

## Medica COVID-19 Response Provider FAQ

For the latest health care news and guidance on this topic, [refer to the CDC website](#).

### **How will Medica reimburse providers for COVID-19 testing and telemedicine services? (Rev. 4/15/22)**

Medica has extended the coverage end date for the following—which will continue at least through July 31, 2022, dates of service:

- Cost-sharing for COVID-19 diagnostic testing and antibody testing for all Medica members, whether in-network or out-of-network, plus related services such as office visits for the test when provided in-network
- **Telemedicine (Emergency) reimbursement policies**; with their expanded code list, these policies continue to include visits from a member's home, FaceTime, Skype and audio-only for non-MHCP members

As a reminder, COVID-19 tests must be FDA-issued, medically necessary and ordered by a medical professional. COVID-19 tests are **not** covered as part of a return-to-work requirement, public surveillance program or travel requirement.

### **Is Medica making changes to PCA services during the public health emergency? (Rev. 4/5/22)**

The Minnesota Department of Human Services (DHS) announced temporary changes regarding personal care assistance (PCA) Qualified Professional (QP) supervision—These changes apply to Medica's Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) members, effective with May 12, 2020, dates of service and lasting through the end of the public health crisis. The changes provide additional flexibility to allow qualified professionals to provide required in-person oversight of PCA workers via two-way interactive telecommunications (i.e., phone or video technology) for all people who receive PCA services. Eligible providers should continue to submit claims to Medica with the place of service as if the services were delivered in person. For all services delivered remotely, eligible providers must document a COVID remote visit and the method of communication, such as a phone. In addition, the DHS announcement increases the number of hours a PCA agency can bill for an individual worker, up to 310 hours per month per worker. **(The change allowing remote oversight ends on June 30, 2022.)**

### **How is Medica handling coverage of over-the-counter (OTC) COVID-19 tests? (As of 1/20/22)**

Beginning January 15, 2022, Medica is covering 8 OTC antigen tests per member per month. This only applies to Medica's commercial and individual and family business (IFB) members. Members should obtain these tests from an in-network pharmacy and present their Medica ID card at the pharmacy counter in order to have the cost waived. Tests purchased from a non-preferred location will be eligible for reimbursement at \$12 per test.

### **Will Medica extend its waiver of requirements like prior authorization? (Rev. 1/18/22)**

Through April 30, 2022, dates of service. Medica will continue to suspend prior authorization for admission to a post-acute care setting. Also, for the repair or replacement of durable medical equipment (DME), we continue to waive a new physician's order, face-to-face visit or medical necessity documentation. These temporary changes will continue at least through the end of April 2022.

### **How will the cost of COVID-19 vaccines—including booster shots—be covered? (Rev. 1/19/22)**

Medica will waive costs for the vaccine and its administration, including booster shots, for all members, based on CDC guidelines. Vaccines, now widely available, can be administered at various in-network and out-of-network retail pharmacies, doctor's offices and hospitals. Medica's cost-sharing waiver for vaccines received out-of-network will apply only through the end of the COVID-19 National Emergency. [See more details](#) in Medica's COVID-19 treatment/vaccine reimbursement policy.

**Will Medica waive costs for outpatient drug treatments?** (Rev. 1/19/22)

Yes – For monoclonal antibody drug treatments, Medica follows the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) guidance and covers the administration of the COVID infusion treatments when furnished consistently with the emergency use authorization (EUA) per the U.S. Food and Drug Administration (FDA). For in-network providers, Medica will cover the administration cost with no member cost-sharing (copay, coinsurance or deductible). This waiver will continue through the end of the COVID-19 National Emergency and is effective retroactively to the EUA date for each drug. For out-of-network providers, standard member cost-sharing will apply. This applies to Medica's fully insured group, individual, Medicare and Medicaid members. Self-insured employers also have an opportunity to waive member cost-sharing. [See more details](#) in Medica's COVID-19 treatment/vaccine reimbursement policy.

**Is Medica continuing to suspend the Medicare sequestration on provider payments?** (As of 12/13/21)

Yes. Medica will extend the temporary suspension of the "Medicare Sequester" through March 31, 2022, dates of service, then reinstate a 1% sequestration reduction from April 1, 2022, through June 30, 2022, dates of service and the full 2% sequestration reduction starting with July 1, 2022, dates of service. This suspension, which began May 1, 2020, was outlined in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. It applies for both in-network and out-of-network providers who have had the 2% sequestration applied to their Medicare rates.

