MEDICA ADVANTAGE PROVIDER MANUAL

2025

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REVISION LOG

Updates are regularly made to the information in this manual. The grid below outlines new changes that have been made to the manual from its immediate predecessor version. In the future, refer to the Historical Revision Log as a reference to past revisions.

Description of Change	Section/Link	Page
Updated: Grid with Medica (formally known as WellFirst Health) Advantage plan offerings for 2023 and monthly premiums and copays.	MEDICA ADVANTAGE PLANS OVERVIEW	6
Updated: Medica (formally known as WellFirst) Medicare Advantage service areas.	MEDICA ADVANTAGE SERVICE AREAS	7
Updated: Medica (formally known as WellFirst Health) Advantage member ID card sample	MEMBER IDENTIFICATION CARD SAMPLE	7
Updated: Medica Advantage Extra Benefits Quick Reference for 2023.	ADDITIONAL BENEFITS	8
Added: Adult vaccines can be administered in a doctor's office or in-network pharmacy (no longer location restrictions) and tier level copay grid for mail and retail prescriptions.	PRESCRIPTION DRUG (PART D)	9
Added: Under the Medicare Part B Step program, providers are required to first try preferred drugs before a non-preferred drug can be prescribed for treatment, if appropriate.	STEP THERAPY	12
Updated: Prior authorization submission methods for medical benefit and pharmacy benefit authorization requests and added oncology and oncology-related prior authorization requests.	PRIOR AUTHORIZATION SUBMISSIONS	13

MEDICA

Medica is an independent, non-profit health plan headquartered in Minnetonka, MN. In 2021, Medica formed a joint venture with Dean Health Plan, which included existing relationships with WellFirst Health and Prevea360 health plans, blending their similar values and dedication to providing exceptional health care coverage to 1.5 million lives across 12 states.

Through integrated delivery networks, strong partnerships with top providers, and enhanced technology alignment, Medica and Dean Health plan continue to grow. In October of 2023, WellFirst Health became known as Medica to reflect this commitment. Together, we have an even greater opportunity to support the health care needs of our communities, members and the patients we share with you, our in-network providers.

In each state, Medica products and services are supported by a local network of clinics, hospitals, and other health care providers. Named legal entities for Medica are filed in adherence to applicable state laws and regulations and therefore may vary by state or product.
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WHAT IS MEDICA ADVANTAGE?

Medica Advantage is a Medicare-approved replacement product that includes Medicare benefits and additional value-added coverage or supplemental benefits within a single plan. With the exception of hospice claims, no claims go to Medicare.

Medica Advantage plan options are available to eligible Medicare beneficiaries residing in Madison County and St. Clair County in Illinois, and Warren County, St. Louis City, St. Louis County, and St. Charles County in Missouri.

HOW TO USE THIS MANUAL

This Medica Advantage Provider Manual contains specific rules, processes, and resources to support in-network providers serving members enrolled in Medica Advantage plans. It is intended to be used as an addendum to the Medica Provider Manual. Medica provider manuals can be obtained from the Medica Providers page at mo-central.medica.com/Providers.

We are here to help! If you have questions about information in this manual, or can't find the information that you are seeking, please refer to the directory on the following page to contact the appropriate department or access the applicable resource. When in doubt, please don't hesitate to contact our Customer Care Center at 877-301-3326.

MEDICA ADVANTAGE CONTACTS

Refer to the directory below to contact the appropriate department or access the applicable resource for assistance.

PROVIDER AND MEMBER SERVICES	
Customer Care Center	877-301-3326
Health Advocate	800-576-8773 (MAPD)
ELECTRONIC DATA INTERCHANGE	
Information about Electronic Data Interchange (EDI) transactions	• MO-Central.Medica.com/Providers/HIPAA-Transactions. • edi@deancare.com
Electronic Payor ID	39113
PAPER CLAIMS	
Mailing Address for Paper Claims	Medica - Claims PO Box 852159 Richardson, TX 75085-2159
HEALTH SERVICES	
Case Management	866-905-7430
AUTHORIZATIONS AND EXCEPTION REQUESTS	
Medica Provider Portal Authorization Submission	mo-central.medica.com/Account-Login
Radiology/Cardiology/MSK including interventional pain management Monday - Friday from 7:00 am to 7:00 pm (CST)	866-307-9729 or Carelon's website
Drug Prior Authorizations	Phone: 866-270-3877| Fax: 855-668-8552
Medicare Drug Prior Auth/Exception Form	Pharmacy Medical Management for Medicare Advantage
Medica WEB SITES	
Medica Advantage Information and Resources for Providers	Access the Providers page by clicking the **Providers** link located at the top of Medica web pages at mo-central.medica.com/providers.
Medica Advantage Information and Resources for Members	central.medica.com/medicare
PROVIDER NETWORK CONSULTANTS	
Medica Provider Network Consultants	• ProviderRelations@medica.com • 314-994-6262

MEDICA ADVANTAGE PLANS OVERVIEW

Medica offers unique plans so that members can select the one that suits their needs. The following Medica Advantage with are available:

- Medica Advantage with SSM Value (formerly SSM Integrity & SSM FlexSpend) – an HMO-POS plan that includes Part D coverage and the option to seek some services out-of-network at higher copays.
- Medica Advantage Salute (formerly SSM Harmony) – an HMO-POS plan that includes an option to seek some services out-of- network at higher copays; it does not offer Part D coverage.

