solutions	71890	"The payer you selected is for Medica commercial plans administered under payer ID 71890. Your inquiry should work if you select the correct Medica payer name from the dropdown. Refer to the member's ID card to confirm the correct payer ID."
Medica Government Programs	MEDM1	"The payer you selected is for Medica government plans administered under payer ID MEDM1. Your inquiry should work if you select the correct Medica payer name from the dropdown. Refer to the member's ID card to identify the correct payer name and ID."
Medica Individual and Family	12422	"The payer you selected is for Medica Individual and Family (IFB) plans administered under payer ID 12422. Your inquiry should work if you select the correct Medica payer name from the dropdown. Refer to the member's ID card to identify the correct payer name and ID."
Medica (UnitedHealthcare)	94265	"The payer you selected is for Medica plans administered under payer ID 94265. Your inquiry should work if you select the correct Medica payer name from the dropdown. Refer to the member's ID card to confirm the correct payer ID."

In addition, the following payer is the former WellFirst Health health plan, now named "Medica."

Medica	41822	"The payer you selected is for Medica plans (formerly branded as WellFirst Health)

(formerly WellFirst)	administered under payer ID 41822 only. The Medica (formerly WellFirst) **provider portal** should be used for plans administered under payer ID 39113. These are separate portals that are not interchangeable. Refer to the member's ID card to identify the correct payer ID."

New complaint, escalation process for case management issues

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

Medica case management teams must not prohibit providers from submitting claims or making benefit determinations for any type of service. To ensure this does not occur, Medica has set up a process for providers to report and escalate complaints when any provider believes a case management team member is acting to prohibit a provider from submitting a claim or making a benefit determination.

To start the process, providers simply submit a new **complaint form**. The complaint will be escalated for review and monitoring will occur to ensure case managers are not engaging in activities that prohibit providers from submitting claims or making benefit determinations for any type of service.

More information is available online **in Medica's Provider Administrative Manual**. Issues or questions regarding this complaint process may be directed to Medica's Provider Service Center at 1 (800) 458-5512.

Clinical News

Effective September 16, 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 September 16, 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 September 16, 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 August 2024 for policies that will be changing effective October 21, 2024. These upcoming policy changes will be effective as of that October 2024 date unless otherwise noted. The affected policies will then be available as noted above.

Annual notice:

Medica monitors Quality Improvement program goals for 2024

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

Medica prepares an annual Quality Improvement Work Plan to outline key quality improvement (QI) activities for the year. The work plan encompasses projects addressing clinical quality, service quality, provider quality and patient safety, as well as ongoing quality monitoring activities. The 2024 QI Work Plan is organized around Medica's key quality priorities for the year, including clinical quality improvement, health equity advancement and improving the member experience.

Some Work Plan initiatives that may interest medical groups include activities to:

- Expand partnerships with community health centers to improve health equity; involve culturally diverse groups of community members in health equity program planning.
- Improve preventive care and screening rates for conditions including colorectal cancer, breast cancer and chlamydia.
- Increase post-hospitalization follow-up rates after admissions for mental health diagnoses.
- Increase rate of eligible members choosing to participate in Complex Case Management program.
- Improve postpartum visit compliance for members participating in Obstetric Medical Home programming.

The Medica QI program supports the Medica mission to meet its customers' needs for health plan products and services. The QI program's purpose is to identify and implement activities that will improve:

- Member care, service, experience, access, equity and/or safety.
- Service to practitioners, providers, employers, brokers and other customers and partners.
- Medica's internal operations related to care, service, experience, access and patient safety.

This program encompasses a wide range of clinical and service quality initiatives affecting Medica members, providers, employers and brokers, as well as internal stakeholders throughout Medica.

Medica evaluates its QI program annually, reviewing the year's QI activities and assessing progress toward goals. Medica also looks at its QI committee structure, program resources, and key challenges and barriers encountered during the year. Each year's program evaluation forms the basis of the next year's work plan.

The Medica Quality Committee directs and oversees QI program implementation. The Quality Committee serves as a peer-review body, receiving and reviewing aggregate data on all aspects of clinical and service quality. The Quality Committee approves program activities, recommends policy changes and follows up on improvement opportunities.

For more details about the Medica QI program:

- **Visit Medica.com**.
- Call the Medica Provider Literature Request Line for printed copies of documents.

Pharmacy News

Effective October 1, 2024:

Medica to add 2 new UM policies for 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 October 1, 2024, dates of service. Medica implements such policies as soon as possible after conducting a clinical review of 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
J9248	Hepzato	melphalan
J9999	Rytelo	imetelstat

Member impact
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, unless noted below. The drugs will be subject to pre-payment claims edit policies as well.

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

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

Effective October 1, 2024:

Medica to update biosimilar-first step therapy for infliximab policy

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

Effective October 1, 2024 Medica will update its utilization management (UM) strategy for Remicade (infliximab). Medica strives to maximize biosimilar utilization to offer members and providers cost-effective, clinically appropriate therapies. In order to accomplish this with infliximab products, this policy will be updated to require trial and failure of or contraindication to *both* preferred biosimilar products: Avsola *and* Inflectra. Documentation such as prior claims or clinical records will be required with prior authorization requests for the brand product Remicade upon renewal or initial use on or after October 1, 2024.