**Will Medica extend coverage of inpatient care for members who have COVID-19?** (As of 8/2/21)

With the wide availability of COVID-19 vaccines, Medica has made the decision to resume standard member cost-sharing for inpatient COVID-19 treatment beginning October 1, 2021. Medica waived member cost-sharing for in-network COVID-19 hospital care through September 30, 2021. This included copays, co-insurance and deductibles and applies to fully insured group, individual and Medicare members. Self-insured employers also had an opportunity to waive member cost-sharing for inpatient hospital services. (Costs for inpatient treatment for COVID-19 will be waived for Medicaid members until the end of the Public Health Emergency.)

**Does Medica cover rapid tests for COVID-19?** (As of 10/9/20)

Yes, Medica covers rapid diagnostic tests as well as standard nasal and saliva diagnostic tests. All tests must be medically necessary and ordered by a medical professional.

**How will Medica advise providers of any new coding and reimbursement considerations related to COVID-19?** (As of 9/17/20)

As the public health emergency (PHE) continues to evolve, additional codes may be created in order to accurately report and reimburse for services related to COVID-19. We encourage providers to reference Medica's [COVID-19 Testing](#) reimbursement policy for the latest coding considerations.

**Do members need an order from a medical professional for COVID-19 tests?** (As of 9/17/20)

*For Medicare and Medicaid, one test per member per year is allowed without a medical professional's order. For Medica's commercial and Individual and Family Business (IFB) members, all tests must be ordered by a medical professional.*

**Does Medica cover at-home diagnostic and antibody testing kits for COVID-19?** (As of 9/17/20)

*Medica will reimburse the reasonable expenses related to the purchase of an FDA-approved test kit for the purpose of COVID-19 diagnostic or antibody testing. As a reminder, these tests must be medically necessary and not used as part of return-to-work or public health surveillance efforts. Members are **not** required to complete a separate visit with their primary care provider or other medical professional prior to ordering a test, as many home test-kit suppliers have interactive screenings and/or telemedicine consultations included in order to verify if consumers qualify for testing.*

**Will Medica extend the copay waiver for Medicare Advantage members to see their doctor in person?** (As of 9/14/20)

*Yes, Medica will continue to waive member copays for in-person, in-network office visits for all Medica members who have Medicare Advantage plans, effective through December 31, 2020, dates of service. (Member benefits will still apply for all services other than the office visit.)*

**When is it appropriate to use the CS modifier during COVID-19?** (As of 8/7/20)

*To properly reflect the waiver of member cost-sharing for COVID-19 testing during the public health crisis (PHE), please use the CS modifier only for services relating to the order for or administration of a COVID-19 diagnostic test. Also, network providers may append the CS modifier to codes used for the evaluation of an individual for purposes of determining the need for diagnostic testing. This guidance applies for all Medica members. (Medica is reviewing the historical use of the CS modifier by providers during the PHE and reprocessing claims that assessed member liability incorrectly dating back to March 18, 2020.)*

**Is home testing covered for COVID-19?** (As of 7/16/20)

*Home tests for COVID-19 that are FDA-approved, ordered by a practitioner and medically necessary are eligible for coverage, except when done for a return to work or public surveillance.*

**Is Medica covering preventive health services that are provided using telemedicine?** (As of 6/24/20; updated 7/27/20; updated 10/9/20)

*Medica is covering certain preventive health services provided via telehealth. For more details, [see Medica's Telemedicine \(Emergency\) reimbursement policies](#).*

**Will Medica allow PAs and NPs to order home health care services for Medicare and Medicaid members?** (As of 6/11/20)

*Yes. The Centers for Medicare and Medicaid Services (CMS) has adopted changes regarding certification and provision of home health services that permit a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist to certify the need for home health services and to order such services for Medicare and Medicaid patients. This change, effective with March 1, 2020, dates of service, applies for all of Medica's Medicare and Minnesota Health Care Programs (MHCP) enrollees, including those in Medicare Advantage and Medicare Cost plans as well as in Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs BasicCare (SNBC) and SNBC dual-eligible plans.*

**Is Medica covering antibody tests for patients?** (As of 6/5/20; updated 7/27/20; updated 10/9/20)

Yes, Medica is waiving member cost-sharing for FDA-approved antibody tests for all Medica members, as long as tests are ordered by a medical professional and medically necessary. Our coverage for the antibody test applies both in-network and out-of-network, and will extend to office visits and other charges related to the antibody test when performed at in-network locations for a suspected COVID-19 diagnosis. [Refer to the COVID-19 Testing policy](#) for full details, including criteria and billing for this test.

