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Medica | PROVIDER NEWS

Your monthly Medica Provider News

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Best practices: Verify key information prior to rendering health care services

At times, our health plan makes changes to prior authorization requirements and medical and drug policies. At least 90 days prior to any change, we notify providers of the changes to our processes, prior authorization requirements and medical or drug policies. These notifications and updates are shared through our monthly provider newsletter and then posted online on our **Provider News webpage**.

To avoid claim denials, we recommend — prior to rendering services — that providers check member benefits and eligibility, as well as consult the following resources on our **Medical management webpage**:

- The medical prior authorization Master Service List and the Medical Injectables List give guidance on prior authorization requirements for procedure codes, service codes and medications.
- And the Non-Covered Services policy details services that don't require authorization because they are broadly considered non-covered.

Regardless of how you choose to submit your prior authorization request, these resources are a great way to ensure that your time is used wisely and the authorization submitted is truly needed for the services being rendered.

And again, stay up-to-date by reviewing our health plan's monthly provider newsletter and any medical or drug policy updates. Located at the end of each newsletter, find the link to any monthly updates we're making to our medical and drug policies.

Availity update:

Tips + tricks for submitting prior authorization requests

Now that prior authorization submission and status (HIPAA 278) transactions are available through the Availity Essentials portal, here are several tips and tricks for knowing when to use (and when not to use) Availity vs. other resources and tools.

- **If you use the Availity tool to search for a CPT/HCPCS code and determine whether PA is required:** Availity will provide results *for all products*. This means in Availity, it may show as required when it is actually not a requirement for the product. For a breakdown of authorization requirements by product, refer to our health plan's **Master Service List**.
- **If an authorization is pending for additional details needed in Availity:** The provider will receive a call or fax requesting the additional necessary information, indicating a timeframe within which it must be received.
- **Admission dates and member eligibility:** When submitting authorizations for inpatient services, ensure that the member has coverage eligibility and a current ID number for the admission date submitted in your request. The member's current coverage timeline, including termination date if known, will display at the top of the "Add Service Information" screen within the prior authorization workflow. If the admission date falls outside the member's current eligibility, but the member has active coverage on the date of admission under a different ID number, please submit your request via fax or e-mail.
- **Out-of-network authorizations:** You can now submit out-of-network prior authorization requests electronically on the Availity portal. For out-of-network prior authorization requests not related to a procedure or service requiring prior authorization, skip the "Is Auth Required?" tool and type "Out of Network" in the Provider Notes box on the "Add Service Information" screen.
- **Carelon:** Prior authorizations for services managed by Carelon should be

submitted through the Carelon portal, though you can still use the “Is Auth Required?” tool on Availity to confirm if a CPT® code is managed by Carelon. If a request is for musculoskeletal (MSK), cardiovascular, pain management or radiology services managed through Carelon, **submit the request directly to Carelon**.

- **Medical injectables:** Prior authorization for provider-administered drugs such as medical injectables cannot be submitted on the Availity portal. In addition, the “Is Auth Required?” tool will not return accurate prior authorization requirements for medications. See our health plan’s **Medical management webpage** for guidelines on how to submit prior authorization for medical injectables.

Many daily transactions are now available from Availity. Providers can learn about all transactions available from Availity Essentials so far. Refer to the **Availity Learning Center** for training on all Essentials transactions.

Update on Carelon retrospective authorizations

If an authorization is not received by Carelon prior to the rendering of services for any Carelon-managed program — radiology, cardiology, muskuloskeletal (MSK), including pain management — providers now have 10 business days (Monday - Friday) post-service to submit requests for authorization (medical necessity review). Such requests should occur prior to submission and adjudication of the claim. As a reminder, the best practice is to submit all requests *prior to the date of service* and within the 10 business day post-service window using **the Carelon portal**.

In circumstances where an authorization has been obtained but intraoperative findings require a different procedure, providers must call Carelon at **1 (833) 476-1463** within 10 business days of the procedure to request authorization of the completed service.

Effective June 1, 2025:

New preferred product to be added for tocilizumab

Effective June 1, 2025, our health plan will make Tyenne the preferred product for

tocilizumab. This product is administered under the member's medical benefit.

Drug/Therapy class	Preferred product (code)	Requested product (code)
tocilizumab	Tyenne (Q5135)	Actemra (J3262); Tofidence (Q5133)

For members on Actemra (tocilizumab) or Tofidence (tocilizumab-bavi), current prior authorizations and any new authorization requests will allow coverage through May 31, 2025. These authorizations and approved requests processed before June 1, 2025, will include an authorization for Tyenne (tocilizumab-aazg), the preferred tocilizumab product, and will be approved for the authorization duration. Effective June 1, Actemra and Tofidence will require a trial and failure of Tyenne, along with the applicable prior authorization criteria. No further action is needed by providers if switching to Tyenne before June 1.

This change will provide our members and their providers with cost-effective and clinically appropriate alternatives when they are indicated. Prior authorization will be required for the corresponding medical pharmacy drugs. Step therapy applies to non-preferred products Actemra and Tofidence.

Note: This change only applies for utilization through the medical benefit. **Utilization management (UM) drug policies** for the medical benefit are available online. Products in this category may also be covered under the pharmacy benefit. Access our health plan formularies to assess coverage under the pharmacy benefit.

Member impact
This change will apply to commercial, Individual and Family Business (IFB), administrative services only (ASO) and Medicare Advantage members. It *will not apply* to Medicare Cost or Medicare Supplement members.

Medical Policy Committee updates

Highlights of recent medical and drug policy revisions, new policies, and formulary updates approved by the Health Plan's Medical Policy Committee, as well as information on how to locate policies and criteria are published as part of our newsletter:

See Provider News Policy Notice for March 1, 2025

Drug policies
Drug policies are applicable to all of our health plan products, unless directly

specified within the policy. **Note:** All changes to the policies may not be reflected in the written highlights in our Provider News Policy Notice. *We encourage all prescribers to review the current policies*.

Medical policies
In addition to our medical policies, all other clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at **1 (800) 356-7344**, ext. 4012.

Coverage of any medical intervention in a medical policy is subject to the limitations and exclusions outlined in the member's certificate (or evidence) of coverage and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note that prior authorization through the Health Services Division is required for some treatments or procedures.

Prior authorization requirements for self-funded plans (also called ASO plans) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

We've partnered with Carelon, a utilization management (UM) program vendor, to support the provider submission and medical necessity review process for select musculoskeletal (MSK), cardiovascular and radiology services, as well as those for interventional pain management. Submissions and review by Carelon replace those previously managed by NIA Magellan (for MSK and radiology). Refer to our Medical Management Master Services List to find which services need Carelon review before providing the service. Submit requests to Carelon **using this portal** or by calling **1 (833) 476-1463**.

For help with the Carelon provider portal, contact Carelon at **1 (800) 252-2021**, option 2, weekdays from 7 a.m. to 6 p.m. Central Time. Or contact them at **WebCustomerService@carelon.com**.

Medica
401 Carlson Pkwy Minnetonka, MN, 55305, USA