June 2024

Medica | MEDICA CONNECTIONS

NEWS FOR MEDICA NETWORK PROVIDERS

General News

Clinical News

Pharmacy News

Administrative News

Tips & Training

General News

Carelon update:

Carelon MSK, cardiovascular, radiology policies available online

Plus helpful set-up steps to use Carelon's portal

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

Carelon has begun accepting prior authorization requests for select musculoskeletal (MSK), cardiovascular and radiology services from providers

for Medica members for dates of service starting May 1, 2024. If a request is for MSK, cardiovascular or radiology services managed through Carelon, **submit the request to Carelon**.

For a complete list of services that require prior authorization and to determine if authorization is required for a given code through Medica or Carelon, **see Medica's prior authorization lists** . When a service requires authorization, send the request through Medica or Carelon as indicated. For reference, the related guidelines are available at Carelon's websites. See Carelon's **MSK policies**, **cardiology policies** and **radiology policies**.

As a reminder, to implement this new prior authorization program, Medica is partnering with Carelon, a utilization management (UM) program third-party vendor, to support the provider submission and medical necessity review process.

'Attaching' provider to an account, associating with Medica
On the Carelon secure provider portal, providers need to individually be "attached" to their provider group account and then associate themselves with Medica as a health plan option in order to submit prior authorization requests online through Carelon. Here are helpful set-up steps for doing this.

1. Log into Carelon's provider portal at **providerportal.com**.
2. Press Carelon's Home button at top left, then Select "Provider Management."
3. Click "Add Provider Identifier" button at right.
4. Select the provider identifier to add—whether by tax ID number (TIN), by national provider identifier (NPI) or group NPI (GNPI)—and then enter the provider/group identifier. Click "Save."
5. Select "Medica" as a health plan the provider should be associated with.
6. The message "Provider identifiers have been added to your account" will display.
7. A list of "Providers Attached to Account" also displays, showing both provider identifiers and health plans associated with the provider's account.

If an authorization should go through Carelon but the provider used Carelon for other health plans before Medica's Carelon implementation, the provider should take the steps above to associate with Medica. Otherwise, this message may result: "An order request cannot be processed for this member at this time."

Annual reminder:

Reviewing medical records for proper diagnosis codes
Outreach coming soon 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 will soon begin conducting its annual Medicare chart review, which focuses on 2023 dates of service for Medica Advantage Solution®, Medica AccessAbility Solution® Enhanced and Medica DUAL Solution® plan members. This effort, which will run through the fall, is administered for Medica by Optum and Datavant.

Datavant 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. Medica appreciates providers' prompt assistance with this annual project for CMS.

Annual reminder:

SNP 'Model of Care' training required for providers

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

As a reminder, each year providers who serve members enrolled in a Special Needs Plan (SNP) — such as Medica DUAL Solution® or Medica AccessAbility Solution® Enhanced — must take the provider Model of Care training. Providers can **find this training and attestation link on Medica.com**.

This requirement is necessary for Medica to comply with requirements put in place by the Centers for Medicare & Medicaid Services (CMS). More details about this requirement are available **in the Medica Provider Administrative Manual**.

Each provider organization should maintain documentation of each provider's completion of training (e.g., dated training attendance list, dated paper or electronic attestation, etc.) that can be provided upon request. One Model of Care training attestation can be completed on behalf of an organization, either by:

- Completing the attestation online using the **Provider Demographicupdate Online Tool (PDOT)**; or
- Completing the electronic attestation **here**.

Medica wishes to thank providers for their participation in completing this training.

Annual notice:

Provider appeals on behalf of Medica members

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

Medica members have the right to appoint representatives, such as their providers, to initiate member appeals. When an adverse medical necessity determination results in member liability, providers may initiate an appeal on behalf of a Medica member by calling the Medica Provider Service Center. At the request of the member or provider, the appeals staff will conduct a case review of previously denied services to ensure accurate review, and coverage of eligible services according to the member's benefit document. **See more details** in Medica's Provider Administrative Manual.

Annual notice:

Member rights and responsibilities, for providers to know

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

Medica recognizes the importance of a three-way relationship among members, their providers and their health plan. Medica believes that educating members about their health care responsibilities is important because it helps members get the greatest benefit from their health plan. Medica outlines member rights and responsibilities for the Medica physician and provider community in order to improve the health of the members Medica serves.

As a reminder, information about member rights and responsibilities is posted online. Providers are encouraged to review and understand these details. **See more** in Medica's Provider Administrative Manual.