**Will Medica reimburse for the specimen collection to test for SARS-CoV-2 in the hospital outpatient clinic setting?** (As of 5/26/20)

Yes. Because hospital outpatient departments will also be conducting widespread testing, the Centers for Medicare and Medicaid Services (CMS) created new HCPCS code C9803 (“Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 [SARS-COV-2] [coronavirus disease (COVID-19)], any specimen source”). Separate payment for C9803 will be made only if it is billed without another primary covered hospital outpatient service or if it is billed with a clinical diagnostic laboratory test with status indicator A. Medica will pay for this code for services provided on or after March 1, 2020, and for the duration of the Public Health Emergency.

**Can providers bill for telemedicine services on a facility form (UB-04 or electronic equivalent)?** (As of 5/15/20)

While Medica’s Telemedicine reimbursement policies apply to services submitted on professional claim forms (CMS-1500 or HIPAA transaction 837P), it’s understood that the Emergency Telemedicine policies do include services that may have historically been billed on a facility claim form (UB-04 or HIPAA transaction 837I). Facility claims received for telemedicine services would follow normal facility editing and contract guidelines, including Medica’s [Hospital-Based Clinics policy](#). Services would be limited to those designated by CPT® codes on our [Emergency Telemedicine Services Code List](#). Documentation of telemedicine services (including method of communication) should be supported within the medical record in the event of an audit. [See Medica’s “Telemedicine \(Emergency\)” reimbursement policies](#) for more details.

**Does Medica have stipulations to cover tests, like they need to be ordered by a physician and be medically necessary?** (As of 5/11/20; updated 5/15/20; updated 6/5/20; updated 7/27/20; updated 10/9/20)

Yes. Medica is waiving all member cost-sharing including copays, coinsurance and deductibles for in-network COVID-19 diagnostic testing as long as tests are ordered by an appropriate medical professional and are medically necessary and appropriate as determined by guidelines from the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA) and/or state public health authorities. These changes are retroactive to March 1, 2020, dates of service.

**How will Medica address concerns about prescribing medications for COVID-19?** (As of 4/28/20)

Effective May 4, 2020, Medica is adding quantity limits on certain drugs used for COVID-19. The fear of COVID-19 and subsequent stockpiling of medications used to treat this virus has put stress on the supply chain, limiting access and availability of these medications. In order to prevent stockpiling, as well as misuse and overuse, Medica is adding quantity limits (QLs) to certain medications effective May 4, 2020, as outlined below. These QLs apply to Medica’s commercial, Individual and Family Business (IFB) and Minnesota Health Care Programs (MHCP) members who have pharmacy drug coverage through Medica. The QL changes do not apply to Medica Health Plan Solutions<sup>SM</sup> (MHPS) or Medicare Part D members, or Medica members who reside in the state of Wisconsin.

Generic name (Brand name)	Medication allowed per 90-day period
azithromycin (Zithromax) 100 mg/5 ml for oral suspension, 15 ml	13 bottles (195 ml)
azithromycin (Zithromax) 200 mg/5 ml for oral suspension, 15 ml	7 bottles (105 ml)
azithromycin (Zithromax) 200 mg/5 ml for oral suspension, 22.5 ml	5 bottles (112.5 ml)
azithromycin (Zithromax) 200 mg/5 ml for oral suspension, 30 ml	4 bottles (120 ml)
azithromycin (Zithromax) 250 mg tablet	15 tablets
azithromycin (Zithromax) 500 mg tablet	15 tablets
azithromycin (Zithromax) 1 gm single-dose packet	2 packets
azithromycin (Zithromax) 600 mg tablets	24 tablets
Generic name (Brand name)	Medication allowed per 365-day period
chloroquine 250 mg tablets	56 tablets
chloroquine 500 mg tablets	28 tablets
hydroxychloroquine 200 mg tablets	28 tablets
lopinavir/ritonavir (Kaletra) 200 mg/50 mg tablets	56 tablets
lopinavir/ritonavir (Kaletra) 100 mg/25 mg tablets	112 tablets
lopinavir/ritonavir (Kaletra) 80 mg-20 mg/ml oral solution	160 ml (1 bottle)

The allowed quantities provide sufficient medication to support the treatment of one episode of COVID-19 as well as indicated short-term conditions. Prior authorization is required for coverage of additional medication. Medica will enter prospective authorizations for members identified as long-term users of hydroxychloroquine and Kaletra to maintain current coverage for these medications. As needed, providers should contact Express Scripts to request access to additional quantities of the medications listed above: [See more on this at Medica.com](#). These QL changes above are intended to be temporary and will be in effect until the end of the current Public Health Emergency.