Preventive care is covered at 100% for all plans.

MEDICA ADVANTAGE AT-A-GLANCE

The above information is a snapshot of some available services and copays. For a complete list of additional services with copays, refer to the MO-Central.Medica.com/Providers/Medical-Management..

Plan Name	Medica Advantage with SSM Value HMO-POS MAPD		Medica Advantage Salute HMO-POS MA-Only	
Benefits	In	Out	In	Out
PCP Copay	$0	40%	$0	40%
Specialist Copay	$35	40%	$40	40%
Outpatient Surgery	$300	40%	$325	40%
Hospital Copay	$325 Days 1-7	40% Days 1-7	$325 Days 1-7	40% Days 1-7
Urgent Care Copay	$35		$40	
ER Copay	$120		$120	
Ambulance (Ground)	$300		$300	
Maximum Out-of-Pocket	$4,500	$8,200	$5,500	$10,000

Member Coverage and Benefits

We encourage providers to always refer to a member's plan coverage and benefits for specific coverage information. Providers can access documentation related to a member's benefits, including certificate of coverage, member policy, or certificate, and the member handbook at memberbenefits.mo-central.medica.com. From this web page, providers can enter the Group Number or Member ID to retrieve information for a particular member.

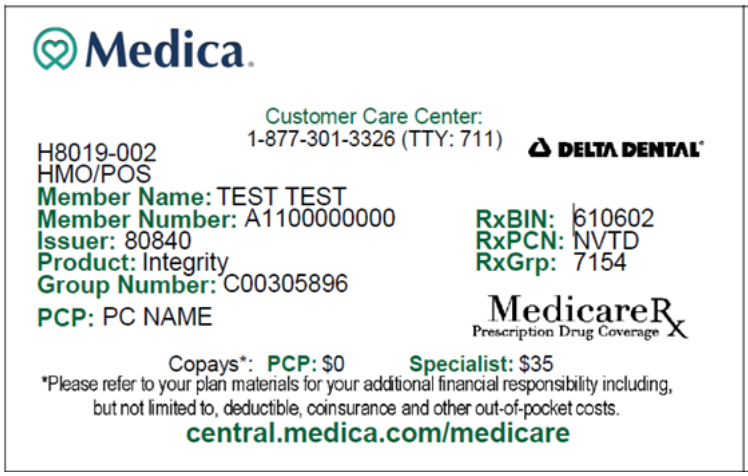
MEDICA ADVANTAGE SERVICE AREAS

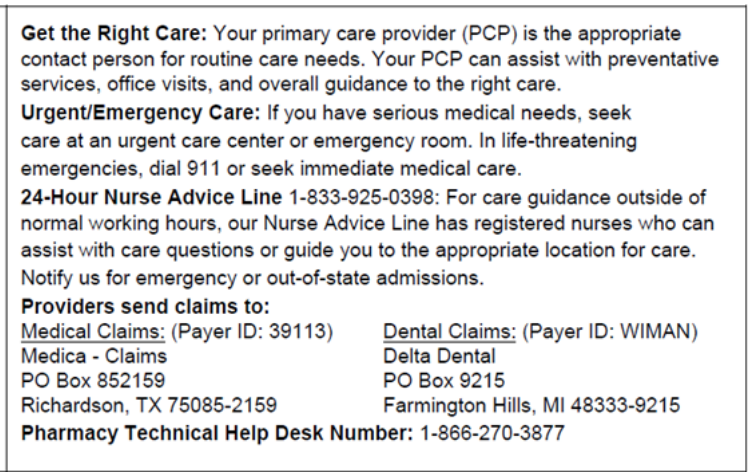
Medica Advantage is available in the following areas:

- Illinois:
  - Madison County
  - St. Clair County
- Missouri:
  - St. Charles County
  - St. Louis County
  - St. Louis City
  - Warren County

