(Central)

St. Louis Area

PROVIDER MANUAL

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WELCOME!

Welcome to the Health Plan! Thank you for participating in our network of physicians, clinics, hospitals, and other healthcare professionals. We are delighted to work with you. As an in-network provider, you are part of our comprehensive network that encourages patients to seek their health care locally and will be listed in our online Provider Directory easily accessible to members from the Find a Doctor/Find Care link located at the top of the Health Plan's website. You also have access to our Provider Network Relationship Specialists who are personnel dedicated to supporting our in-network providers.

ABOUT 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.

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.

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 and the term "Medica Central" is used to further define this network and population of providers in the greater St. Louis region during our ongoing integration. 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.

ABOUT THIS MANUAL

This manual is a resource for policies and practices to support in-network providers serving patients enrolled in Dean Health System Corporation (DHSC) benefit plans under the Medica Central (St Louis) region (Individual and Family Business under payer ID 41822 and Self-Funded Plans under payer ID 71890). It also includes important phone numbers, website URLs, and references to provider resources and how to access them.

This manual is intended to be an extension of the provider contract. Providers should also refer to their contract agreement, the member's benefit certificate, summary plan description, medical policy, and applicable state and federal laws for specific coverage, brands, products and network information.

*These processes do not apply or carry over to our affiliate Medica, with a home office in Minnetonka, MN. For information regarding a contract agreement with Medica or Medica-specific processes please refer to the Medica Administrative Manual.

Updates to this manual are made on a regular basis. New changes that have been made to the manual from its immediate predecessor version are documented in the Revision Log. Refer to the Historical Revision Log as a reference to recent past revisions.

Providers are encouraged to refer to the online version of this manual to ensure they have the most current information.

Not an in-network provider, but would like to become one?

The information in this Provider Manual is applicable to in- network providers contracted with Medica to provide services to Medica members. Request to join the network by submitting an online Provider Network Application.

TIPS ON NAVIGATING THROUGH THE MANUAL

Clarification of Terms

In this manual, “you,” “your,” “practitioner,” or “provider” refers to any health care provider subject to the information in this manual, including physicians, health care professionals, facilities, and ancillary providers, except when indicated otherwise.

“We” and “our” refers to the health plan.

“Members” and “patients” refer to individuals enrolled in Medica benefit plans.

Finding Information

The Table of Contents links to the applicable section within the manual. To search using a specific keyword:

1. Select CTRL+F.
2. Type in the key word.
3. Click Enter.

We are here to help!

For questions about information in this manual or need help locating information, please refer to the directory on the next page for a list of contacts and resources. For additional assistance, please feel free to contact our Customer Care Center at the phone numbers found in directory section of this manual. These phone numbers will also be reflected on the members ID card as applicable.

DIRECTORY

PROVIDER SERVICE CENTER	
Provider Service Center Interactive Voice Response (IVR) is available 24 hours a day / 7 days a week.	800-458-5512
Language Assistance Line for In-Network Providers Available 24 hours a day, 7 days a week	844- 526-1386
HEALTH SERVICES	
Utilization Management	800-458-5512
Case Management	866-905-7430
CLAIMS	
Claims Manager	608 827-4432 800 356-7344, ext. 4432
ELECTRONIC DATA INTERCHANGE	
Information about Electronic Data Interchange (EDI) transactions	**For electronic Payer ID 39113**: EDI support Team at edi@deancare.com **For electronic Payer ID 41822 and 71890**, navigate to Welcome to Availity, Your New EDI Gateway* - Overview for set up instructions or use the Availity EDI Gateway quick link found towards bottom of Medica's provider page Providers - Medica. For questions, contact Availity Client Services at 1-800-AVAILITY (282-4548) Monday - Friday from 7a.m. to 7p.m. Central Time.
DRUG PRIOR AUTHORIZATIONS	
Drug Prior Authorizations via Phone	855-847-3554
Drug Prior Authorizations and Reconsiderations via Fax	855-668-8551
Navitus Health Solutions	866-333-2757
ESI/Northstar	
Drug Denial Appeals (Formulary, Non-Formulary, and Medical Injectables)	608-252-0812
GRIEVANCE AND APPEALS	
Grievance and Appeals Address	Medica Route CP595 P.O. Box 9310 Minneapolis, MN 55440-9310
WEBSITES	
Provider Resources	Partner.Medica.com/Providers – Medica Central
PROVIDER NETWORK RELATIONSHIP SPECIALISTS	
Email	ProviderRelations@medica.com
Phone	314-994-6262

Provider Service Center IVR

We have implemented automated phone system technology, Interactive Voice Response (IVR). The IVR system offers 24/7 self-service for member eligibility, benefits, or claim status information through pre-recorded prompts, and menu options. You'll always have the option to exit the IVR and speak with a live call agent during business hours. To utilize the IVR system have the following information ready:

- Organization 9-digit tax ID number
- Member's Group and ID numbers

HEALTH EQUITY AND MEDICA

Health equity means that every person has opportunity as well as the support and resources to be as healthy as possible. As a health plan, we recognize that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. In support of this, Medica espouses the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity and help eliminate health care disparities.

