June 1, 2025

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Look out for annual survey on patient access to practitioners

The National Committee for Quality Assurance (NCQA) requires an annual evaluation of patient access to practitioners for provider network NCQA accreditation. On an annual basis, a Patient Access to Practitioner Survey is conducted and intended for clinic managers or schedulers at locations within each organization. The questions within the survey 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.

So watch for this survey, coming soon, and thank you in advance for your time and valuable insights.

Quick Hits

Be sure to verify benefit limitations for Medicare patients

It's important to review member benefits and their limitations before providing

services. For Medicare patients, frequency limitations can apply to coverage — such as requesting lipid panels (cholesterol tests) for cardiovascular disease screening multiple times for a patient when the limit on Medicare coverage is once every 5 years. Patients who are Medicare members could end up paying more out of pocket, up to the full billed amount, for these types of services if they exceed such frequency limits. However, if a doctor deems a lipid panel medically necessary for diagnosing or monitoring a condition like high cholesterol or heart disease, it may be covered outside the 5-year screening cycle. Note: This particular frequency limitation is different for Medicare than for most commercial members.

We're looking for physicians to join our policy committees

We are seeking primary care physicians to serve on our health plan's Medical Policy Committee, which is responsible for advising our health plan on matters of medical appropriateness, clinical criteria, and community standards of care related to internally developed utilization management (UM) policies, clinical guidelines, and other program documents as requested.

In addition, we are seeking specialty care physicians to serve on our new Pharmacy and Therapeutics Committee. This committee is charged with making pharmacy formulary, utilization management, and medical drug policy decisions. Specialties we are seeking include behavioral health, oncology, rheumatology, gastroenterology, cardiology and pulmonology.

The primary function of these policy committees is to provide our health plan with clinical expertise on issues relating to appropriate utilization of medical services and medications by our members. Such expertise is essential for us to deliver safe and effective health care for all of our members.

Primary care and specialty care physicians who are interested in joining these committees may contact us at **MedicalAffairsTeam@medica.com**. Meetings are held quarterly using Microsoft Teams. Compensation is provided.

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 June 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

checlist

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