September 1, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Important prior authorization changes on the Availity portal

We recently let you know about some important changes with online submission of prior authorization requests, including:

- The requirement to use the Availity Essentials portal to submit all medical, non-drug prior authorization online requests starting Sept. 1.
    - This transition will apply *only* to the prior authorization application, along with related prior authorization status inquiries. All other self-service applications for payer ID 39113, such as Eligibility & Benefits (270/271), continue to follow the path laid out by payer ID in our Provider Quick Reference resource.
- New features that Availity has started rolling out that will enhance your prior authorization experience on the Essentials portal — Provider Location Lookup, Attachments and Is Auth Required? (coming soon!)

Read more about this news from mid-August.

Quick Hits

Upcoming changes to the Master Prior Authorization Service List
Beginning in October 2024, the Master Prior Authorization Service List published on our health plan's website will have a new look. The updated list will contain all of the same information, in a streamlined, easier-to-read format. The list will include 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.

Reminder: Carelon program launching on Oct. 1!

Carelon to take prior authorization requests starting Sept. 23

Beginning Sept. 23, 2024, Carelon will accept prior authorization requests for select services from network providers for dates of service starting Oct. 1, 2024.

As previously announced, Carelon, a utilization management (UM) program vendor, will replace NIA Magellan in the support of provider submission and medical necessity reviews for select musculoskeletal (MSK) and radiology services. Carelon will also manage cardiovascular services, helping to achieve consistent, high-quality care and access.

Our **medical prior authorization service list** will soon be updated to reflect which services require prior authorization from Carelon. Please review this resource to ensure radiology, cardiology and MSK services — inpatient, outpatient and ambulatory surgery center (ASC) — that require prior authorization are properly managed. Refer to our Carelon webpage for clinical guidelines, authorization timeframes, and additional resources coming in October 2024.

Submitting prior authorization requests
Authorizations can be submitted to Carelon using the following methods:

- Use the **Carelon provider portal** available 7 days a week. It's fully interactive and processes requests in real time using clinical criteria. Network providers must register to use this submission portal.
- Call Carelon toll-free at 1 (833) 476-1463, Monday through Friday, 8 a.m.-5 p.m. CST.

Excluded services

- Procedures performed during an inpatient hospital stay *are not included* in the Carelon cardiology and radiology programs.

- Procedures performed on an emergent basis at the ER and prior to the patient's discharge from the hospital are *not included* in the Carelon cardiology, radiology or MSK programs.

Upcoming Q&A sessions

Service type/topic	Date	Time (CT)	Registration
Radiology/Cardiology (Q&A only)	Sept. 4	2-3 p.m.	**Click to register**.
MSK (Q&A only)	Sept. 12	2:30-3:30 p.m.	**Click to register**.
MSK (Q&A only)	Nov. 7	2:30-3:30 p.m.	**Click to register**.
Radiology/Cardiology (Q&A only)	Dec. 3	2-3 p.m.	**Click to register**.

Or view previously recorded trainings:

Service type/topic	Recording
Radiology/Cardiology (full training)	**Click to view**. (Password: MwsYykv4)
MSK (full training)	**Click to view**. (Password: Musculoskeletal1)

Maintenance of authorizations through NIA/Magellan
NIA/Magellan will continue to provide status, appeals and edit capabilities for prior authorizations completed through Sept. 30, 2024.

- For services scheduled to be delivered through Sept. 30, 2024, provider offices should continue to work with NIA/Magellan to obtain necessary prior authorizations.
- Authorizations approved by NIA/Magellan prior to the transition date of Oct. 1 will be honored and claims will be processed accordingly.
- For radiology, cardiology and MSK procedures and services that will have dates of service on or after Oct. 1, 2024, submit prior authorizations to Carelon beginning Sept. 23, 2024.

To learn more about Carelon, visit **carelon.com**. Or see individual **MSK**, **radiology** and **cardiology** microsites from Carelon.

The latest HEDIS measurement of our members' ED utilization

Through its Healthcare Effectiveness Data and Information Set (HEDIS®) **program**, the National Committee for Quality Assurance (NCQA) assesses emergency department (ED) utilization among commercial (18 years of age and older) and Medicare (18 years of age and older) health plan members.

Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. The observed and expected rates are used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less emergency department visits than expected, while accounting for incremental improvements across all plans over time.

2023 results
The observed-to-expected ratio is multiplied by the ED visit rate across all health plans to produce a risk-standardized rate which allows for national comparison. An observed-to-expected ratio below one indicates there were fewer ED visits than expected while an observed-to-expected ratio greater than one indicates more ED visits occurred than expected. Lower rates signify better performance.