Understanding and implementing the National CLAS Standards ensures higher quality of care to all patients. Medica expects all network providers to support health equity standards and deliver honest, unbiased, and respectful care regardless of a patient's race, ethnicity, language, sexual orientation, or gender identity.

Medica encourages providers to collect information regarding a patient's race, ethnicity, preferred language, sexual orientation, and gender identity to ensure health care services are meeting the multi-cultural needs of that individual. Requests for this information should be conducted respectfully in a sensitive and unbiased manner that also upholds a patient's privacy.

For more information, trainings, and other resources regarding health equity, please visit the Health equity - Medica.

Language Line

To address diverse language needs and enable important communication between providers and patients, Medica offers a free telephonic Language Line for language assistance/interpreter services. The Language Line is available to in-network providers who do not have access to language assistance services and need to interact with Health Plan members who have limited English language proficiency.

How to access an interpreter/use the language line:

- Call the Language Line at 844-526-1386, available 24 hours a day, 7 days a week.
    - You will be prompted to indicate the language needed:
        - Press 1 for Spanish. This will directly connect you with a Spanish-speaking interpreter.
        - Press 6 for all other languages. This will prompt you to indicate which language you need interpretation services for.
        - After confirming the language needed, you will be connected to an interpreter.

- The interpreter will share their name and ID number at the beginning of the call. They will ask you
    - Your name and/or the name of the provider performing the service.
    - The clinic or facility name where the service is being provided.
    - The member's name or their member ID number.

- You'll also brief the interpreter on any special communication instructions or needs.
    - The interpreter will also ask if this is an in-person call (the member is with you) or if a third-party call is needed (to connect you and the interpreter to the member who is at another location). If a third-party call is required,

the interpreter will ask for the member's telephone number and initiate a three-way call.

Working with an interpreter

- Note the interpreter's name and ID number provided at the beginning of the call for future reference. Once engaged with the member, speak directly to that individual, not the interpreter.
  Pause at the end of a complete thought to allow time for the interpreter to convey the information to the member.
  To ensure accuracy, your interpreter may ask you for clarification or repetition.

Using phone interpreting equipment

If you have phone interpreting equipment for in-person calls, use one handset to call the Language Line. Once connected, give the second handset to the member.

Customer service

If you wish to provide feedback on your Language Line experience, email the Provider Network Services. Along with your feedback, include your name, company/organization name, date/time of your call, interpreter's name and ID number, and the member's ID number

VISIT OUR WEBSITE

The Health Plan offers provider information and resources from the Providers' home page. This page is directly accessible at Partner.Medica.com/Providers. Medica Central specific documents are located under "Resources".

PROVIDER NETWORK SERVICES

The Health Plan's Provider Network Services' department's main purpose is to support in-network providers. This includes maintaining provider data, facilitating the provider contracting process, updating provider manuals, and issuing provider communications. These processes or contract designations do not apply or carry over to our affiliate Medica, with a home office in Minnetonka, MN. Please review medica.com under "For Providers" for questions and resources pertaining to contracts directly with Medica.

PROVIDER NETWORK RELATIONSHIP SPECIALISTS

The Provider Network Services department includes Provider Network Relationship Specialists (PNRS), who are responsible for fostering and maintaining network provider relationships by being a resource for initial onboarding, ongoing education and escalated issue resolution.

In partnership with Provider Network Communications, provider education may include:

- Updating providers on new policies and procedures distributed via email, Provider Newsletters (Connections and Medical Provider Newsletter), provider mailings, or workshops.
- Orientations for new practitioners and facilities, as requested.
- Ongoing education for network providers on topics such as day-to-day interaction with the health plan.

NETWORK SETUP AND PROVIDER STATUS

The Health Plan is a closely managed health maintenance organization (HMO) comprised of contracted in-network providers to provide health care services to our members. To provide quality coverage and cost savings to our members, there are two distinct statuses for providers based on how they are contracted with Medica Central Networks.

- **Plan** — referred to as an in-network provider in this manual. This is a provider with a "Plan" status, contracted as an in-network Medica provider who can provide health care services to Medica members and is listed in our provider directory.

- **Non-Plan with Agreement** — referred to as an out-of-network provider in this manual. This is a provider with a "Non-Plan with Agreement" status contracted to provide services to Medica members but is not considered to be a "Plan" or in-network provider due to their specific contract language. These providers require a prior authorization to be submitted to the health plan by an in-network provider on their behalf for approval before providing services to Medica members.

Providers contracted with he Health Plan may only be allowed to provide care to members for specific products, brands, practitioners, services, and/or locations. It's important for providers to be familiar with their provider agreement and always check member eligibility prior to providing services to prevent claims payment issues.

A non-plan/non-contracted provider is an out-of-network provider that does not have a signed contract with the Health Plan. The Health Plan has no liability or responsibility for the quality of care provided by an out-of-network provider.