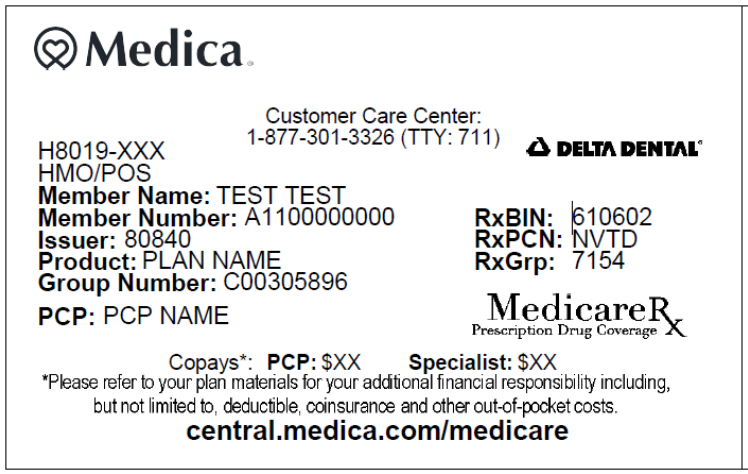
MEMBER IDENTIFICATION CARD SAMPLE

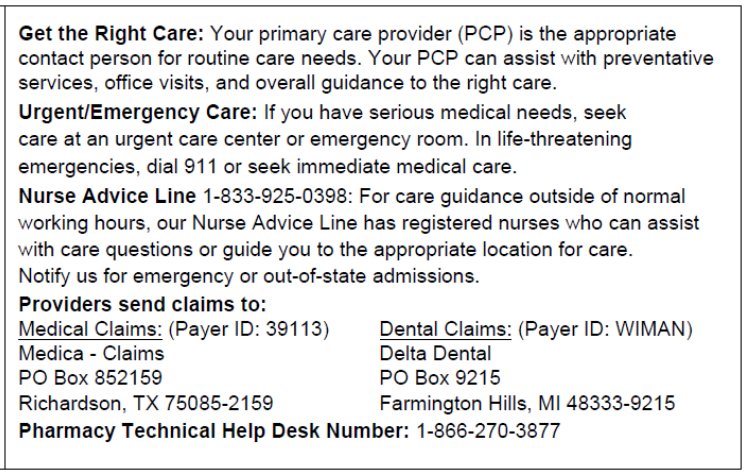
The Medica Advantage member ID cards have the Medica logo in the top left corner. They list the shortened plan name (e.g., Harmony, Integrity) in which the member is enrolled. The Medicare Rx logo is on member ID cards for members who have prescription drug (Part D) coverage.





FRONT – MEMBER WITH PART D **BACK**





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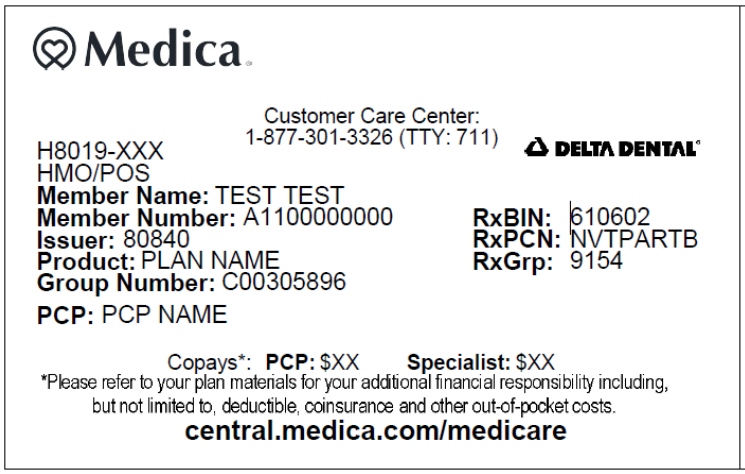

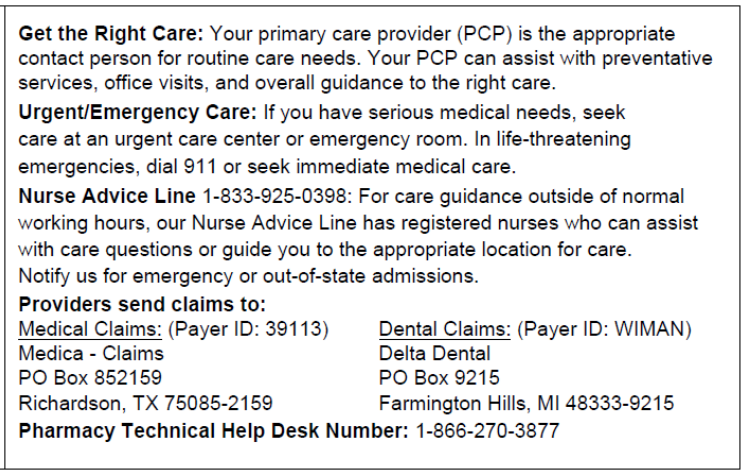

The Medica Advantage member ID number is an 11-character alpha/numeric value, always starting with "A." This value

is required for member enrollment and claims verification.

ADDITIONAL BENEFITS

Extra benefits are offered as a part of Medica Advantage Plans. Providers are encouraged to be familiar with the supplemental benefits available to members enrolled in Medica Advantage Plans. Medica Advantage plans differ; refer to the Medica Advantage Plan and Options web page for specific plan coverage and benefits.

