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Medica | PROVIDER NEWS

Your monthly Medica Provider News

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Availity update:

The latest development on Availity Essentials portal

As previously mentioned, Availity is updating its prior authorization submission application on its portal. This change will bring the integration of simple clinical criteria questions that allow providers to easily provide clinical rationale for the requested health care service. The question set presented in the workflow will vary based on the Current Procedural Terminology (CPT®) code or diagnosis code indicated. This update can decrease the turnaround time of the submission and improve communication between providers and our health plan.

Availity will host the following short trainings so you can learn more about this development.

Topic	Date/time	Registration
MCG Integration for Authorizations	Thursday, Aug. 14, at 1 p.m. CT	Register now.
MCG Integration for Authorizations	Tuesday, Aug. 19, at 10 a.m. CT	Register now.

As a reminder, prior authorizations should not be submitted on the Availity Essentials portal for medications or for radiology, cardiology or musculoskeletal services.

- Submit medical drug prior authorization requests to our health plan by fax at **1 (608) 252-0814**.
- Submit prescription drug prior authorization requests through the **Navitus portal**.
- And submit prior authorization requests for radiology, cardiology and musculoskeletal services using the **Carelon portal**.

Quick Hits

Accessing medical benefit drug UM policies
Last month, we announced that we'll be retiring the Medical Injectables List (MIL) effective Oct. 1, 2025. We also provided a link to our medical benefit drug utilization management (UM) policies on the Prime Therapeutics website to search for medical benefit drugs that require prior authorization. As a hot tip: You can also access these Prime Therapeutics policies from **our Medical management webpage** on our health plan's website. Simply click on "Medical drug PA policies" under "Authorization and coverage."

Clarifying the premium grace period for IFB members

When Individual and Family Business (IFB) members fail to pay their premium in a timely manner, they enter a premium grace period. Depending on eligibility, the member's policy may have a 31-day grace period or a 93-day grace period. Members with a 93-day grace period, and in their second or third month, will have a claims hold placed on their account until premiums are paid. This prevents us, the health plan, from needing to recoup claims payment if the member were to fail to pay their premium and be retrospectively terminated.

If you receive a claim denial indicating your patient with an IFB plan is not eligible for the date of service, but you've confirmed the member is active based on our eligibility and benefits transaction on the Availity Essentials provider portal (or by calling us), it is likely your patient is in a premium grace period. The Availity eligibility transaction also indicates a grace period, if one is applicable: "HIX Grace Period" would show up under the Health Benefit Plan Coverage section.

CARC + RARC codes indicating grace period
When claims are received during months two and three of the grace period, the following informational codes will be displayed on the Provider Remittance Advice (PRA) or Explanation of Payment (EOP):

- **N617 (RARC code):** This enrollee is in the second or third month of the advance premium tax credit grace period.
- **OA 257 (CARC code):** The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends.

These Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) adjustment codes indicate neither member nor provider liability. Once the grace period expires, claims will be reprocessed to be either paid or denied.

Appealing on behalf of the member
Until the member pays their overdue premium, we will not provide payment for the member's claims if they are in months 2 or 3 of their grace period. An appeal to our health plan will not resolve this issue, as we would be waiting for member action. Providers should only bill our IFB members if the "PR" code (for patient responsibility) shows up on PRAs or EOPs. This would also indicate when providers can contact our health plan to discuss how to resolve any claim denials, which may include beginning an appeal process for the member.

Our members have the right to appoint representatives, such as their providers, to initiate member appeals. Providers may initiate an appeal on behalf of a member by calling the Provider Service Center.

Questions? Contact our Provider Service Center at **1 (800) 458-5512**.

Administrative update:

Time to revise bookmarks linking to Prime Therapeutics website

Prime Therapeutics changed its medical pharmacy website URL to **gatewaypa.com**, and for some time, the former **mrxgateway.com** URL would redirect to the new web address. However, this redirecting has ceased, no longer redirecting users and instead generating an error message.

As a result, providers should update any outdated **mrxgateway.com** bookmarks and replace them with **gatewaypa.com**. This update to the Prime Therapeutics website domain name *pertains to all Prime Therapeutics drug utilization management (UM) policy pages* , which are linked under "Clinical Guidelines" at the left side of the **gatewaypa.com** landing page.

