May 31, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

Mo-Central.com and Central.Medica.com are the websites for health plan information

Continue referring to **Mo-Central.Medica.com** and **Central.Medica.com** for health plan (formerly WellFirst Health) information. While we proceed with aligning business platforms, processes, and policies with our partner Medica, the information and resources on the above websites continue to be for health plan (formerly WellFirst Health) information.

Not sure which resource applies to your Medica patient? Refer to the Medica Provider Quick Reference by Payer ID and Medica's Just in Time for Providers on our **Provider communications** page.

In this edition:

Coming in September - New UM program to manage certain prior authorization services

Carelon to review submissions for MSK, radiology, and cardiology authorizations

Effective on or after Sept. 1, 2024, Medica is partnering with Carelon, a utilization management (UM) program third party vendor, to support the provider submission and medical necessity review process for select musculoskeletal (MSK), cardiology, and radiology services. These prior authorization requirements, of which cardiology will be new, are being added to help achieve consistent, high-quality care while maintaining appropriate access to related health care services.

As a result of this program launch in September 2024, prior authorization will apply to select MSK, cardiology, and high-tech radiology procedures and services including but not be limited to: hip, knee and shoulder arthroscopy; various interventional pain management injections such as sacroiliac joint injections; imaging such as MRI, MRA and CT scans; angioplasty and stent placement; implantable pacemakers; and vascular imaging. Some services are currently on prior authorization with Magellan Health. Those services will continue with Magellan Health when rendered through Aug. 31, 2024, and then move to Carelon for review. Medica will add or update UM and coverage policies for affected MSK, cardiology, and radiology services. All impacted services will be outlined in Carelon's policies on the Carelon website, to be available online in September 2024. Our Master Service List will also be updated by September 2024 with the new requirements. Or for further information, providers can call the Medica Provider Literature Request Line toll-free at 1 (800) 458-5512, option 2, then option 8, ext. 2-2355.

In the near future, watch for more information on this topic, including provider trainings. Providers will need to become familiar with the Carelon website to submit prior authorization requests specifically for the newly impacted MSK, cardiology, and radiology services.

New reimbursement policy for Emergency Department Evaluation & Management Codes – Facility

We're implementing a new Medica reimbursement policy for reporting Emergency Department evaluation and management (E/M) codes on outpatient facility claims billed under payer ID 41822, beginning with Sept. 1, 2024, dates of service.

When the Emergency Department Evaluation & Management Codes – Facility reimbursement policy is implemented, we'll review claims that have Level 4 or Level 5 Emergency Department E/M codes using the **Optum Emergency Department Claim (EDC) Analyzer™** . The EDC Analyzer is a tool used to determine whether the billed E/M level is supported by the medical services coding data received on the claim. The EDC Analyzer will use the following claim data to determine if the billed Level 4 or Level 5 E/M is supported:

- Patient's presented health issues
- Diagnostic services performed during the visit
- Any complicating conditions the patient has

If the EDC Analyzer determines a lower level of E/M service should have been billed, we'll deny that line item on the claim because the information submitted on the claim doesn't support the billed level of E/M service. Facilities may submit an appeal for reconsideration of payment through their usual appeal submission method.

Other levels of Emergency Department E/M codes are eligible for reimbursement when billed at the appropriate level. Medica follows interpretive guidelines sourced to Centers for Medicare and Medicaid Services (CMS) coding guidelines, American Medical Association (AMA) Current Procedural Terminology (CPT®) code descriptors, and specialty society guidelines for the reimbursement of Emergency Department E/M codes.

The new policy will apply to outpatient facility claims reported on an 837I (Institutional) Health Care Claim transaction or UB-04 claim form for Medica members in benefits plans under payer ID 41822.

Annual medical record review starts soon

Each year, the Centers for Medicare and Medicaid Services (CMS) requires health plans validate the diagnosis codes that are submitted for payment, through claims, by conducting a medical record review for documentation that supports these codes. This summer, we'll begin conducting our annual Medicare chart review, which focuses on 2023 dates of service for our Medicare plan members. This effort, which will run through the fall, is administered on our behalf by Optum and Datavant.

Datavant will notify provider offices of which Medicare members' medical records are being requested and when records are needed. We appreciate the prompt assistance with this annual CMS requirement.

Be on the lookout for your Patient Access to Practitioner Survey

We conduct an annual *Patient Access to Practitioner Survey* in compliance with National Committee for Quality Assurance (NCQA) requirements for provider network NCQA-accreditation. The focus of the survey is to obtain information regarding members' access to their providers. The survey is intended for clinic managers or schedulers at locations within each organization. The survey questions are formulated to include clinic based and individual specialty type questions pertaining to wait times for scheduling appointments for primary, specialty, and behavioral health care.

This year's survey is planned for release this summer. If you receive a survey from us, we appreciate your time in responding.

Diabetes screening and antipsychotics for adults with serious mental illness

Antipsychotics are associated with a variety of adverse effects, including diabetes. Because individuals with serious mental illness who use antipsychotics are at

increased risk for diabetes, screening and monitoring of this condition is important. Adult patients 18+ with schizophrenia or bipolar disorder who are taking an antipsychotic, American Psychiatric Association (APA) guidelines recommend the following to assess diabetes:

- At baseline, screening for diabetes risk factors and fasting blood glucose levels
- Fasting blood glucose or hemoglobin A1c 4 months after initiating a new treatment and at least annually thereafter
- More frequent monitoring may be indicated in the presence of weight changes, symptoms of diabetes, or a random glucose > 200 mg/dL

What can you do for your patients? Determine if your adult patients 18+ with schizophrenia or bipolar disorder who are taking an antipsychotic medication need screening for pre-diabetes or diabetes.

We provide free case management services for members with mental health needs. Email **caresupport@medica.com** or contact Provider Services to refer a patient.

Provider network consultants

While online self-service resources and Customer Service are your first sources of information, Provider Network Consultants (PNCs) are health plan personnel who assist with more in-depth inquiries, when necessary. (And always, contact your PNC to report changes or updates to your demographic information.)

Contact the Medica PNC team at **ProviderRelations@medica.com**.

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, linked below.

See Provider News Policy Notice, June 1, 2024

Drug policies

Drug policies are applicable to all 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 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 benefit certificate 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 contract with National Imaging Associates (NIA) (also referred to as Magellan Healthcare) for authorization of **high-end radiology services** and **musculoskeletal services** . A link to the NIA Magellan portal is available on our Account Login page. Providers can contact NIA by phone at 866-307-9729, 7 a.m. - 7 p.m. CT, Monday – Friday, or by email at **RadMDSupport@MagellanHealth.com**.