Medica Advantage plans include the following benefits:

- **Preventive & Comprehensive Dental** — offered through Delta Dental and includes preventive and comprehensive dental services. Providers may direct members to the Medica Advantage Additional Benefits page
- **Vision** — includes a yearly vison exam and an eyewear allowance per calendar year. Providers may direct members to the Provider Directory at central.medica.com/locations to find an in-network eyeglass provider. (Change specialty to "Eyeglasses- Medicare Advantage" to search.) Members may also use their allowance at any in or out of network eyewear provider that accepts Visa.
- **Hearing** — includes a yearly hearing exam and hearing aid allowance (for both ears combined) per calendar year. is available to members as part of the member's flex benefit on their Health+ by Medica card. In addition, members on the Salute plan have a $750 hearing aid benefits at in network providers. Providers may direct members to the Provider Directory at central.medica.com/locations to find an in-network hearing aid provider. (Change specialty to "hearing aid" to search.)
- **Living Healthy Rewards** — members are eligible for $150 in rewards per calendar year. Providers may direct members to the Medica Advantage 2025 Additional Benefits page for more information.

1. **Fitness** — through the One Pass fitness benefit, members have access to fitness centers and home fitness kits per year at no cost. Providers may direct members to One Pass to register for the fitness benefit.
2. **Over-the-Counter Allowance** —members are given a $60.00 allowance per quarter to purchase over-the-counter items such as pain relievers, pill cutters, incontinence products, etc. Providers may direct members to the Medica Advantage Additional Benefits page for a full list of participating stores and links to online shopping.
    - Purchases may be made in-store, online at OTCNetwork.com, or through a catalog.
3. **Patient Transportation** — services are provided by Lyft. Members are allotted 24 one-way rides per year to medical appointments or local pharmacies. Providers may direct members to the Customer Care Center to schedule a ride.

- Members can call the Customer Care Center at 877-301-3326 to request a ride in advance of their appointment.
- No money is exchanged between the member and Lyft.
    - Transportation is provided in a non-medical vehicle that members will need to enter and exit without assistance. Caregivers or companions may also ride with the member.

4. **Post-Discharge Meals** — meals provided by Mom's Meals. Members are allotted 14 meals after an inpatient, observation, or skilled nursing facility stay.
    - The discharge planner, health plan's Care Management team, or member engages Mom's Meals for services. Providers may direct members to the Customer Care Center at 877-301-3326 to coordinate meal benefits.
    - Mom's Meals phones the member directly to screen for dietary needs and meal preferences, and to confirm delivery details.

Prescription Drug (Part D)

Prescription drug (Part D) coverage is included in the Medica Advantage with SSM Value (formerly SSM Integrity and SSM FlexSpend) plan. Part D coverage is **not** included in the Medica Advantage Salute (formerly SSM Harmony) plan.

Part D coverage assists members in paying for self-administered prescription drugs. The amount a member pays depends on the drug's tier and what stage of the benefit they have reached. Each medication falls into one of six tiers:

- Tier 1 - Preferred Generic
- Tier 2 - Non-Preferred Generic
- Tier 3 - Preferred Brand
- Tier 4 - Non-Preferred Brand
- Tier 5 - Specialty Drugs
- Tier 6 - Vaccines

***** Any vaccine can be administered at either a doctor's office or at an in-network pharmacy.

The Medica Formulary is available on the Medica Advantage formulary web page.

We offer lower copays to our Medica Advantage members who fill their prescriptions within the Medica preferred retail pharmacy network and through our mail order pharmacy. The preferred retail pharmacy network includes SSM Pharmacies, Walgreens, Walmart, Costco, and CPESN. Costco is also our mail order pharmacy; members do not need to be a Costco member to use the Costco Pharmacy.

	Tier Level	Mail Order		Tier Level	Preferred Pharmacy	Non-preferred Pharmacy
Mail Order: 30-day	Tier 1	$7	Retail: 30-day	Tier 1	$0	$7
	Tier 2	$8		Tier 2	$8	$13
	Tier 3	20%		Tier 3	20%	25%
	Tier 4	45%		Tier 4	45%	50%
	Tier 5	See table below		Tier 5	See table below	See table below
	Tier 6	N/A		Tier 6	$0	$0
Mail Order: 60-day	Tier 1	$14	Retail: 60-day	Tier 1	$0	$14
	Tier 2	$16		Tier 2	$16	$26
	Tier 3	20%		Tier 3	20%	25%
	Tier 4	45%		Tier 4	45%	50%
	Tier 5	N/A		Tier 5	N/A	N/A
	Tier 6	N/A		Tier 6	N/A	N/A
Mail Order: 90-day	Tier 1	$0	Retail: 90-day	Tier 1	$0	$7
	Tier 2	$16		Tier 2	$16	$26
	Tier 3	20%		Tier 3	20%	25%
	Tier 4	45%		Tier 4	45%	50%
	Tier 5	N/A		Tier 5	N/A	N/A
	Tier 6	N/A		Tier 6	N/A	N/A

Medica Central Health Plan Names	**Retail Tier 5 Coinsurance for 30 Days only**
Medica Advantage with SSM Value (HMO-POS)	33%

The insulin savings plan is $30 or $35 at preferred/non-preferred pharmacies per 30-day supply.