**Will Medica pay claims for IFB members who are having trouble paying their premiums during the current crisis?** (As of 4/21/20; updated 5/26/20)

Yes. To ensure that provider reimbursements are not slowed down during the current Public Health Emergency, and ensure that members have uninterrupted access to health care services and medications at this critical time, Medica is paying Individual and Family Business (IFB) member claims even for members not current on their premiums, beginning with March 1, 2020, dates of service. This IFB premium-relief period will end on June 1, 2020, when Medica will revert to standard grace period timeframes (pending additional regulatory or state notifications and/or guidelines). When IFB member accounts are fully reconciled later this year, some provider recoupments may result if a member's coverage is terminated retroactively due to non-payment of premiums.

**How will COVID-19 diagnostic testing codes be paid on inpatient claims?** (As of 4/15/20)

COVID-19 diagnostic testing codes are included in the Centers for Medicare and Medicaid Services (CMS) grouper rates and the Medica proprietary grouper rates. COVID-19 diagnostic testing codes will not be paid in addition to the diagnosis-related group (DRG), per diem, per case-rate payment.

**Is Medica making credentialing adjustments for practitioners?** (As of 4/13/20; updated 5/5/20)

Yes. Effective immediately, Medica is making changes that address modified credentialing and recredentialing criteria in accordance with new National Committee for Quality Assurance (NCQA)



exceptions to health plan accreditation requirements. These changes are temporary and extend through the end of the Public Health Emergency (PHE):

- Practitioners moving from one clinic to another clinic within the same organization **do not** need to send Medica information to reflect additional practice sites, unless the sites are under a different federal tax ID than the tax ID the practitioners are currently set up under.
- For locum tenens positions, Medica is now extending locum tenens, one-time credentialing at a participating clinic or facility from 90 days to 180 days. Practitioners who are currently practicing in a hospital setting and moving to another hospital setting are considered active and non-credentialed, and **do not** need additional credentialing. Practitioners who are moving from a hospital to a clinic setting must be credentialed to practice at the clinic – To do so, they can use the locum tenens application [at Medica.com](https://www.medica.com), under “Credential a Practitioner.”
- The 3-year credentialing cycle for eligible practitioners is now extended by 2 months, from 36 months to 38 months. As a result, recredentialing due dates are now 2 months later, so March is extended to May, April to June, and so on.

**How are you incorporating CMS changes for telehealth services and COVID-19 testing?** (As of 4/10/20)  
Medica made the following recent updates per the Centers for Medicare and Medicaid Services (CMS).

- Updated reimbursement rates for recently added G-codes: Medica’s reimbursement rates are based on rates recently announced by CMS for COVID-19 testing. Medica will reimburse contracted and non-contracted providers for COVID-19 testing and has added Healthcare Common Procedure Coding System (HCPCS) codes G2023 and G2024 to Medica’s COVID-19 Diagnostic Testing reimbursement policy. [See this updated policy.](#)
- Billing for telehealth distant-site services during the Public Health Emergency (PHE): CMS recently revised billing guidelines for these services. When billing on professional claims for all telehealth services for Medica’s Medicare members, including dually eligible members in MSHO and SNBC plans – for dates of services on or after March 1, 2020, and for the duration of the PHE – providers should bill with: a Place of Service (POS) equal to what it would have been had the service been furnished in-person; and Modifier 95, indicating that the service rendered was actually performed via telehealth.

**Has Medica made policy updates to expand telehealth reimbursement and coverage?** (As of 4/3/20)

Yes. We recently made several changes to reimbursement and coverage policies that address telehealth, as outlined below. These changes continue to expand coverage and payment, to make it easier for providers to provide services remotely during the current COVID-19 pandemic. Changes apply immediately for all Medica members, except as indicated for Minnesota Health Care Programs (MHCP).