Annual notice:

Medica reaffirms its policy regarding utilization management

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

Utilization management (UM) is a process Medica uses to evaluate health care services for appropriateness and efficacy. Medica UM decisions are based on national and local standards that support the provision of evidence-based care. All decisions also incorporate a member's benefits and Medica coverage policies. Medica does not specifically reward providers, practitioners, staff members or their supervisors who conduct utilization reviews on the behalf of Medica for issuing denials of coverage or service. It is important to note that UM decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the underutilization of services. **See more online** about Medica's UM process as well as UM policies.

Reminder:

Minnesota providers required to enroll with MHCP for claim payment

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

For all of Medica's Minnesota Health Care Programs (MHCP) products, Minnesota providers need to enroll with MHCP to serve these members and submit claims for payment. The 21st Century Cures Act requires Minnesota to enroll Medica-contracted providers who currently provide or wish to provide services to members enrolled in MHCP managed care. The screening and enrollment process for Medica-contracted providers started in July 2023.

All Medica network providers who already have an existing contract *must enroll by July 15, 2024*, except for the following provider types that require a site visit from the Minnesota Department of Human Services (DHS) and must enroll by December 31, 2024:

- Provider type 10 – Community Mental Health Center
- Provider type 11 – Rehab Agency
- Provider type 46 – Day Treatment
- Provider type 64 – Home Care Nursing Organization
- Provider type 82 – Medical Transportation

Learn more from DHS
Refer to the **Minnesota Provider Screening and Enrollment (MPSE) portal training** for more on how to use this portal to enroll. And then **Enroll with Minnesota Health Care Programs** by selecting "Enrollment process for managed care organization (MCO) network providers."

Clinical News

Effective July 15, 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 July 15, 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 July 15, 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 June 2024 for policies that will be changing effective August 19, 2024. These upcoming policy changes will be effective as of that August 2024 date unless otherwise noted. The affected policies will then be available as noted above.

Clinical best practices:

Substance use disorder in adults: Initiation and engagement in treatment

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

Medica appreciates that health care providers take an active role in screening adult patients for a substance use disorder (SUD). The National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration recommends following the Screening, Brief Intervention and Referral to Treatment (SBIRT) guideline at **samhsa.gov/sbirt**.

Screening tools

Screening tools and information about behavioral health issues can be found on **providerexpress.com** on the Behavioral Health Toolkit – Adult page, under "Substance Use Disorder." Here are some examples:

- AUDIT-C – Adult Alcohol and Substance Use Screening Questionnaire
- CAGE-AID – Adult Alcohol and Drug Use Questionnaire
- DSM-5 Opioid Use Disorder Checklist
- Single Item Alcohol and Drug Screeners
- Drug Abuse Screening Test (DAST-10)

How to help patients with a SUD

- It is essential for these patients to engage in treatment with health care providers or a SUD treatment specialist promptly if they have indicated willingness to enter treatment. To meet national quality standards, this initial appointment should be within 14 days of their diagnosis.
- Identify where the patients are in the stages of change model, and be flexible in offering support appropriate to that stage.
- Help them identify and address challenges to connecting with care.
- Help them decide how to include family and other supports in their recovery plan.
- Follow up regularly as an active partner in their recovery journey.

Refer to a SUD treatment specialist
Health care providers can request coordination of care, find patient education information and request referrals for members by calling the number on the back of the member's health plan ID card or searching **Liveandworkwell.com** (use guest code "clinician").

Documenting SUD remission
Here are some reasons why it's important to accurately document a remission diagnosis:

- It establishes current status and drives treatment planning.
- It prevents patients from continually being identified as active users when they are not.
- It improves quality scores by removing members in remission from the measure.

When using remission codes, other SUD diagnoses must be removed from the active diagnosis list. **Refer to this list of ICD-10 codes to document remission**.

Continuing Education
Some providers can earn credit for completing a session on "Substance Use Disorders in Primary Care." There are no fees for participating in or receiving credit for this activity. Activities are designed to meet the educational needs of primary care physicians, physician assistants, nurses and nurse practitioners who are interested in learning about pertinent topics in behavioral health. **Learn more**.

Pharmacy News

Effective July 1, 2024:

Medica outlines upcoming changes to commercial member drug formulary

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

As noted last month, Medica will be making several changes in coverage status to its commercial member drug formulary (drug list) effective July 1, 2024. The changes to this formulary are now posted online. **See the latest Summary of Changes** to the 2024 Medica Commercial Drug List.

("Summary of Changes" notifications for drug lists are available at Medica.com under For Providers, "Pharmacy," then

respective member types **under "Pharmacy Resources by Segment**.")