To find an in-network pharmacy, refer to the Provider Directory by clicking the Find a Doctor link located at the top of Medica web pages and clicking the Find a Pharmacy link at the bottom of the search screen.

AUTOMATIC ASSIGNMENT OF PRIMARY CARE PRACTITIONER

Members are encouraged to choose a primary care practitioner when they enroll in a Medica Advantage plan. If they do not choose a primary care practitioner, Medica will assign them one. Members can call the Medica Advantage Customer Care Center at 877-301-3326 to change their primary care practitioner at any time.

AFTER HOURS CARE FOR PRIMARY CARE PRACTICES

Primary care practices are responsible for providing 24 hour/7 days a week coverage for urgent or emergent care. Members must be instructed to call 911 or go directly to the emergency room in the case of a true emergency. Answering services or machines must instruct members how to reach an on-call practitioner.

UPDATING PROVIDER INFORMATION

It is critical that the Health Plan has current and correct provider information on file, which includes address, phone number, hours of operation, panel status, specialties, and language-fluency capabilities. Please notify the Medica Provider Network Consultant Team in writing at ProviderRelations@medica.com of any changes to your provider information at least 30 days in advance of the change.

Providers are mailed quarterly attestations to verify that their information on file with the Health Plan is current and accurate. These communications come from our contracted vendor, BetterDoctor, Inc. Providers are required to communicate any changes to their Provider Network Consultant promptly and should not wait for these reminders to update their information with the health plan.

CENTERS FOR MEDICARE AND MEDICAID SERVICES COMPLIANCE

The Health Plan complies with all federal and state requirements. Some provider-facing examples of compliance are detailed below.

CMS Medicare Advantage Compliance and Fraud, Waste, and Abuse Annual Attestation

CMS requires the Health Plan to ensure its First Tier, Downstream, and Related Entities (FDRs) complete compliance and fraud, waste, and abuse (FWA) training within 90 days of hire/contracting and annually thereafter. Within the health plan, FDRs are defined to include providers contracted for Medica Advantage products. All FDRs must complete the required FWA training and sign and submit an annual attestation to remain in compliance. The Health Plan's Provider Network Solutions team mails the attestation forms annually in November.

Qualified Medicare Beneficiaries

CMS prohibits providers from collecting cost share from members who are Qualified Medicare Beneficiaries (QMBs) and therefore dual eligible for both Medicare and Medicaid. QMB enrollment provides members with Medicare monthly premiums for Part A, Part B, or both and covers coinsurance, copayment, and deductible for Medicare-allowed services. The QMB program ensures beneficiaries with limited income and assets have meaningful access to Medicare benefits. While providers may be reimbursed at the lesser of the Medicaid or Medicare rates, providers are prohibited from balance billing or collecting any cost sharing.

PRACTITIONER REIMBURSEMENT

Reimbursement for covered services rendered to members enrolled in a Medica Advantage plan are subject to the reimbursement terms of your provider agreement with Medica. Providers should bill the Health Plan for all Medica Advantage covered services except hospice services, as detailed below.

Hospice Reimbursement

Members may elect to receive hospice services while they are enrolled in a Medica Advantage plan. Although, if a member receives hospice services while enrolled in one of the plans, providers should bill CMS for those services. The Health Plan is not responsible for payment of claims for hospice services for Medica Advantage members.

MEDICAL MANAGEMENT

In some cases, medical management policies and requirements for Medica Advantage are separate from those for commercial products. The Social Security Act is the primary authority for coverage provisions and subsequent policies for Medicare. Medicare is limited to the items and services that are medically necessary for the diagnosis or treatment of an illness or injury within the scope of the Medicare benefit category.

Medica uses the CMS-established Medicare Coverage Guidelines for Medica Advantage coverage and determinations, when available, and will reference the following resources in the order they are listed:

1. National Coverage Determinations (NCDs) – CMS criteria for an item or service applicable on a national basis to Medicare beneficiaries meeting the criteria for coverage are referred to first.
2. Local Coverage Determinations (LCDs) – when there is not NCDs criteria, LCDs (coverage decisions made by Medicare Administrative Contractors) are referenced.
3. Health Plan will review drugs based on Medicare guidance in Pub. 100-02, Chapter 15, Sec. 50.4.1 which highlights that an FDA approved Use of Drug or biologicals are reviewed for safety and effectiveness if it is deemed appropriate for the drug or biological indications specified on the FDA approved labeling.

The Medicare Coverage Guidelines are available online at medicare.gov/coverage/your-medicare-coverage. Providers can call the Customer Care Center at 877-301-3326 to request a paper copy of an MCG Guideline or a specific medical policy.

