May 1, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

Strong beginnings for your patients and their babies

We offer the Strong Beginnings program to Medica members who are pregnant or have recently delivered. Through this program, members can get help with making healthier choices, connect with community resources and services, access health education classes, and more. Our **Strong beginnings pregnancy page** highlights resources for your Medica patients before and after delivery.

In this edition:

Spotlight on prior authorization functionality in Availity Essentials

With the recent **activation of prior authorization applications in Availity Essentials** , the provider portal for plan types under payer ID 41822, you may be navigating new functionality for the first time. Here's a few tips to help you get started.

Choosing the applicable request type

When submitting prior authorization requests through Availity Essentials, you must first click the request type applicable to the request you're submitting:

- Select the **Outpatient request type** when submitting an authorization for any services or procedures requiring prior authorization, including procedures performed in an acute inpatient setting.
- Select the **Inpatient request type** for inpatient stays unrelated to a service requiring prior authorization (e.g., skilled nursing, long term acute care, acute rehabilitation, and swing bed services).

If the service or procedure requires prior authorization and the member will also require an inpatient stay, you'll need to submit two authorization requests: An outpatient request for the service or procedure **and** a request for the inpatient stay.

Searching authorization requests and status
There are two ways to search for your authorization status request:

- Use the **Authorization/Referral Inquiry Application** to search authorization requests submitted on and after Jan. 1, 2024, regardless of submission type (e.g., Availity Essentials, email, or fax). Select the request type that matches that of the authorization you are searching.
- Use the **Authorization /Referral Dashboard Application** to search authorization requests submitted through Availity Essentials. Authorization status is color-coded. Authorization cards listed on the dashboard won't automatically show the latest authorization status. Click anywhere on the card to refresh the status.

Authorization status (i.e., pending, approved, denied, etc.) definitions and codes are listed in the **Authorization/Referral Inquiry Application** for easier reference. Retain the authorization ID number on the confirmation page to help you retrieve future status for the authorization submission. The ID number begins with the 4-digits of the submission date (MM/DD) and has 9 alpha-numeric digits.

Visit the **landing page in the Availity Learning Center** (from your secure Availity Essentials account) to view training materials about these applications.

Backlog claim payments are processed

InstaMed has released the backlog Medica claim payments delayed because of the Change Healthcare cybersecurity incident in February. To mitigate further financial impacts to providers and resume claim payments, **we switched from Change Healthcare to InstaMed** as our new permanent payment services vendor for our benefit plans under payer ID 39113. As a reminder, InstaMed is already our payment service vendor for our benefit plans under payer ID 41822. Go to the **InstaMed web page** to register for an account.

New design for medical policy documents

We're adopting a new design and organizational format for our medical policy documents to align with our partner Medica more closely. We'll gradually transition policy documents to the new design in the coming months, starting May 1, 2024.

Here are some of the changes you'll see:

- Policy document PDFs in the Document Library may be assigned a new naming convention (e.g., MED -medical, TRA-transplant, and SUR-surgical) and/or without a numerical designation.

  Note: Medical policy titles listed within documents are not changing.

- Additional sections or information within documents, such as background, definitions, FDA approval, or coding considerations may be added to further explain coverage.

  Note: Medical necessity criteria, prior authorization requirements, benefit considerations, and coverage determinations aren't changing as a result of adding this information.

New vendor for post-payment claim COB reviews

Starting in June, The Rawlings Group, a payment integrity services vendor, will help us identify claim overpayments related to coordination of benefits (COB) for claims processed under payer ID 39113. This review is already occurring for claims processed under payer ID 41822. Their focus will be on post-payment claim reviews and may include review of claims with dates of service before June 2024. They will identify when another carrier, including Medicare, is the primary payer over Medica, initiate recoveries, and update COB information.

If an overpayment is identified, The Rawlings Group will help the member understand their coordination of benefits and contact the provider directly for payment recovery. All outreach and communication on our behalf will be presented as The Rawlings Group who will then resolve the COB overpayment directly with Medica.