Out-of-network providers can request to join the network by completing and submitting the online Provider Network Application. Providers contracted to provide services for Dean Health Plan, Prevea360 Health Plan and Medica Central may not have the same contracted relationship with Medica. Please review with your office administrator before providing services to a member in a plan type not covered under your contract.

PROVIDER CHANGES FOR DIRECTORY ACCURACY

We are committed to ensuring that our provider directories are accurate and current for the members who rely on this information to find in-network providers for their care. Additionally, the Centers for Medicare & Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories.

To help accomplish this, providers must notify the Provider Network Consultant of any updates to their information on-file with us as soon as they are aware of them. Notify your assigned Provider Relationship Specialist or ProviderRelations@medica.com if there are changes to the following data elements.

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	

On a quarterly basis, outreach is provided by our vendor BetterDoctor requesting providers to validate their information on-file with us is current and accurate. Providers should not wait for these reminders to update their information with the Health Plan.

Providers must also notify the Health Plan of terminations for individual practitioners, clinics, facilities and any other locations under an organization. Communicate the terminations in writing to your assigned Provider Relationship Specialist or ProviderRelations@medica.comwith as much advance notice as possible.

As we prepare our provider directories to accommodate additional information for our in-network providers and additional requirements in the future, please review your directory information regularly at https://www.medica.com/find-care to verify it reflects current and accurate information for you and your organization.

Providers are encouraged to review and update their National Plan and Provider Enumeration System (NPPES) information when they have changes. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format. NPPES data serves as an important resource to improve provider directory reliability and accuracy.

REQUESTING TO JOIN THE NETWORK

Providers can request to join Health Plan's network of contracted providers by completing and submitting our online Provider Network Application Please note, this link and application is applicable for providers interested in joining Health Plan.

Our Contracting team contacts interested providers upon receipt of the request. Requests are reviewed internally by the Health Plan and may take extended time to review and decide. The determination will be communicated to you by the NetManQuest@medica.com.. Providers contracted to provide services for Dean Health Plan, Prevea360 and Medica Central may not have the same contracted relationship with Medica. Please review with your office administrator before providing services to a member in a plan type not covered under your contract.

Providers are not considered in-network providers until they have satisfied all credentialing requirements, completed the credentialing process (whether at the organization or practitioner level), have a signed agreement, and are configured in the Health Plan's system. Once these are all completed, the provider will be notified, generally via email, of the date they are approved to begin providing services to Health Plan members and submit claims for these services. For information on credentialing and recredentialling, refer to the Credentialing Process section in this document.

REQUESTING A NEW PRACTITIONER, LOCATION, OR SERVICE

Contracted providers must formally request in advance to have new practitioners, office or practice locations, and services/specialties added. Requests should be submitted in writing to the assigned Provider Network Relationship Specialist or ProviderRelations@medica.com.

The request process is as follows:

1. Provider requests a new practitioner, location, or specialty in writing to their Provider Network Relationship Specialist. Providers should also specify if the new practitioner is replacing a practitioner in the organization. If so, include the practitioner's name, specialty, degree, and term date in the request.
2. The Provider Network Relationship Specialist may require the provider to provide additional information or documentation, which will then be submitted to the Health Plan for review.
3. Health Plan reviews and decides on the request:

- If denied:
    1. The provider will notify the provider of the denial. Denials remain on file for 12 months and therefore providers must wait for that time before submitting a new request.
- If approved:
    1. The provider will be notified of the approval and instructed on whether the new practitioner must undergo credentialing.
        - If credentialing is not required, the new practitioner's effective credentialing date is the same as the notification date.
        - If credentialing is required, the new practitioner will receive a credentialing application to complete and submit.
            - The new practitioner cannot provide services to the Health Plan members until their credentialing is approved.
            - No retroactive effective dates are granted.
    2. The new practitioner will be notified once credentialing is successfully passed, and they can begin providing services to the Health Plan members and claims can be submitted for the new practitioner, location, or service.

Mid-Level Practitioners and Locum Tenens Physicians

The Health Plan network is composed of many practitioner types, including locum tenens physicians and physician extenders/mid-level practitioners such as nurse practitioners (NP/APNP) and physician assistants (PA/PA-C).

- Mid-level practitioners and locum tenens physicians are required to complete the credentialing process.
- Health Plan requires in-network providers to send **advance** notification of the need for a locum tenens physician. Please contact your Provider Network Relationship Specialist or ProviderRelations@medica.com to request a locum tenens physician and their expected time coverage.
- Mid-level practitioners must have a supervising physician. When requesting a mid-level practitioner, please include the supervising physician's name, degree, specialty, and practice location.

Replacement Practitioner

If requesting a practitioner who will be replacing an existing practitioner who is terming from your organization, please ensure the terming practitioner's name, specialty, degree, and term date is included in the request.