Refer to the Medica Advantage Medical Management page, accessible from the Medica Medical Management page at mo-central.medica.com/Providers/Medical-Management, for specific Medica Advantage information. Information accessible from this page includes:

- Prior authorization requirements and forms
- Specific medical policy web pages
- Medica Advantage Plans Prior Authorization List
- Medica Advantage coverage guidelines

PRIOR AUTHORIZATION PROCESS

The primary care practitioner acts as a gatekeeper to ensure that members receive appropriate, high-quality care in a cost- effective manner. Primary care practitioners (and sometimes in-network specialists) should assist members by completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically necessary. In-network providers are responsible for ensuring that the approved prior authorization is in place prior to services being rendered; failure to follow these guidelines may result in claim payment denials or the reduction of benefits.

Medica Advantage members have the right to go directly to the Health Plan to request a prior authorization. We strongly encourage our members to work with their in-network provider for authorization requests. However, if the member does come directly to the Health Plan, the primary care practitioner and servicing provider will receive a copy of the determination letter for that request.

PRIOR AUTHORIZATION REQUIREMENTS

Medica requires authorization for some services under the Medica Advantage plans. Refer to the Medica Advantage Prior Authorization List for an up-to-date listing of services that require prior authorization. The list is accessible from the Medica Advantage Medical Management page. If you do not find the information you are seeking on the list, please call the Customer Care Center at 877-301-3326.

Please note that the Medica Advantage Prior Authorization List is a separate list from, but similar to, the Medica Master

Service List for our Commercial products. The key differences in the Medica Advantage Prior Authorization List are the following:

- Durable Medical Equipment (DME) – The prior authorization list contains only the specific codes that require prior authorization.
- Outpatient Surgery – Similar to DME, only specific outpatient surgeries require prior authorization. The comprehensive list of codes requiring prior authorization is available on the prior authorization list.
- Medical Injectables - Medical injectables that require prior authorization are listed within the Medica Advantage Plans Prior Authorization List, not separately like they are for other Medica products. Refer to the Medical Injectables section in this Provider Manual for more information.
- Medica Advantage Medical Criteria may vary by state. In these cases, separate links and lists for each state will be clearly denoted.

Medica will review all prior authorization requests using the CMS-established Medicare Coverage Guidelines for Medica Advantage coverage and determinations, when available, and will reference the following resources in the order they are listed:

1. National Coverage Determinations (NCDs) – CMS criteria for an item or service applicable on a national basis to Medicare beneficiaries meeting the criteria for coverage are referred to first.
2. Local Coverage Determinations (LCDs) – when there is not NCDs criteria, LCDs (coverage decisions made by Medicare Administrative Contractors) are referenced. Medica refers to MCG Guidelines (formerly Milliman Care Guidelines) for LCDs criteria.
3. Health Plan medical policies or MCG Guidelines – when there is not NCDs or LCDs criteria, Medica's medical policies or MCG Guidelines are referenced.

The Medicare Coverage Guidelines are available online at MCD Search. Providers can call the Customer Care Center at 877-301-3326 to request a paper copy of an MCG guideline or specific medical policy.

The following services **do not** require prior authorization, but may be compared to Medicare coverage requirements at claims payment:

- Botox injections
- Intrathecal pumps

STEP THERAPY

Under the Medicare Part B Step program, providers are required to first try preferred drugs before a non-preferred drug can be prescribed for treatment, if appropriate. If a member has been on a non-preferred therapy for the past 365 days, they will be able to continue on that same therapy. If a member is new to therapy, providers will need to fill out a MAPD Medical Exception form located in the Navitus Portal to request an exception for their patient (indicating why the preferred drug cannot be used).

MEDICAL INJECTABLES

Certain medical injectable drugs covered under a patient's medical benefit require prior authorization. Medical injectables covered under the medical benefit that require prior authorization are listed in the Medica Advantage Plans Prior Authorization List accessible from the Medicare Advantage link on the Medica page at mo-central.medica.com/Providers/Medical-Management.

Medica manages medical injectables prior authorizations. The Medical Benefit Drug Prior Authorization Forms are available through the Navitus Prescriber Portal. Providers should refer to the fax and phone numbers on the forms for submission.

Medica follows CMS-mandated priorities and turnaround times for medical injectable prior authorization determinations:

- Standard Medical Injectable – 72 hours
- Expedited Medical Injectable – 24 hours

PHARMACY BENEFIT DRUG PRIOR AUTHORIZATION

Prior authorization requests for drugs covered under the medical benefit for Medica Advantage must be submitted to the Health Plan. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms that are available through the Navitus Prescriber Portal.

PRIOR AUTHORIZATION SUBMISSIONS

All relevant clinical documentation to support medical necessity must be included with prior authorization requests at time of submission to avoid determination delays and authorization denials.

