July 1, 2025

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Effective July 1, 2025:

Credentialing Corner: Important updates to our credentialing procedures

Staying up-to-date on credentialing requirements is one of the most important steps you can take so that our members can access your services. Please review and share these updates and reminders with your team members to minimize confusion or delays.

- Per the National Committee for Quality Assurance (NCQA), if **locum tenens (LT)** health care providers will be working longer than 60 days, they must undergo full credentialing. Please *be sure to indicate providers' LT status clearly* when submitting new provider start and end dates. LT providers working 60 days or less may still be accepted under provisional credentialing.
- NCQA now requires that specific **health equity language** be included on credentialing applications. If the application is submitted without the required information, the Credentialing team will reach out to obtain the missing information, which could result in delays. The Council for Affordable Quality Healthcare (CAQH) application and the Medica standard application both include these required fields.
- Medica is enhancing its **license expiration review process** and will set monthly cycles to ensure that all licensed providers are maintaining these required credentials. Providers who have an expired license will be administratively terminated and will need to reapply to be in-network once they have renewed an active license.

- We send out **determination letters** when providers undergo initial credentialing. Starting Oct. 1, 2025, when providers undergo *recredentialing*, they will only receive a notice from us if more information is needed for completion or if their recredentialing has been denied.
- We've historically sent out credentialing **letters differentiated by brand** within the Dean Health Plan and Medica family of brands. However, you may start seeing our letters branded simply as Medica that will apply for Dean Health Plan by Medica and Prevea360 Health Plan as well.

Quick Hits

Our website content is moving to Medica.com
Our websites **wellfirstbenefits.com** and **mo-central.medica.com** have started to transition to a new home on Medica.com. During this transition, providers can navigate to URL **mo-central.medica.com/Providers** to access familiar provider resources such as Medical management, Pharmacy services, Provider communications and the Medica Central provider portal. We'll publish and share updated links when current URL redirection is discontinued.

Contact Availity directly for specific transaction issues
As a reminder, if you encounter any issues or have questions while using the Availity Essentials provider portal, your first course of action is to reach out to Availity Client Services at **1 (800) 242-4548**. If you have questions on a particular authorization or appeal or need clarification on a determination, our Provider Service Center can review these with you at **1 (800) 458-5512**.

Effective Oct. 1, 2025:

We'll be retiring our Medical Injectables List

Our health plan will be retiring the Medical Injectables List (MIL) effective Oct. 1, 2025. Providers should rely on the medical benefit drug utilization management (UM) policy list **on the Prime Therapeutics website** to search for medical benefit drugs that require prior authorization. This online policy list includes HCPCS codes that providers can find using the Control-F function. Questions? Please contact our Provider Service Center at **1 (800) 458-5512**.

Note: The medical benefit drug UM policies hosted on the Prime Therapeutics website only address those requiring prior authorization. If a medical benefit drug does not appear on the Prime Therapeutics website, this indicates that it may not need an authorization. Some medical benefit drugs may not be considered for coverage. You can search for drugs by name in our Document Library to verify that they will be considered for coverage.

Effective Oct. 1, 2025:

Reimbursement policy update for IONM coming soon

Our health plan will soon implement revisions to the reimbursement policy indicated below, effective on or after Oct. 1, 2025, dates of service.

Intraoperative Neurological Monitoring (IONM)
Following Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT®) and the American Academy of Neurology (AAN), we're making the following changes to our IONM policy. IONM codes 95940, 95941 and G0453 must be reported with a Study Code and Place of Service (POS) code 19, 21, 22 or 24 to be reimbursable. They also must not be reported by the surgeon or anesthesiologist performing the surgical procedure because IONM codes are included in the global package.

This policy change will apply to claims for our commercial, Medicare, Medicaid, and Individual and Family Business (IFB) members. The revised policy will be available online or on hard copy:

- **View reimbursement policies** as of Oct. 1; or
- Call the Provider Literature Request Line for printed copies of documents, at **1 (800) 458-5512**, option 1, then option 8, ext. 2-2355.

Note: Our health plan and Medica are aligning on how our reimbursement and policy criteria are shared. While we're in the midst of this transition, you can find reimbursement policies that have been communicated previously on our Communications page under its own drop-down. A full list of **current reimbursement policies is available at Medica.com** .

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 ○ Telehealth Optional / Telehealth Only ○ Modalities (chat, phone & video) ○ 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. You can contact us by using our **provider support e-mailbox**.

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 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 July 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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