October 1, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Authorizations in Availity Essentials: New functionality coming in October

In October, watch for new functionality in the Availity Essentials authorization workflow to determine “Is Auth Required?” at the time of prior authorization submission. This step in the submission process is a self-service method to help you determine if the codes being requested require an authorization. This decision applies only to the Current Procedural Terminology (CPT®) codes based on our health plan Medical Prior Authorization Service List found on our **Medical Management page** and is determined by the authorization requirements as of the date of the inquiry. Please note that this tool can’t be used for determinations on authorizations that may be required by location or those that might be required by a

certain product.

Find more information in the **Availity Learning Center** on the Essentials portal, including a short training video on the new authorization features.

Note: As a reminder, Availity only handles medical prior authorizations, not those that are drug-related. Providers should continue to use existing means for authorization of medications, since sending them to Availity can result in substantial delays in turnaround times.

Quick Hits

COB program expands post-payment claim review to medications
In May, we communicated our partnership with the Rawlings Group for medical claim overpayment related to coordination of benefits (COB), focusing on post-payment medical claim review. Beginning Nov. 1, 2024, the Rawlings Group will also work with Navitus, our pharmacy benefit manager (PBM), to identify claim overpayments related to COB, focusing on post-payment pharmacy claim review. Members will be notified and educated on use of their primary insurance if other insurance is identified in the post-payment claim review process.

Reminder on changes to the Master Prior Authorization Service List
As noted last month, our Master Prior Authorization Service List on our health plan's website will have a new look beginning in October. The updated list contains all of the same information, in a streamlined, easier-to-read format. The list includes information on prior authorization and coverage for specific codes, submission information and contact information. You can also find information specific to the Carelon prior authorization requirements.

Effective Jan. 1, 2025:

Our IFB product, benefit changes for 2025

We've finalized our Individual and Family Business (IFB) plan offering for next year. Here are service area and benefit updates for 2025.

Changes to 2025 product and plan offerings

- **Illinois:** The WellFirst by Medica product in Illinois will no longer be offered in 2025. Medica is exiting the Illinois market in 2025.

Continued 2025 plan offerings

- **Missouri:** WellFirst by Medica plans will continue to be offered. Available both on- and off-exchange, with no change in service area availability.

Other product changes for 2025

- Continuous glucose monitors (CGMs) will *only be covered* under the pharmacy benefit (see “CGM coverage changes” article below for more details)
- Introducing $0 for preferred diabetes supplies
- Continuing $0 cost-sharing for diabetes education (excludes Health Savings Accounts, or HSAs, and catastrophic plan offerings)
- Discontinuing free transportation benefit

Effective Jan. 1, 2025:

Our Medicare product, benefit changes for next year

We will continue to offer multiple plan options in our Medicare Advantage (MA) service areas for 2025. There will be a service area reduction of 7 counties in the Peoria/Bloomington area of Illinois. The remaining service areas in Wisconsin and Missouri/Illinois (St. Louis market) will remain unchanged.

We will continue to offer $0 premium Medicare Advantage Part D (MAPD) plans and MA-only plans in our service areas. The Health+ by Medica card continues to be offered with benefits such as eyewear and over-the-counter (OTC) allowances so MA members can access their supplemental benefit amounts at a wide array of retail locations. Rewards for healthy behaviors also continue to be available on the card. Both Medicare-covered and non-Medicare-covered eye exams (i.e., routine) will be $0 for all MA plans. For Part D plans, we’re moving from a 100-day supply to a 90-day supply for 3-month prescription fills. Plans with $0 Part D deductibles will retain them.

Effective Jan. 1, 2025:

New prescription payment plan for our Medicare Part D members

Medicare plans, including ours, will be rolling out a Medicare Prescription Payment Plan (or “M3P”), to begin Jan. 1, 2025, as required by the Inflation Reduction Act of

2022. This new program will be available to our Medicare Advantage members with Part D coverage. It will allow them to spread out their out-of-pocket costs for prescription medications throughout the plan year, during which they'll make monthly payments. The members won't pay anything at the point of service, but they will need to pay off the entire amount by January of the following plan year.

Medicare members can elect to join this M3P program at any time as long as they have enrolled in a Part D drug plan. The members who would most likely benefit are those who have a single copay of $600 or more for a prescription, or those who will reach a maximum out-of-pocket (MOOP) limit of $2,000 by August of a plan year. For these members, M3P may reduce their monthly costs by spreading them over the remainder of the plan year.

The M3P payment option might help members manage monthly expenses, *but it won't save them money or lower their out-of-pocket costs*. It may not be beneficial to all members. Even though they won't pay for the drugs at the pharmacy, members will still be responsible for all out-of-pocket costs.