ORGANIZATION AND PRACTITIONER UPDATES

It is important to report organization and practitioner changes to the Health Plan. Failure to do so may impact claims processing and payments. Report any of the following changes or updates to your assigned Provider Network Relationship Specialist or ProviderRelations@medica.com for your organization with as much **advance notice** as possible to avoid claims payment issues:

Practitioner-Related

- Name change
- Adding or discontinuing specialty
- Moving locations – including when moving to another in-network organization
- Hospital affiliations
- Leave of absence, vacation, or extended leave
- Medicare certification/decertification (claims will not be retroactively paid)
- Terminating from your organization (see next section)

Organization-Related

- Name change
- Accreditation or decertification
- Billing information (TIN or NPI)
- Taxonomy
- Physical change to billing or practice location addresses on file with the Health Plan
- Selling or transferring ownership
- Clinic closure
- Facility handicap accessibility
- Website URL

PRACTITIONER TERMINATIONS

As outlined in each provider's contract, a provider retains the right to terminate his/her participation status as a network provider. If a provider desires to terminate the participation agreement with Medica, a written notice is required in accordance with the time frames outlined in the provider's contract with Medica.

MISSOURI:

Within 15 days from when the provider gives or receives notice of termination, they must supply Medica with a list of the names of their patients in adherence to Missouri state law to safeguard continuity of care for patients. The law requires that providers and health plans provide for the continuation of care for up to 90 days in the event of provider termination "where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness." Members are not liable to the provider for any amounts other than deductibles or co-payments as specified in the member's benefit certificate.

ILLINOIS:

In adherence to Illinois state law, continuity of care is required for up to 90 days from the date of the notice or through post-partum care for individuals who are in their third trimester of pregnancy. This is contingent on the provider agreeing to continue to accept reimbursement from the health plan at the rates applicable prior to the start of the transitional period.

Providers must communicate any practitioner terminations in writing to their Provider Network Relationship Specialist with as much **advance notice** as possible in accordance with state law, and include the following information:

- Practitioner name and degree
- Practice location(s)
- Termination date
- Reason for termination (i.e., moving to a new practice, retirement, etc.)
- Where the practitioner will be providing services (if still actively practicing)
- A copy of your member notification letter communicating the practitioner's termination

FACILITY TERMINATIONS OR CLOSURES

Providers must notify their patients in writing if a site is closing permanently within 30 days of their term or closure date. Within 15 days from when the provider gives or receives notice of termination or closure, they must supply Medica with a list of the names of their patients in adherence to Missouri state law to safeguard continuity of care for patients. The law requires that providers and health plans provide for the continuation of care for up to 90 days in the event of facility terminations or closures "where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness." Members are not

liable to the provider for any amounts other than deductibles or co-payments as specified in the member's benefit certificate.

In adherence to Illinois state law, continuity of care is required for up to 90 days from the date of the notice or through post-partum care for individuals who are in their third trimester of pregnancy. This is contingent on the provider agreeing to continue to accept reimbursement from the health plan at the rates applicable prior to the start of the transitional period.

Providers must communicate any facility terminations or closures in writing to the Medica Provider Network Consultant team with as much advance notice as possible, but within 30 days prior to the termination at a minimum, and include the following information:

- Location name
- Address
- Termination date
- If practitioners at that site are moving to another location
- A copy of your member notification letter communicating the termination/closure

OTHER SITUATIONS

Please communicate the following situations to the Medica Provider Network Relationship Specialist in writing:

- Leave of Absence/Vacation: when a practitioner will be out of the office, vacationing, or on extended leave, and which other facility or location will be covering their practice. Medica requires **written** notification to include:
    - Name
    - Location
    - Duration of the covering practitioner or facility

  The covering practitioner must be a **plan provider** and have completed the credentialing process**.**

- Panel Status: when a practitioner finds it necessary to discontinue accepting new patients or limit their practice. This notice must be provided to your Provider Network Relationship Specialist in writing.

PROVIDER SERVICE OBJECTIONS

Providers in the Health Plan network who refuse to provide a service to members based on moral or religious objections must notify their Provider Network Relationship Specialist or ProviderRelations@medica.com in writing of the objection and its basis in a timely manner. The Health Plan will notify the member so that the member can seek another like in-network provider that is available to provide the service in question.

TERMINATION OF PATIENT/PRACTITIONER RELATIONSHIP POLICY AND PROCEDURE

In-network providers are required by the Health Plan to send copies of member termination of care notification letters to their assigned Provider Network Relationship Specialist or ProviderRelations@medica.com.

Practitioners may terminate a member's care only with good cause. The following are examples of good cause, in which a member:

- Physically injured or threatened a practitioner or other member of the clinic staff.
- Repeatedly and materially refused to pay coinsurance, copayments, or deductibles associated with Dean Health Plan claims after all reasonable collection efforts have been exhausted.
- Displayed verbally abusive behavior or harassment towards a practitioner or other member of the clinic staff.
- Repeatedly refused to cooperate with the practitioner, was non-compliant with medical care, or there was a breakdown in the practitioner-patient relationship.

- Failed to attend or late-cancel three or more scheduled appointments after having received a written warning.
- Communicated to the practitioner that they would like to select a different practitioner.