Medica’s updated [reimbursement policies](#):

- **Telephone Services Reimbursement Policy** – Renamed the Telephone and Virtual Care Services Reimbursement Policy, it now includes information regarding virtual care services. Virtual care services are professional evaluation and medical management (E/M) services provided to new or existing patients through email, telephone or webcam to address non-urgent new or ongoing medical symptoms to which providers respond with substantive medical advice. The code list has been expanded to include telephone services and virtual care codes, including new 2020 virtual care codes.
- **Telemedicine (Emergency) Reimbursement Policy (Excluding MHCP)** – Telemedicine services are reimbursed at the same rate as in-person face-to-face visits. The code list, expanded to align

with the Centers for Medicare and Medicaid Services (CMS) Telemedicine code list, identifies codes that require use of audio and visual communication methods, not only audio.

- **Telemedicine (Emergency) Reimbursement Policy (MHCP)** – Telemedicine services are reimbursed at the same rate as in-person face-to-face visits. The code list, expanded to align with the CMS Telemedicine code list, identifies codes that require use of audio and visual communication methods, not only audio. The policy has been expanded to allow telephone calls as telemedicine services; to allow a provider's first visit with a patient to be conducted on the phone for certain services where it is normally required to be conducted in person; and to increase the number of weekly visits for state enrollees.
- **COVID-19 Diagnostic Testing Reimbursement Policy** – CMS recently established new specimen-collection codes for laboratories billing for COVID-19 testing. Clinical diagnostic laboratories should use these 2 Healthcare Common Procedure Coding System (HCPCS) codes effective with March 1, 2020, dates of service: G2023 (Specimen collection for severe acute respiratory syndrome, any specimen source) and G2024 (Specimen collection for severe acute respiratory syndrome, from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source).

Medica's updated **coverage policies**:

- **Virtual Care Coverage Policy** – This policy is updated with new codes for expanded coverage.
- **Telemedicine Coverage Policy** – This has been replaced with an Emergency Telemedicine coverage policy, which includes language for temporary expanded coverage.

Emergency Telemedicine policies are intended to be temporary. Telemedicine services are reimbursed at the same rate as in-person face-to-face visits. Also, for all products, Medica will follow the CMS expanded Telemedicine code list for expanded telemedicine coverage during the duration of the COVID-19 pandemic (policies identify effective and end dates).

**How are telehealth services reimbursed when billed with place of service (POS) 02?** (As of 4/3/20)  
POS 02 has no impact on payment. Per Medica's Emergency Telemedicine reimbursement policies, telehealth services are paid at the same rate as if the service were provided in a face-to-face encounter.

**Is Medica suspending requirements like prior authorization to help provider offices?** (As of 4/1/20)  
Yes, in certain situations we are suspending administrative requirements. The following two temporary changes apply for all Medica members and are effective beginning with April 2, 2020, dates of service.

**1.)** We are suspending prior authorization requirements to a post-acute care setting, so no prior authorization is needed for admission to the following facilities:

- Long-term acute care (LTAC)
- Acute inpatient rehabilitation (AIR)
- Skilled nursing facilities (SNFs)
- Home health care

Our intent is to open hospital beds for those critically ill. Consistent with existing policy, the admitting provider should continue to notify Medica within 48 hours, and length-of-stay reviews still apply, including denials for days that exceed an approved length. Concurrent review will also continue.

**2.)** Any repair or replacement of durable medical equipment (DME) will not require a new physician's order, face-to-face visit or medical necessity documentation. These are still required, however, for new

equipment requests.

*These measures are intended to be temporary. Coverage continues to follow each Medica member's benefits. Medica continues to review its policies and procedures during the COVID-19 crisis. We are adjusting processes to reduce administrative burden for physicians and facilities, and to help our members access the care they need as easily as possible.*

**Is Medica reviewing/updating its telehealth policies for greater flexibility?** (As of 3/26/20; updated 6/1/20; updated 6/3/20)

*(See above, as of 4/3/20, for more on Emergency Telemedicine reimbursement policies.)*

*Yes. In accordance with new guidance from the Centers for Medicare and Medicaid Services (CMS) and various state actions, Medica has made temporary changes to two existing reimbursement policies that address telehealth. These changes expand the code lists for payment to make it easier for providers to provide services remotely during the current COVID-19 pandemic. Changes apply immediately for all Medica members and are retroactive to March 6, 2020, dates of service. Coverage continues to follow each Medica member's benefits. Medica's updated **reimbursement policies** are:*