Questions? Contact Prime Therapeutics at **ProviderInquiry@PrimeTherapeutics.com**.

New pharmacy-related CMS Stars measures for 2025

The Centers for Medicare and Medicaid Services (CMS) introduced two new Stars measures for 2025 aimed at improving medication safety for Medicare enrollees. The focus of Measure 1 relates to the use of multiple anticholinergic (ACH) agents in older adults, while Measure 2 focuses on prescribing of opioids in combination with benzodiazepines for adults 18 years of age or older.

Measure 1: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)
This measure tracks Part D beneficiaries 65 years of age or older prescribed two or

more ACH medications simultaneously for over 30 days. Beneficiaries enrolled in hospice during the measured period are excluded.

Prolonged use of multiple ACH medications in older adults is associated with risk of cognitive decline. This measure helps providers identify at-risk patients and reduce harmful polypharmacy. Common ACH medication classes include:

- First-generation antihistamines (e.g., diphenhydramine)
- Antipsychotics (e.g., haloperidol)
- Antiemetics (e.g., ondansetron)
- Antimuscarinic agents (e.g., oxybutynin)

Measure 2: Concurrent Use of Opioids and Benzodiazepines (COB)
This measure evaluates how often Part D beneficiaries aged 18 years or older are prescribed an opioid and benzodiazepine concurrently for at least 30 cumulative days. Beneficiaries are excluded if during the measurement period they were receiving hospice or palliative care or carried a diagnosis of cancer or sickle cell disease.

While there may be circumstances where it is appropriate to use an opioid and benzodiazepine together, the combination of central-nervous system (CNS) depressants is deemed a serious safety concern as it can lead to higher risk of respiratory depression, cognitive impairment, falls, or other negative outcomes for beneficiaries.

See more about these 2 Stars measures.

Post-discharge follow-up care for mental health, substance abuse

Continuity of care after a hospitalization for mental health or substance use is crucial for minimizing patients' risk for relapse and readmission. Patients who are engaged in their care and treatment after a hospital discharge may have improved outcomes, fewer emergency room presentations, reduced hospital readmissions, and for those with substance use disorders, a reduction in overdose.

Here are some strategies to engage patients:

- **Schedule a follow-up appointment before discharge.** The first appointment should be scheduled within 7 days but no later than 30 days based on National Committee for Quality Assurance (NCQA) 2025 Healthcare Effectiveness Data and Information Set (HEDIS®) Specifications. **See more about HEDIS measures**.
- **Manage medications.** Discuss the importance of medication adherence and not stopping any medications on their own.
- **Provide referrals to community support services.** Support groups, peer-led programs, and health insurance case management are important tools to help patients transition to outpatient care. Our health plan provides case management services for members with mental health or substance use needs, such as finding and scheduling an appointment with a contracted provider. Patients can self-refer by calling the Customer Care Center number on their member ID card. Providers can refer by e-mailing us at **caresupport@medica.com** or contacting the Provider Service Center.
- **Address barriers.** Identify and address any barriers to the patient attending follow-up appointments.

- **Plan for possible relapse.** Prepare a crisis plan with steps the patient can take if their symptoms worsen.

Reminder:

Billing protections for Qualified Medicare Beneficiaries

Federal law prohibits the billing of Qualified Medicare Beneficiaries (QMBs). This means that Medicare providers and suppliers, including pharmacies, cannot bill individuals enrolled in the QMB program for Medicare cost-sharing.

The QMB program ensures beneficiaries with limited income and assets have meaningful access to Medicare benefits. For Medicare beneficiaries enrolled in the QMB program, Medicaid covers the Medicare Part A and Part B deductibles, coinsurance and copays for which a Medicare beneficiary is generally responsible. While providers may be reimbursed at the lesser of the Medicaid or Medicare rates, providers are prohibited from balance billing or collecting any cost-sharing from these QMBs.

Refer to the Centers for Medicare and Medicaid Services (CMS) **QMB program web page** for more information.

Medical Policy Committee updates

Highlights of recent medical and drug policy revisions, new policies, and formulary updates approved by our 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 Aug. 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**.

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