The following should be included in the termination of care letter, per the Health Plan guidelines:

- Member's full name, including middle name (not just initial)
- Member's date of birth (optional)
- Member's address, which can be on the address line
- Clinic/facility name
- Practitioner name
- Notice in the body of the letter stating that the member may see the practitioner for 30 days from the date the member received the termination notice if the member presents for urgent or emergent care
- Reason for the termination
    - If reason is due to the member missing or late-canceling appointments, include when their initial warning letter was sent to them
    - If reason was due to non-payment, include proof of attempts to collect payment
- Health Plan's Customer Care Center phone number using the phone number on the member ID card
- Copy of a patient authorization form, as the member may want to transfer care to a different clinic/facility

PRODUCTS AND SERVICE AREAS

Medica offers a variety of products for members, each designated to serve specific needs. Below is an overview of the products that are available to Medica Plan members. For information on specific plans or examples of the member ID Cards visit the Product Portfolio Sheets or the Provider Quick Reference.

Medica Individual and Family Business (IFB) Plans

IFB plans were designed to provide coverage to those who cannot get health coverage through an employer or Medicaid. IFB products offer multiple plans with Single or Family options and a variety of deductible and benefit levels.

Self-Funded Plans (ASO)

A self-funded insurance arrangement whereby an employer provides benefits to employees with its own funds. This is different from fully insured plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and covered benefits are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy.

***Note*:** In *some* cases, self-funded ASOs employer groups are not required to follow State or Federal health care mandates. Therefore, Medica ASO, self-funded employer groups policies may be different from those for other products. Please contact the Provider Service Center or verify member benefits and eligibility in the Availity Essentials Provider Portal.

CHECKING MEMBER ELIGIBILITY

Providers should verify member eligibility for each date of service and cannot charge a member for failing to do so and providing services. Because Health Plan products vary and members can move between eligibility groups, it is important that providers determine member eligibility using real-time eligibility sources only — the 270/271 Eligibility and Benefit Inquiry and Response transaction **or** the Eligibility application in the Availity Essentials Portal. The information in these transactions also includes real-time details about a member's cost share, deductible, copay, and coinsurance amounts.

Providers may call our Provider Service Center with any questions about a member's eligibility and coverage.

HEALTH PLAN COMMUNICATIONS FOR PROVIDERS

The Health Plan issues a variety of communications to providers about changes to health plan procedures, benefits, and other areas of interest involving health plan products and services:

- **Provider Newsletters** — a monthly health plan newsletter specifically for Health Plan in- network providers. The Medica Central Provider Newsletter *and* *Connections* informs providers of changes to health plan procedures, benefits, and other areas of interest involving health plan products and services.
- **As-needed communications** — to communicate changes outside of the monthly newsletter schedule due to the planned implementation date or for larger initiatives that require more detail. As detailed below, these communications are usually sent via email to those provider portal users who have "opted-in" to receive health plan communications. This ensures that your organization receives these messages and can disseminate them to impacted users
- **Policy updates provider notifications** – emailed monthly as part of the Provider News to communicate select medical benefit drug policy and medical policy updates, as well as Health Plan initiatives when applicable.
- **Communications Webpage** — links to a variety of our past and current provider notifications that were originally communicated via emails to serve as an on-demand communications repository. Examples of the notifications that are available from this page are monthly Provider News, as-needed communications and additional resources. Published communications contain information that was accurate when the notification was originally released and may not reflect current process. The Provider Communications page is the hub for updates and communications regarding updated interim process for self- service as we transition to our new business platforms, as well as self-service education and resource documents.

In most cases, we communicate to providers through email. Providers can subscribe to the Connections Newlsetter from the Medica Provider pages.

CREDENTIALING PROCESS

PRACTITIONER CREDENTIALING AND RECREDENTIALING PROCESS

The Health Plan adheres to a credentialing/recredentialing process for evaluating and selecting practitioners who practice within the Health Plan delivery system. The Health Plan is National Committee on Quality Assurance (NCQA) accredited, and therefore requires specific documentation is reviewed within established timelines during the credentialing/recredentialing process. Practitioner credentialing applications are reviewed and approved by the Health Plan's Credentialing Subcommittee or its delegate prior to being authorized to provide services to Health Plan members. Recredentialing applications are required to be completed and approved by the Health Plan Credentialing Subcommittee at least every 36 months to continue to provide services to Health Plan members. The attached link includes the full Credentialing Plan*:* Partner.Medica.com/-

/Media/Documents/Provider/Programs-and-Resources/Medica-Credentialing-Plan.pdf?la=en

If an organization has entered into a Delegation of Credentialing Agreement with Medica Health Plan, credentialing/recredentialing for practitioners within that organization are delegated to their organizational group. In these cases, the terms of the credentialing/recredentialing process are outlined in the delegation agreement and may differ slightly from the process overview in this manual.

PROVIDER PORTAL

OVERVIEW OF AVAILITY ESSENTIALS

Availity Essentials enables provider teams to perform transactions for multiple payers from a single account. Availity Essentials is a widely utilized provider portal between health plan payers and providers. If your organization uses Availity Essentials for another payer, our new payer IDs will be added as an option to your dashboard. There's nothing you need to do. If your organization doesn't use Availity Essentials, visit the Availity Essentials web page.