Effective in July 2024:

Medica tentatively plans to update MHCP member drug list

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

Medica expects to make upcoming changes in coverage status to the 2024 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP), tentatively effective in July 2024. Any such changes are determined by the Minnesota Department of Human Services (DHS) since Medica follows the DHS drug list. As with all Minnesota managed care organizations (MCOs) that follow the DHS drug list for MHCP patients, DHS provides Medica with advance notice of changes to the drug list, which Medica **posts as soon as possible to Medica.com**.

The Medica MHCP drug list applies to the following products: Medica Choice Care℠ (for Minnesota Senior Care Plus program, or MSC+), Medica AccessAbility Solution® (for Special Needs Basic Care program, or SNBC) and both Medica DUAL Solution® (for Minnesota Senior Health Options program, or MSHO) and Medica AccessAbility Solution Enhanced, for non-Part D drugs. Any changes will *not* apply to Medica Medicare Part D drug formularies.

Effective August 1, 2024:

Medica to add new UM policies for 2 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, 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
J9999	Anktiva	nogapendekin alfa inbakicept-pmln
J3590	Beqvezi	fidanacogene elaparvovec-dzkt

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 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 August 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 August 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
J9333	Rystiggo	rozanolixizumab-noli

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 August 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

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

As of June 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 August 1, 2024:

Medica to implement new post-payment claims recovery program

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

Beginning with August 1, 2024, dates of processing, Medica will implement another claims recovery program to help identify and recover overpayments through a data-mining solution. The vendor, Carelon, will use its Claims Anomaly Detection platform to achieve this end, which should help strengthen payment integrity at Medica. If overpayments are identified, Carelon will notify providers on behalf of Medica. This program will apply to all types of Medica claims (including physician/professional, facility, behavioral health) other than those submitted under payer ID 94265.

Questions regarding Carelon's reviews and appeals should be directed to Carelon:

Carelon Payment Integrity
P.O. Box 17130
Denver, CO 80217-0130
CADC-001

Or by email at **CarelonCADdisputes@Carelon.com**.

See more on Medica's Payment Integrity program.

Reminder:

Balance billing not permitted for network providers

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

As a reminder for Medica's network providers, balance billing of Medica members is not permitted. Information on restrictions related to balance billing is outlined in Medica's Provider Administrative Manual. For example, see the Supplementary Contracting and Regulatory Requirements section in **the General Contracting Requirements** subsection, on page 6, under "Member Protection Provisions."

Members are responsible for paying copays, deductibles and coinsurance amounts for covered services. A bill or payment should not be collected, or lien imposed on a member, for any amount outside of such responsibility. Network

providers are encouraged to review the terms of their Participation Agreement with Medica to ensure an understanding of contractual rights on billing for covered services.

Members who receive a bill or lien from a network provider for covered services outside of their required cost-sharing responsibility may file a complaint. If that occurs, Medica will address the issue according to the terms of the provider's Participation Agreement with Medica.

Ensuring proper payment for health care services
Before providing services to Medica members, providers should be sure to check member eligibility and benefits as well as any prior authorization requirements. Resources to do so are available through **Medica's secure portal** or the **Availity Essentials portal**, and **on Medica's website**.

Tips & Training

SELF-SERVICE RESOURCES

Featured this month: Keeping demographics up-to-date

Keeping demographic data up-to-date ensures accuracy for Medica's systems and provider directories. It is also a critical factor for accurate and timely claims payment! Providers should be sure to confirm that their provider-specific demographics are correct and current with Medica. If any changes are needed, follow the process to make updates through the Provider Demographic-update Online Tool (PDOT) **in the secure portal** or take steps **outlined on Medica.com**.

Provider administrative training webinar for June

(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

"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	June 12	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**.

Getting Connections?
Sign up for regular updates, if you haven't already.

Subscribe

Looking for past issues?
Access the archive on our website.

View archive

Colleagues not receiving Connections?
Forward this month's newsletter.

Forward to Colleagues

What do you think of our newsletter?
Let us know!

Take survey

Leadership in Provider Support Areas

Jennifer Alm, Vice President of Provider Partnerships and Solutions
Rob Geyer, Chief Operations Officer and Senior Vice President
David Webster, MD, MBA, Chief Clinical and Provider Strategy Officer
Amit Khurana, PharmD, Vice President of Pharmacy
John Piatkowski, MD, MBA, Vice President of Physician Services
Ken Schellhase, MD, MPH, Senior Medical Director
Kristen Kopski, MD, Senior Medical Director

'Medica Connections' editor

Hugh Curtler III, Communications
Email: **Hugh.Curtler@Medica.com**

Distributed: 5/22/24