For measurement year 2023, the observed visits for our commercial members is more than expected with an observed-to-expected ratio of 1.1007. The observed visits for our Medicare members is less than expected, with an observed-to-expected ratio of under .9952.

Why it matters
ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED visits may be preventable or treatable in a lower-acuity care setting. A high rate of ED utilization may indicate a need for better care coordination, inadequate access to outpatient care, or an opportunity to educate patients on choosing the most appropriate level of care.

At-risk populations for avoidable or preventable ED visits
Patient risk factors for increased ED use include:

- Physical or cognitive impairment
- Psychiatric illness
- Alcohol/drug abuse
- Low health literacy
- Social determinants of health impacts
- Medical conditions such as asthma, heart disease, chronic pain
- A pattern of frequent ED visits

Best practices

- Encourage patients to engage with their primary care physician (PCP) for annual wellness visits, screenings and care coordination.
- Engage with patients who are diagnosed with chronic conditions to help prevent and minimize exacerbations and complications.
- Educate patients about appropriate ED use and other options available such as same-day appointments, urgent care, nurse lines and telehealth.
- Consider extended clinic and telehealth hours and addition of a nurse line.
- Offer/coordinate support services for patients diagnosed with chronic conditions or experiencing exacerbations.

Clinical best practices:

Intended use, safety considerations for GLP-1 medications

Glucagon-like peptide-1 (GLP-1) medications are becoming of interest to patients as many are seeing advertisements via social media, television, etc., that report GLP-1 products may assist with weight loss. Some advertisements encourage consumers to visit their website to speak to a medical provider to receive GLP-1 products. The medication is provided after just a few questions, with no medical exam.

It is important for patients to understand that GLP-1 medications are one component of a comprehensive weight-loss strategy. GLP-1 medications have multiple well-characterized side effects that necessitate provider evaluation. Patients often need medication, nutrition and exercise support from primary care providers or weight-loss specialists to maximize safety and results.

U.S. Food and Drug Administration (FDA)-approved GLP-1 formulations may or may not be covered under a member's health plan. Members who have coverage for GLP-1 agents for weight loss will require a prior authorization through our health plan to ensure that medical necessity criteria are met. Members without health plan coverage for these agents may be offered compounded semaglutide (the active ingredient in Ozempic and Wegovy) as a more affordable option. *We recommend against the use of compounded GLP-1 medications* as they are not reviewed by the FDA for safety, effectiveness or quality, and may not contain the same ingredients as the FDA-approved formulation.

Learn more about GLP-1 safety concerns and proper use **from the FDA**.

Annual reminder on formulary

management procedures

Our health plan's drug formulary is reviewed every month. With the approval of newer generic entities, changes and updates are made on a regular basis. In addition to updating the formulary status of covered drugs, formulary restrictions are also modified as necessary. Here is a reminder of restrictions and limitations associated with the drug formulary:

- **Closed Formulary.** We employ a closed formulary. If a drug is not listed on the formulary, the product is not covered by the member's pharmacy benefit. However, an Exception to Coverage request may be submitted if a non-formulary medication is medically necessary.
- **Mandatory Generic Substitution.** If a drug is available in a generic version, our health plan may require the use of the generic version. If the generic version of the drug is mandated and the patient chooses to receive the brand, the patient is responsible for the highest tier branded copay plus the ingredient cost difference between the brand and generic versions. If the patient's physician requests the branded version, the patient is only responsible for the highest tier branded copay.
- **Prior Authorization.** When a drug is prior authorized, the physician must receive approval prior to prescribing the drug. The list of prior authorized drugs and the request forms are available on our health plan's website.
- **Step Therapy.** Step edits are often used within a therapeutic class to require generic or preferred drug use prior to a non-preferred drug. When a step edit is in place, the patient must have trialed therapy with one or more preferred drugs prior to receiving approval for the non-preferred drugs. Step edits are completed at the point-of-service at the pharmacy, and there are no prior authorization requirements.
- **Specialist Restrictions.** Specialist restrictions limit the prescribing of a drug to a unique specialty. These decisions are based on the indications and uses for the specific drug.
- **Quantity Level Limits.** Quantity level limits restrict the supply of drug product that may be dispensed either per prescription or per a specific amount of time.
- **Specialty Pharmacy.** If a drug is available or mandated to be dispensed by a specialty pharmacy, the specialty pharmacy designation will be applied.

Find a complete listing of all our pharmacy resources, including the drug formulary, **on our website**.

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, September 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 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 contract 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. A link to **the NIA/Magellan portal** is available on our Account Login page. (Starting with Oct. 1 dates of service, this will change 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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