May 1, 2025

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Availity adding new step to prior authorization transaction this summer

This summer, additional enhancements will be added to the Availity Essentials prior authorization submission application. A step for MCG (previously Milliman Care Guidelines) will be integrated into the tool so submitters can demonstrate that criteria have been met for the procedure being requested, allowing for clear communication between submitter and reviewer. This step will apply to all authorizations submitted through Availity, and MCG guidelines will display based on Current Procedural Terminology (CPT®) code or diagnosis code indicated.

Training on this change will be available soon through **the Availity Learning Center** , so be sure to check back for live training dates as well as recorded webinars. More information on this Availity tool and other portal announcements will be available in upcoming editions of our Provider News.

Annual reminder:

Reviewing Medicare medical records for proper diagnosis codes

Each year, the Centers for Medicare and Medicaid Services (CMS) requires that 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. We will soon begin conducting our annual Medicare chart review, which focuses on 2024 dates of service for our Medicare plan members. This effort, which will run through the fall, is administered for our health plan by Optum and Datavant.

Datavant notifies provider offices when records are needed, providing a list of requested Medicare members' medical records as well as remote retrieval options that are available. We appreciate providers' prompt assistance with this annual project for CMS.

Effective July 1, 2025:

Stelara to be removed from commercial, IFB formularies

Effective July 1, 2025, Stelara will be removed from coverage for all of our health plan commercial and Individual and Family Business (IFB) drug formularies. Stelara is being removed as numerous ustekinumab biosimilars have recently entered the market that provide alternatives to the reference product Stelara. A biosimilar is a biological product that is highly similar to a biologic product already approved by the U.S. Food and Drug Administration (FDA) and has no clinically meaningful differences from that product.

The following biosimilars for Stelara are currently available on our health plan's commercial and IFB formularies:

- SteQeyma (ustekinumab-stba)
- Yesintek (ustekinumab-kfce)

Additional biosimilars may be added as they become available.

Prior authorization for biosimilars
Our members must transition to a biosimilar agent for Stelara to ensure continuation of therapy. A new prior authorization request isn't required for

members already on Stelara therapy. In those instances, we'll transfer the prior authorization to the biosimilar through the end date of the original approved Stelara authorization. Members newly starting biosimilar therapy will need a new prior authorization. If none of the biosimilar agents are clinically appropriate for the member, the prescriber can submit an Exception to Coverage (ETC) form to Navitus, our pharmacy benefit manager (PBM).

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 May 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

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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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