Electronic Submission

If your organization has a Medica Provider Portal, most authorization requests can be sent electronically through the secure Provider Portal, with the following exceptions:

- Authorization requests for medications covered under the medical benefit which must be submitted to the Health Plan using the prior authorization forms available through the Navitus/Navi-Gate Prescriber Portal at prescribers.navitus.com.
- Authorization requests for medications covered under the pharmacy benefit which must be submitted through the Navitus/Navi-Gate Prescriber Portal at prescribers.navitus.com.
- Authorization requests for oncology and oncology-related drugs which must be submitted to the Health Plan using the one universal prior authorization form that is linked from the Health Plan's Medical Injectable List.
- High-end radiology, and musculoskeletal services which should be submitted through Carelon's Provider Portal.

Providers submitting authorization requests through the Medica Provider Portal will receive the Health Plan's authorization response/determination electronically via the Provider Portal. The member and the servicing physician will receive a response/determination to the request via written correspondence from the Health Plan.

If you are not submitting your authorizations through the Provider Portal, we strongly encourage you to do so. Our secure Provider Portal is accessible 24/7 as a direct line between your organization and our self-service applications to exchange electronic transactions. To register for a Provider Portal account, click the Go to Portals link on the Medica Providers page at mo-central.medica.com/Providers. Refer to the Medica Provider Registration User Guide accessible from the Account login page for complete instructions on how to create an account.

Paper/Fax Submission

If your organization is not able to submit authorization requests electronically, you can submit them on a paper Authorization Request Form and fax them to the Utilization Management at 608-252-0840. To submit a prior authorization via paper, please review the following guidelines:

- The Prior Authorization Request Forms can be obtained from the Medical Management page at mo-central.medica.com/Providers/Medical-Management.
- Prior authorization forms should be faxed on the date the request is completed to ensure timely processing of the request.
- Complete ALL fields on the top of the form in their entirety to avoid having the Utilization Management Department return it to the referring physician for completion.

PRIOR AUTHORIZATION PRIORITIES AND TURNAROUND TIME

Medica follows CMS-mandated priorities and turnaround times for Medica Advantage prior authorization requests. The priority of the prior authorization request must be indicated during the submission process.

Standard

prior authorization request should be submitted as "Standard" in any scenario where the request is for routine services that do not meet the definition of an expedited request. Standard requests will be reviewed and determined as expeditiously as the member's health condition might require, but no later than 72 hours for a drug or biologic and 14 calendar days for a DME product after receiving the prior authorization request.

Expedited

A prior authorization request should be submitted as "Expedited" if the physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be reviewed and determined as expeditiously as the member's health condition might require, but no later than 24 hours after receiving the prior authorization request.

The date of receipt is defined as the date when all the authorization information and documentation required for a determination has been provided to the health plan.

HOSPITAL ADMISSIONS

Approved prior authorization is required for planned hospital admissions and is reviewed for medical necessity and appropriateness of site. If the hospital admission meets the Medicare definition of emergency, prior authorization is not necessary at the time of admission. However, the Health Plan must be notified of the admission immediately (or the next business day if a weekend or holiday) so that discharge planning and post-discharge support can be provided.

CASE MANAGEMENT

CASE MANAGEMENT PROGRAM OVERVIEW

Medica offers Case Management to optimize the overall health of our members across their health care continuum by engaging them in population-informed programs and services available through the Health Plan, care delivery, and community. Core objectives of Case Management programs are to help members self-manage complex or chronic conditions, promote the primary care provider relationship, connect members with appropriate community resources, and assist in navigation of the health care system including optimum utilization of health coverage and benefits.

Member participation in Case Management is voluntary, and members may opt out at any time. Please see below for how to refer patients to Health Plan Case Management.

Medica's Case Management team includes registered nurses, licensed social workers, engagement coordinators, and others who help members learn how to manage their health care needs. Through various outreach methods, the team provides education, support, and resources for members while promoting quality, cost-effective services and interventions to achieve quality outcomes. An assessment of the member's health and wellness needs informs development of an individualized plan of care with member-centric goals.

Case Management staff:

- Educate members to promote self-management of their health conditions.
- Support and guide members in setting achievable goals as they work toward improving their quality of life, overall health, and well-being.
- Help members understand their individual health care plan, including how to maximize benefits.
- Connect members with the services and community resources necessary to self-manage their health care needs.
- Serve as an advocate to help members achieve their optimal physical and mental health.
- Help members learn how to navigate the complex health care system.

Care Management is not able to answer questions or resolve issues specifically related to:

- Enrollment (e.g., questions about services before becoming a member)
- Billing
- Claims
- Prior authorizations
- Denials
- Grievance and appeals
- Benefit determinations
- Provider availability and scheduling of health care appointments

CASE MANAGEMENT PROGRAMS

Advance care Planning:

Advance care planning is the process of thinking about, communicating, and documenting future health care wishes in case of illness, accident, or sudden medical event. The Health Plan wants to ensure that members' health care wishes are known and respected. Social workers are available to help any member over age eighteen begin or continue the process of advance care planning. . Providers may direct members to the Medica Advance Care Planning page at mo-central.medica.com/Individuals-and-Families/Wellness/Care-management/Advance-care-planning to get the process Started.