Members can opt in to the program by calling us, using our member portal or submitting an election form by mail. After enrolling, members may have two bills to pay: one for their premium and one for the M3P program — The two payments are billed and paid separately. Members enrolled in M3P can remove themselves from the program at any time, but if they have a balance due, they will be billed until it is paid off.

Note: Once members enroll in the M3P program, *all the medications they fill* will then be included on the payment plan. Members cannot choose which drugs they want to include in the program.

To learn more about this program, **visit the CMS website**.

Effective Jan. 1, 2025:

CGM coverage changes: For most members, pharmacy benefit + prior authorization will apply

We are making a coverage change to continuous glucose monitors (CGMs) and CGM supplies for commercial plan members and Individual and Family Business (IFB) members beginning Jan. 1, 2025. These members will need to purchase CGMs and CGM supplies at a network pharmacy, rather than through durable medical equipment (DME) providers, for coverage. Our preferred CGMs and supplies are Dexcom and Freestyle products. *Claims for these products will be*

denied if these items are received from a DME provider beginning on Jan. 1, 2025, for a commercial or IFB member.

This change will apply to commercial and IFB members only. This benefit change will *not* apply to insulin pumps and supplies for insulin pumps, which members can continue to purchase from DME vendors.

CGMs will require prior authorization for coverage
Starting Jan. 1, 2025, continuous glucose monitors (CGMs) will require prior authorization for most of our members, in most situations. Submit a prior authorization request before prescribing a CGM. This step is necessary to secure coverage and avoid any delays in the patient receiving the device. It is advisable to initiate this process well in advance of the member's anticipated need. Prior authorization will *not* be needed for members currently utilizing insulin therapy.

This prior authorization change will be effective for our commercial and IFB members as of Jan. 1, 2025.

Medicare CGM coverage
For our Medicare Advantage members, CGMs and supplies will be available at a $0 out-of-pocket cost whether they buy them from a network retail pharmacy or a DME provider. The pharmacy-only benefit change will also *not* apply to insulin pumps and supplies for insulin pumps, as members can continue to purchase them from DME vendors. For our Medicare Advantage members, prior authorization will continue to be required for coverage determinations for CGMs obtained through a medical supplier. However, if these members obtain their CGM through a pharmacy and are currently using insulin therapy, prior authorization will *not* be needed.

Language Line bridges provider + 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 and interpreter services. This Line is available 24/7 to our network providers who need to interact with members who have limited English language proficiency. Request language assistance by calling **1 (844) 526-1386**. For more information on the Language Line, **see our Provider Manual**.

New universal lead testing guidelines from Wisconsin DHS

In January 2024, the Wisconsin Department of Health Services (DHS) released new guidelines for lead screening in children. Universal testing is now recommended, meaning all children should get at least two lead tests by age 2. Wisconsin recommends all children receive a lead test at age 1 and again at age 2. Children 3-5 years of age should get tested if they have no record of a previous test. These recommendations apply to all children regardless of what type of insurance coverage they have, where they live, how old their housing is, and what kind of water they use.

Lead poisoning affects children statewide. Every Wisconsin county has had at least one lead-poisoned child within the last five years. Lead can hurt anyone, but it's especially dangerous for young children because their bodies are still developing and growing so fast. Younger children who are crawling and learning to walk are at greater risk of being exposed to lead-contaminated soil and dust. Children this age often put objects or their hands into their mouths; this can cause the child to ingest lead and over time can poison a child.

The decrease in number of children tested since the COVID-19 pandemic means there is not enough information to identify which neighborhoods and children are at greatest risk. DHS will use testing and poisoning data from after January 2024 to see how testing and poisoning rates change after we recommend universal testing, and figure out which neighborhoods and children in Wisconsin are most at risk for lead poisoning.

Early detection is key in preventing devastating consequences of lead poisoning. With early action and support, children exposed to lead can achieve better developmental outcomes. See full guidelines, FAQs and other information **from Wisconsin DHS**.

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 Oct. 1, 2024

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 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.

Through Sept. 30, 2024, dates of service, we contracted with National Imaging Associates (NIA, also referred to as Magellan Healthcare) for authorization of high-end radiology services and musculoskeletal services as found on our Medical Management page. Starting with Oct. 1 dates of service, this changes to Carelon. Providers can contact NIA by phone at **1 (866) 307-9729**, 7 a.m. - 7 p.m. CT, Monday - Friday, or by email at **RadMDSupport@MagellanHealth.com** .

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