- *Emergency Telemedicine Reimbursement Policy (Excluding MHCP)*
- *Emergency Telemedicine Reimbursement Policy (MHCP)*

*In addition, Medica has the following related coverage policies and reimbursement policy, which are currently under review (we will notify providers if anything changes):*

- *Telemedicine Services Coverage Policy*
- *Virtual Care Coverage Policy*
- *Telephone Services Reimbursement Policy*

*Given the current COVID-19 pandemic and the need to provide additional access and care for members, Medica is continually reviewing its policies to ensure clarity of requirements and to meet changing needs. Medica is covering telehealth services to ensure access to care while reducing the opportunities for disease transmission. As an example of a change to allow more remote care for the duration of the Emergency policies above, Medica is temporarily waiving site restrictions so members can be located at home to receive telehealth services, as well as allowing audio-visual applications such as Skype and FaceTime to be used for telehealth visits. The Emergency policies are intended to be temporary. [They are in place during the Public Health Emergency; see policies for effective and end dates.]*

**Will Medica reimburse telemedicine and virtual care services if a member receives telehealth at home?** (As of 3/26/20)

*Yes, Medica is temporarily waiving the CMS and state-based site restrictions and will allow members to be located at home when they receive telehealth services.*

**Can telehealth be provided over the telephone with no video component?** (As of 3/26/20)

*Medica still recommends that telehealth include both an audio and a visual component, but is waiving the requirement of a visual component for the duration of the Emergency Telemedicine reimbursement policies related to COVID-19. In certain circumstances, telehealth services may be provided over the telephone if the video component is inaccessible to a member. Providers should continue to follow proper coding guidelines for services provided. Note: There are situations that do still require both audio and video components, such as physical, occupational, and speech therapy. Codes for these services are noted on the telemedicine code list in the Emergency Telemedicine reimbursement policies; this code list*



*was expanded to mirror CMS recommendations. Medica is waiving the video requirement for the majority of telemedicine services, yet some still do require both components.*

**What are the requirements for the audio-visual applications being used for telehealth?** (As of 3/26/20)

*In accordance with CMS and state guidance, Medica will waive the Health Insurance Portability and Accountability Act (HIPAA) security requirements and allow audio-visual applications, such as Skype and FaceTime, to be used for telehealth visits.*

**Do participating providers need to make any changes to contracts to provide telehealth or virtual care services?** (As of 3/26/20)

*No contracting changes are needed. Providers should follow proper coding requirements. Eligible codes are listed in both of the Emergency Telemedicine reimbursement policies as well as in the Telephone and Virtual Care Services reimbursement policy.*

**What about member cost-sharing for office visits and other health services related to coronavirus (COVID-19) testing?** (As of 3/20/20)

*For the duration of the national emergency declaration noted above, Medica is waiving cost-sharing for in-network COVID-19 diagnostic testing and office visits, urgent care, and ER visits affiliated with the diagnostic testing. This coverage change applies to Medicare Advantage, Medicaid, self-funded groups, fully insured groups and individual health insurance coverage. Medica is currently assessing the requirements of this new law and will provide further updates when we have more information.*

**Will Medica extend timely filing deadlines?** (As of 3/20/20; updated 1/4/21)

*Yes; beginning March 1, 2020, for Medica's commercial/ERISA group health plans only, Medica temporarily paused timely filing requirements for claims that would have exceeded the filing limitation during the COVID-19 National Emergency, per Department of Labor (DOL) and Internal Revenue Service (IRS) regulation. This change for timely filing does not apply to Medica's self-insured/non-ERISA commercial groups, Individual and Family Business (IFB), Medicare or Medicaid plans.*

*This requires group health plans to disregard the "outbreak period" of the national emergency when calculating timely filing for claim submission deadlines, which started March 1, 2020. There will be an additional 60-day extension of timely filing requirements for claim submission following the last day of the national emergency or such other date announced by DOL and IRS. Following the 60-day extension after the last day of the national emergency, Medica intends to resume standard processes, policies and procedures in the manner that was in effect prior to March 1, 2020.*

**Will Medica cover medical supplies such as masks, gloves, disinfectant that consumers may want?** (As of 3/10/20)

*Most of these supplies are **not** currently covered as take-home items for Medica members. Some of these costs may be built into care costs for certain medical conditions currently under treatment in a clinical setting, such as wound care.*