As a reminder, Medica's preferred infliximab biosimilars are as follows:

Drug name	HCPCS code	Preferred biosimilars	HCPCS codes
Remicade (infliximab)	J1745	Inflectra (infliximab-dyyb) Avsola (infliximab-axxq)	Q5103 Q5121

This biosimilar strategy change will apply to Medica's commercial, Individual and Family Business (IFB), and Medica Health Plan Solutions℠ (MHPS) members. It will *not* apply to Medica's Minnesota Health Care Programs (MHCP), Mayo Medical Plan, Medica Advantage Solution®, Medica DUAL Solution® or Special Needs BasicCare (SNBC) Special Needs Plan (SNP) members.

(Update to "Medica to make biosimilar-first ST change for infliximab" article in **November 2022 edition** of *Medica Connections*.)

Effective October 1, 2024:

Medica to add new drug UM policy for Mayo Medical Plan

(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) policy for Mayo Medical Plan members. This change will be effective with October 1, 2024, dates of service. 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
J9248	Hepzato	melphalan

The new medical pharmacy drug UM policy above for Mayo Medical Plan members will be available online or on hard copy:

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

Effective August 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 August 1, 2024. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of August 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.

Network News

Effective October 1, 2024:

Medica to make quarterly update to Medicare physician fee schedules

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

Effective with October 1, 2024, dates of service, Medica will implement the quarterly update to its Medicare physician fee schedules for applicable Medica products. This fee schedule change will implement updates from the Centers for Medicare and Medicaid Services (CMS) and have an impact on home infusion therapy and public health agency providers, as well as physicians and convenience care. Medica will make these updates within 30 days of the CMS quarterly files becoming publicly available. By day 10 after each effective date, in order to keep these quarterly updates timely, Medica will move ahead and post updated Medicare rates with the files CMS has published at that time.

This fee schedule change incorporates CMS relative value units (RVUs) and conversion factor as well as various Medicare non-RVU fee maximums (such as labs, injections, immunizations, etc.). In addition, Medica will update its

Medicare fee schedules with rates for codes without a fee maximum established. Overall reimbursement for providers will depend on specialty and mix of services provided.

Details on Medicare changes to drug fees, which typically see the greatest impact from these quarterly CMS updates, **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Effective October 1, 2024:

Medica to make quarterly update to MHCP physician fee schedule

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

Effective with October 1, 2024, dates of service, Medica will implement a revised physician fee schedule for its enrollees in Minnesota Health Care Programs (MHCP) products. The revised Medica MHCP fee schedule will be based on the fee schedule used by the Minnesota Department of Human Services (DHS) to pay providers for services provided to its fee-for-service enrollees. Updates to Medica's MHCP fee schedule will follow DHS professional fee schedule updates.

The effect on reimbursement overall for specific clinics will vary by specialty and mix of services provided. Providers who have questions may contact their Medica contract manager.

Effective October 1, 2024:

Medica to make quarterly update to standard reference lab fee schedule

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

Effective with October 1, 2024, dates of service, or as soon thereafter as the CMS quarterly reference lab fee schedule updates are publicly available, Medica will implement the next quarterly update to its standard reference lab fee schedule, for all Medica products. This quarterly update will reflect any applicable Centers for Medicare and Medicaid Services (CMS) reference lab code or fee schedule updates that are effective October 1, 2024. The reimbursement impact of this CMS quarterly update will vary based on mix of services provided.

Details on Medicare changes to lab fees **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Effective October 1, 2024:

Medica to make quarterly update to standard home infusion therapy fee schedule

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

Effective with October 1, 2024, dates of service, or as soon thereafter as the Centers for Medicare and Medicaid Services (CMS) quarterly updates are publicly available, Medica will implement the next quarterly update to its standard home infusion therapy fee schedule, for all Medica products. This quarterly update will reflect any applicable

CMS fee schedule updates that are effective October 1, 2024. The reimbursement impact of this CMS quarterly update will vary based on mix of services provided.

Details on Medicare changes to fees **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Administrative News

Reminder:

Payment enhancement implemented for MA claims with taxonomy codes

Taxonomy codes improve claims processing

After an enhancement for Medica's Medicare Advantage (MA) claims processing last year, the turnaround time on paying MA claims has improved. When providers include the taxonomy codes, it results in more accurate and faster claims processing, so Medica can make payments to providers more quickly. Medica relies on providers to use taxonomy codes on claims for MA (i.e., Medica Advantage Solution® and Medica Advantage℠) and Minnesota Health Care Programs (MHCP) services in particular.

Medica's Medicare Advantage plans uses taxonomy codes on claims to determine benefit coverage and payment during claims processing. Taxonomy codes are 10-digit alpha/numeric codes that enable providers to identify their specialty at the claim level. These specialty codes are required for Medicare providers by the Centers for Medicare and Medicaid Services (CMS). **See more about taxonomy codes from CMS**.

Tips & Training

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 lists. These lists contain 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 lists also include Current Procedural Terminology (CPT®) codes related to each service, along with associated utilization management (UM) policies with coverage criteria. The lists also indicate where requests should go — whether to Medica or to Carelon, for particular services.

To request prior authorization or provide notification, the appropriate form from Medica.com should be completed and submitted in a timely manner. It's also important to review authorization and notification requests to ensure accurate details for seamless claim processing. **See Medica's prior authorization lists and forms**.

Provider administrative training webinar for August

(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	August 8	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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