The Health Plan provider set-up and resource page can be found ***here*** or at availity.com/medica-health-plans. This page also allows you to sign up for live webinars or play a Health Plan-specific recorded training to get to know a particular application or function better. Please note that not all Availity functionality will be available, but updates on additional available functionality will be located on our Provider Communications Webpage.

OVERVIEW OF THE HEALTH PLAN PORTAL

The Medica Central Plan Provider Portal is a 24/7 online resource for our in-network providers free of charge to assist with managing key patient data, simplifying everyday tasks, promoting efficiency in business, and streamlining electronic transactions. It has functionality to check HIPAA-compliant real-time transactions along with web-based self-service applications. While the health plan transitions to a new claims' platform, this portal only applies to information for members in plan types utilizing payer ID 39113.

ACCESS THE PROVIDER PORTAL

1. Medica Plan Provider Portal - directly at https://providerauth.mo-central.medica.com/
    - Claims Status and Claim Appeals for payer ID 39113
2. Availity Essentials Portal – directly at Apps.Availity.com/Web/Onboarding/Availity-fr-ui/#/login
    - Prior Authorization Submissions and Status
    - Member eligibility and benefits
    - Claims Status and Appeals

PROVIDER PORTAL APPLICATIONS

Eligibility & Benefits (270/271 EDI) Transactions

This application provides human readable real time Electronic Data Interchange (EDI) 270/271 Eligibility & Benefit Inquiry and Response transactions, including detail regarding eligibility, benefit plan coverage, co-payments, and deductibles for a member. It also provides the member's primary health plan, if applicable. Please be sure to use the correct portal based on payer ID of the member's plan type to ensure that the correct information is returned.

Authorization

The Health Plan contracts with the following entities for authorization review and approval of certain services:

- Availity Essentials Provider Portal - Medical Benefit Authorizations except if listed below.
- Carelon – for authorizations of high-end radiology services, musculoskeletal services (MSK), pain management and cardiovascular services.
- Pharmacy Team – Medical Injectables
    - Submit Medical Benefit Prior Authorization Form to Pharmacy Department Fax: 608-252-0814
- Navitus/Navi-Gate — for pharmacy benefit drug authorization requests

Links to Navitus/Navi-Gate portal and Carelon portal are available on our Account Login webpage.

Refer to the Submitting Prior Authorization Requests for more information as well as tips for prior authorization submissions.

Claim Status (EDI 276/277) Transactions

This application provides human readable real-time EDI 276/277 Health Care Claim Status Request and Response transactions, which allows providers to check the status of a claim to see if it is pending, processed, or in a finalized status. This application is available in both portals based on the payer ID of the member's plan type.
Note: Claims cannot be submitted via the Medica Provider Portal.

Claim Appeals

This application allows users to appeal processed claims with a finalized status (paid-denied).

Claim Payments

Providers can view claim payments and remit with the vendors below:

- The primary location for claims payments and remits is Instamed.
- For Self-Funded Plans
    - Sign up with VPay for payment
        - To sign up for VPay, email **support@vpayusa.com** or call: **1 (855) 893-3029**
    - Remits are available through the ERA function in SDS.

Opt In/Opt Out for Electronic Communications in the Health Plan Provider Portal

The Opt In for electronic communications option is available in the Health Plan Provider Portal in "Account Settings." By selecting Opt In, providers will receive direct and expedited provider email communications from Medica. No communication preferences are available specific to the Health Plan in the Availity Essentials portal, so please ensure that your Health Plan portal account reflects this preference to ensure that your email is collected for this purpose. Providers can also register to receive the Connections Newsletter.

Communications include notifications about changed or new policies or upcoming changes that may affect daily operations, for example. Opt In will not replace all paper communications. Email addresses that are provided to the health plan through Opt In will not be shared with outside organizations or used for purposes other than the electronic distribution of health plan communications.

Health Plan will email communications to the email address that was provided during registration. Check your email "junk" or "spam" folders periodically to ensure that communications are not being filtered as spam. Health Plan will not send a high volume of emails, but you may want to consult your IT department if you have not received an email from Health Plan after three months of your Portal registration.

While Opt In is available through the Portal, opting out after selecting Opt In can be done through the "Unsubscribe" link at the bottom of email communications that you will receive from Medica. Once you unsubscribe, your email address is automatically inactivated from the system and further electronic communications cannot be sent to that address.

CLAIMS, TIMELY FILING, AND ADJUSTMENTS

CLAIMS SUBMISSION

To allow for more efficient processing of claims, please adhere to the following:

- Medica requires providers to use the correct and complete member number. For payer ID 39113, families share the first nine digits of their subscriber number. For other products families share the first 10 digits of their subscriber number. The remaining two digits signify the individual member (i.e., spouse, dependents, etc.). Using the correct member number on claims submitted to Medica will help to ensure correct claim payment.
    - For payer ID 39113 the complete eleven-digit member number is required for claims submission.
    - For other lines of business ONLY the first 10 digits are required for claims submission. If the claim is submitted with the full 12 digits the claim will be rejected.