This oversight is an industry-standard practice and will apply to all Medica products and include all medical claims for our benefit plans under payer IDs 41822 and 39113. (Worker's compensation and subrogation claims aren't in scope.)

The Rawlings Group is a trusted business associate — as defined by the Health Insurance Portability and Accountability Act (HIPAA) — which allows the sharing of protected health information for specific purposes such as inquiring about other health insurance coverage.

Health equity and Medica

Health equity means that every person has the opportunity to be as healthy as possible. Medica recognizes that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. In support of this, we invite providers and their support teams to visit our **Cultural Awareness & Health Equity web page** featuring the Cultural Awareness Training Series and free telephonic Language Line for language assistance/interpreter services.

Cultural awareness training series
Viewers can watch modules at their convenience and refer back as often as they wish. Each module reflects timely topics and patient populations.

- Module 1: Introduction to Cultural Competency and Humility
- Module 2: Introduction to Refugee Communities
- Module 3: Introduction to LGBT Populations
- Module 4: Organizational Cultural Competence

Each module lists clear learning objectives. Viewers can watch modules at their convenience and refer back as often as they wish.

Language Line bridges provider and patient communications
To address diverse language needs and enable important communications between providers and patients, we offer a free, telephonic Language Line for language assistance/interpreter services. This service is available 24/7 to Medica in-network providers who need to interact with Medica members who have limited English language proficiency. You can request language assistance by calling 844-526-1386.

Metabolic monitoring and antipsychotics for children/adolescents

Antipsychotics are associated with a variety of adverse effects, including metabolic side effects. The rate and severity of these adverse effects vary by agent. Because many antipsychotics are associated with side effects related to metabolic syndrome, clinical guidelines recommend regular monitoring of these effects (e.g., weight gain, lipid

abnormalities, and glucose dysregulation).[i]

Determine if your child/adolescent patient taking an antipsychotic medication needs metabolic screening. For children/adolescent patients taking an antipsychotic, guidelines recommend the following to assess cholesterol glucose levels:

- At baseline, screening for high cholesterol and diabetes risk factors, and draw lipid profiles and fasting blood glucose levels.
- Lipid profile and fasting blood glucose or hemoglobin A1c 3 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.

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

[i] **American Academy of Child and Adolescent Psychiatry**. Practice parameter for the use of atypical antipsychotic medications in children and adolescents. Published 2011.

Make chlamydia screening part of routine preventive care

The National Committee for Quality Assurance (NCQA) recommends that all women between 16-24 years of age who are identified as sexually active be tested for chlamydia once a year. Sexually active patients are identified by a pregnancy test, pregnancy, gynecological care [PAP], or prescription for a contraceptive.

75% of women with chlamydia infections don't show symptoms and don't think that they need to have a screening. Yet if they are infected and left untreated, chlamydia infections in young women can cause permanent infertility, premature delivery in pregnant women, and pneumonia in newborns. Because of the serious consequences from untreated chlamydia, it is best to screen even if the patient's risk of infection is low, or they say they are not sexually active.

Too often, people feel embarrassed or fearful to get the screening they need. We recommend that providers incorporate chlamydia screening into their practice as a default part of an annual office visit to minimize the stigma of this testing , especially for females between 16-25 years old.

For more information, go to **Chlamydia – CDC Detailed Fact Sheet** or NCQA's **Chlamydia Screening in Women web page**.

Accessibility of services standards

It is important for Medica network providers to understand the Accessibility of Services standards. Medica 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 under the Quality Improvement section of the Medica Provider Manual.

Notify us of changes to your provider information

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. Additionally, Centers for Medicare & 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 at **central.medica.com/Find-A-Doctor** or **mo-central.medica.com/Find-A-Doctor** to verify it reflects current and accurate information for you and your organization. Notify the Provider Network Consultant team 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 the Provider Network Consultant team 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.

National Plan and Provider Enumeration System (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.

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, May 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**.