Advance care planning social workers help members:

- Explore personal values, beliefs, and meaning of quality of life.
- Weigh options for the kind of care and treatment members would or would not want.
- Consider who members should appoint to speak on their behalf.
- Start the conversation with family, friends, clergy, and health care and other providers.
- Complete advance directive documents (Power of Attorney for Health Care and Living Will) to clearly state values and wishes.
- Review current advance directive to ensure it continues to reflect the member's wishes.
- For more information on Advanced Care Planning, click here Advance care planning - Medica

Behavioral Health Case Management

Behavioral health case management provides an individualized approach for members with mental health and substance use disorders to help them manage their health and live their best lives.

Behavioral health case management can help members to:

- Understand individual health care plans to help self-manage their health condition.
- Coordinate care with providers, clinics, and programs to facilitate treatment for mental health or substance use conditions.
- Connect to community-based services and resources to enhance wellness.
- Understand how to use available health care services to receive the right care at the right time in the right place.

Complex Case Management

Medica complex case management is a multi-disciplinary approach to the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The complex case management team helps members and caregivers:

- Navigate the complex health care system.
- Understand current acute and chronic medical conditions.
- Manage medications, including how to communicate with providers to get the best results from medications.
- Understand how to use available health care services to receive the right care at the right time in the right place.
- Identify self-care needs, including arranging referrals to therapeutic services and community-based support resources.
- For more information on Complex Case Management, click here Complex case management and care coordination - Medica

Transplant Case Management

Transplants are life-changing and complex, not only affecting the member but involving their family as well. The Medica Case Management team offers support before, during, and after the procedure, providing education and coordination of services to ensure members receive the care they need. A Case Manager or Care Coordination Specialist collaborates with the transplanting facility and care team.

A transplant Case Manager and Care Coordination specialist helps members:

- Understand and manage the complex disease that is leading toward transplantation.
- Coordinate care with providers, clinics, and programs through the transplant process.
- Navigate and understand health coverage and benefits before, during, and after the transplant.
- Ensure appropriate prior authorizations for transplant services are in place.
- Connect with an advance care planning social worker, if desired.
- For more information on Transplant Case Management, click here Transplant case management - Medica

CASE MANAGEMENT REFERRALS

Members may self-refer to Case Management by calling the Medica Customer Care Center at 866-905-7430 or completing the enrollment form online at Wellness - Medica.

Providers may refer a member to Case Management programs by:

- Calling the provider referral line at 866-905-7430. Please be prepared to provide the following information:
  - Provider name/office information
  - Member name
  - Member date of birth
  - Reason for referral, including pertinent diagnosis
  - Email

In addition, Medica Case Management identifies members for possible services through:

- Discharge Planners and Nurse Navigators
- Pharmacy data
- Claims
- Hospital discharge data
- Health Assessments
- Internal referrals from other departments
- Medica Utilization Management

CASE MANAGEMENT OUTREACH PROCESS

Case Management's standard hours of operation are 8:00 a.m. to 4:30 p.m. (CST), Monday through Friday, excluding nationally recognized holidays.

- The goal is to outreach to members within two business days of provider referral or member self-referral.
- Case Management makes three contact attempts (typically two phone calls and a letter) over approximately a week timeframe before closing the case if a member does not respond to the outreach attempts.
- Members must engage with a Health Plan Case Management team member and accept referral to additional services/resources before said service can be provided (e.g., Health Plan Case Management cannot arrange transportation to appointments without the member's permission).

Note: Medica's case management team **does not** provide urgent or emergent services.

MEMBER GRIEVANCES AND APPEALS

Members or their authorized representative have the right to file complaints (grievances) and reconsiderations/redeterminations (appeals) with the Health Plan by calling the Customer Care Center phone number listed on their member ID card. Grievances and appeals may also be filed in writing to the following address or fax number:

Attn: Grievance and Appeals

Route CP595

PO Box 9310

Minneapolis, MN 55440-9310

HISTORICAL REVISION LOG

With the next revision of this manual, the grid below will list past revisions to the manual for historical reference.

Description of Change	Revision Date
Updated: WellFirst Health Medicare Advantage plan information for 2025, including available plans and copay grid	January 2025
Updated: WellFirst Health Medicare Advantage plan information for 2024, including available plans and copay grid.	January 2024
Updated: WellFirst Health Medicare Advantage plan information for 2022, including available plans and copay grid.	January 2022
Updated: WellFirst Health Medicare Advantage supplemental benefit information for 2022.	January 2022
Updated: Effective January 15, 2022, the Health Plan will manage medical benefit drug prior authorizations in place of Navitus Health Solutions. Forms will continue to be available through the Navitus Prescriber Portal. Navitus will continue to manage pharmacy benefit drug authorizations.	January 2022