- Medica requires contracted providers to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Refer to the Timely filing section for more information.
- The Health Plan requires that all services billed be appropriately documented in the patient's medical records. If the services billed are not documented in the patient's medical record, they will not be considered reimbursable by Health Plan.
- All claims for services regarding work-related injuries or illness should be submitted to the member's worker's compensation carrier. If the worker's compensation carrier denies the claim, you may submit the claim along with the denial for consideration by Medica. **All prior authorization guidelines apply in this situation.** Providers must submit the claim(s) in a timely manner along with the denial as outlined in the timely filing guidelines.
- Submit subrogation claims (where the third party may have caused the injury or illness due to an auto accident, a slip or fall, and/or a defective product) to Medica for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. **All prior authorization guidelines apply in this situation.** You must submit the claim(s) in a timely manner as outlined in the timely filing guidelines.
- While Health Plan will accept paper or electronically submitted claims, it's recommended to submit electronically to expedite processing and reduce claim rejections. All claims submitted, regardless of submission method, must comply with the applicable national billing rules as well as the published Companion Guides. Only the latest published versions of the claim forms will be accepted for processing. If necessary, providers can mail claims to Dean Health Plan or Prevea360 Health Plan, PO Box 56099, Madison, WI 53705 for payer ID 39113. For additional payer IDs and products visit the Medica Claim Submission and Product Guidelines webpage.
- Coordination of Benefit (COB) claims must be received along with the primary payer's explanation of payment within the timely filing limit outlined in your agreement with Medica, beginning with the date noted on the primary payer's explanation of benefits. COB claims may also be submitted via electronic data interchange (EDI) on the 837 claims transaction. When submitting COB claims electronically, please include the prior payer's payment information in the relevant segments.
    - Check the status of a claim through the Provider Portal Claim Status application, Availity Essentials or through the HIPAA-compliant 276/277 Health Care Claim Status Request and Response transaction.

- When a physician or a clinic becomes a "Contracted Provider," they agree to accept payment made by Medica as payment in full. Discounts and withholds are not to be billed to the member or the secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services

***Failure to submit all required information could result in claim denials.**

CORRECTING CLAIMS

Medica recognizes that it is sometimes necessary to submit a corrected claim (e.g., changes or corrections needed to codes, dates of service, etc.) due to error. Steps for submitting a corrected claim are:

1. Create a new claim with the corrected claim detail(s).
2. Include all lines billed on the original claim on the corrected claim.
3. Include the Claim Frequency Code ('7' for replacement claims) and the Payer Claim Control Number (original claim ID).
4. When replacing/deleting original procedure code, send the original billed code in the 2300 loop.
5. Add a note in the NTE segment (Box 19) about what has been changed from the original claim.
6. Submit the corrected claim using the same submission method as the original claim.

If a provider disagrees with the denial determination the claim can be appealed. Please see the Provider appeals section of the manual for further details.

The scenarios in the following tables explain specifically which information is required for correcting claims.

Scenario #1: Corrected Claims - Not Requiring Supporting Documentation

	General Rule	837P & 837I	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: • '7' - Replacement • '8' - Void *Note: Corrected claims submitted with a '1' will be denied as duplicates.*	Loop 2300: CLM05-3	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill *Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.*
Payer Claim Control Number	Must include the original Medica claim number associated with the correction. *Note: Corrected claims without a Medica formatted original claim ID will be rejected.*	Loop 2300: REF*F8	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

Scenario #2: Corrected Claims – Requiring Supporting Documentation

Supporting documentation may still be required for certain claim-edit denials related to code bundling, new patient visits, global surgery, diagnosis, unlisted codes, etc. Submitters must only submit claims requiring supporting documentation via the CMS-1450 or CMS-1500 forms, using version 02/12. No electronic processing of these claims is currently supported. While Medica is able to accept the PWK segment on an 837 transaction, we cannot guarantee it is being used in claims processing.

In addition, submitters must complete a Code Review Request Form along with any additional required supporting documentation. In order to abide by HIPAA guidelines, only documentation pertinent to the correction should be submitted.

If a provider disagrees with the denial determination, the claim can be appealed. Please see the Provider Claim Appeals section of the manual for further details.

	General Rule	CMS-1500	CMS-1450
Claim Frequency Code	Must include one of the following: • '7' - Replacement • '8' – Void *Note: Corrected claims submitted with a '1' will be denied as duplicates.*	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill *Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.*
Payer Claim Control Number	Must include the original Medica claim number associated with the correction. *Note: Corrected claims without a Medica formatted original claim ID will be rejected.*	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

TIMELY FILING GUIDELINES FOR INITIAL SUBMISSION

The initial submission of a claim is subject to the timely filing guidelines outlined in your agreement with Medica.

If a claim is rejected for improper submission, resubmission must be completed by the provider within the filing limit outlined in your agreement with Medica.

