April 1, 2025

Medica | PROVIDER NEWS

Your monthly Medica Provider News

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# Medicare telehealth flexibilities extended through Sept. 30, 2025

The approval of the recent federal funding bill means the Centers for Medicare and Medicaid Services (CMS) will extend the temporary telehealth flexibilities that were in effect for Original Medicare during the COVID-19 Public Health Emergency (PHE). This means no changes through Sept. 30, 2025, for providers' administration and billing of telehealth services. Providers are encouraged to **refer to CMS** for more details on telehealth guidelines. We will also continue to convey up-to-date information about any health plan impacts related to this.

**Credentialing process enhancement:**

# Our health plan will soon begin accepting CAQH applications

Beginning April 14, 2025, Council for Affordable Quality Healthcare (CAQH) applications will be accepted through the credentialing process for our health plan. If you maintain a CAQH application, please submit your CAQH ID on the Provider Network Application. The Credentialing Team will use the CAQH ID to obtain a copy of your CAQH application. For those who maintain a CAQH application, this addition will streamline the process by reducing the need to complete another credentialing application. We will continue to have a separate credentialing application available for providers who don't maintain a CAQH application.

# Clarification on tocilizumab change effective June 1

To clarify what we published last month: In addition to Actemra and Tofidence becoming non-preferred products effective June 1, 2025, *any new tocilizumab products will also be considered non-preferred* . Tocilizumab biosimilar products that are expected to be available soon include Avtozma and tocilizumab-anoh — So this means that, effective June 1, Actemra, Tofidence, Avtozma and tocilizumab-anoh will all be non-preferred products and require a trial of at least three months of the preferred tocilizumab product as well as the criteria noted in the policy. Again, Tyenne will be our health plan's preferred tocilizumab product effective June 1. Please see last month's Provider News for further details on this change.

As a reminder, this change only applies for utilization through a member's 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.

# Language Line bridges provider + patient communications

As a reminder: To address diverse language needs and enable important communications between providers and patients, we offer a free, telephonic Language Line with language assistance and interpreter services for providers that do not have a language line service available. Our service is available 24/7 to our network providers who need to

interact with members who have limited English language proficiency. Request language assistance by calling **1 (844) 526-1386**. For more about the Language Line, see our **Provider Manual**.

**Reminder:**

# Accessibility of Services standards

It is important for network providers to understand the Accessibility of Services standards. Our health plan is committed to ensuring that members using the provider network for their care have appropriate appointment accessibility. The Accessibility of Services standards for members pertain to services provided by primary care, specialty care and behavioral health care clinic locations and can be found in the Quality Improvement section of our Provider Manual.

**Reminder:**

# Notify us of changes to your demographic details

We're committed to ensuring that our provider directories are accurate and current for the members who rely on this information to find in-network care. Plus, Centers for Medicare and Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories.

Review your directory information regularly on our website to verify it reflects current and accurate information for you and your organization. Notify your Provider Network Consultant of any updates to your information on file with us, including changes to any of the following:

| Practitioner Data Elements | Location Data Elements |
|---|---|
| Practitioner Name | Location Name |
| Degree/Title | Address |
| Specialty | Phone Number |
| Ability to Accept New Patients | Handicap Accessible |
| Board Certification | Website URL |
| Gender | Accepted Plan Types at Location |
| Language(s) Spoken by Practitioner | Language(s) Spoken at Location |
| Telehealth Available<br>○ Telehealth Optional / Telehealth Only<br>○ Modalities (chat, phone & video)<br>○ 3rd Party Caregiver | Handicap Accessible |
| Language(s) Spoken by Practitioner | Services |
| Participating Hospital Affiliation(s) | |
| Practice Locations | |

Also notify us of terminations for individual practitioners, clinics, facilities and any other locations under your organization. Terminations need to be communicated in writing to your assigned Provider Network Consultant with as much advance notice as possible.

While our vendor BetterDoctor conducts quarterly outreach to validate that our on-file information for you is accurate, don't wait for these reminders to update your information.

**NPPES information**
We encourage you to also review and update your National Plan and Provider Enumeration System (NPPES) information and keep it updated. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format and serves as an important resource for provider information. **Refer to NPPES online**.

# 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 April 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**

checklist

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**.


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