Retain 277CA files or confirmation reports from Medica for your records in the event that you need to file a timely filing claim appeal**. Please be aware that when a provider fails to submit a claim timely, rights to payment from Medica are forfeited and the provider may not seek payment from the member as compensation for these covered services.**

Exceptions to Timely Filing Guidelines on Initial Claim Submission

- Requests for a temporary waiver of the timely filing limit must be made **in advance** due to system conversions or other short-term circumstances. Such requests must be made in writing to your assigned Provider Network Relationship Specialist.
- If the provider had difficulty obtaining Medica coverage information for a member, claims must be received within the timely filing limit beginning with the date the Medica coverage is identified, but not longer than 180 days from the date of service. The provider shall submit supporting documentation to demonstrate measures that the provider has taken to obtain this information. Upon receipt of such information, the provider must submit claims and supporting documentation within the timely filing limit outlined in their agreement.
- Claims for prenatal visits, which normally would have been billed as part of a global obstetrics (OB) charge, must be billed separately due to a change in physician and the need to be submitted within the timely filing limit, beginning with the date of delivery. Medica will not accept a global obstetrical charge from a provider.

TIMELY FILING GUIDELINES FOR CLAIM RESUBMISSION/CORRECTIONS

All resubmitted/corrected claims need to be received by Medica within the timely filing limit outlined in your provider agreement. The first day of the filing limit for resubmissions/corrections begins with the date upon which Medica notifies the provider that a claim has failed processing or was denied. You will find this date on the Explanation of Payment (EOP) or your 835 Health Care Claim Payment/Advice (835).

Exceptions to Timely Filing Guidelines on Claim Resubmissions

- Claims rejected as a result of our error can be resubmitted/corrected up to one year after the run date of the Confirmation Report showing the rejected claims or the EOP date.
- If the provider has hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital-based provider who must wait for the inpatient discharge of the member, the provider must submit claims within the timely filing limit from the discharge date of the inpatient confinement for Medica to consider payment.
- If the provider discovers new or additional information and requests additional payment on a processed and paid claim. Provider must submit this information within the timely filing limit in order for Medica to consider additional payment.
- Newborn claims must be received no later than 14 months from the date of birth.

EXPLANATION OF PAYMENT

Health Plan produces Explanation of Payments (EOP) information on a weekly basis. Providers are encouraged to receive remittance information electronically free of charge through Instamed.

PAYMENT ADJUSTMENTS

When either Medica or a provider determines that payment has been made for services for which payment should not have been made, the provider should promptly return such overpayments to Medica. Upon the discovery of any such overpayments, Medica may alternatively offset such overpayments against any amounts otherwise due or thereafter becoming due from Medica as in the terms of your provider agreement/contract terms.

The offset adjustments are made to the provider's claims in Medica's claims processing system. These adjustments will appear on the EOP or 835 following the processing of a provider's claims. Adjustments will be on the EOP in the "negative" (-) adjustment field.

The negative adjustments deduct payments from the provider's future claims. Overpayments may be taken from the same EOP or 835, as the adjusted claims appear or may be on future EOP or 835s. Medica will continue to offset the negative amount on a provider's future claims until the overpayment is satisfied.

CLAIMS CODING PROCESS

CLAIMS CODING

Medica is committed to processing claims in a consistent, timely, and accurate manner. To support this ongoing effort, our claims processing logic is maintained to support the application of correct coding principles and HIPAA code-set standards. These payment policies are derived from recommendations from a variety of clinical and coding sources including but not limited to:

- American Medical Association (AMA) correct coding principals
- Centers for Medicare and Medicaid (CMS) medical and coding policies including local and regional Coverage Determinations
- Nationally recognized academy and society guidelines
- Manufacturer's package insert (FDA approved indications) for injectable drugs and biologic agents.

CODE REVIEW REQUEST

If, after review, a provider believes their claim is coded correctly and that the charge was denied in error, they have the option to request a coding review via the Health Plan's Claim Review process.

To submit electronically:

- Submit appeals for denials for claims in member plan types under payer ID 39113 on the Claim Appeals application on the Medica Central Provider Portal.
- Submit appeals for denials for claims in the Availity Essentials provider portal.
- Include a brief but detailed statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

To submit via paper:

- Complete the Claim Review Request form available in our Document Library.
- Include a brief statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

Please call the Provider Service Center with questions.

PROVIDER CLAIM APPEALS

PROVIDER APPEALS PROCESS

If Health Plan denies a claim or benefit those results in a partial payment, denial to a practitioner, or makes a determination that is unsatisfactory to the practitioner, the practitioner of care is entitled to appeal the denial.

Appeal requests must be submitted in writing or formal electronic process to be considered by an appropriate representative of Health Plan and should be submitted using the Claim Appeals Application in the Medica Provider Portal for payer ID 39113 or the Availity Essentials portal for efficiency. Decisions are communicated in writing to the requesting provider specifying the reason(s) for the decision and advising the provider of their subsequent appeal rights should they be dissatisfied with the decision made by the Health Plan representative. These letters are available in the provider portal for electronic submissions.

The results of the final review shall be considered final and binding upon Health Plan and provider.

TIMELY FILING APPEALS

If a claim is specifically denied for timely filing, the provider may appeal the timely filing denial. The provider must submit additional documentation to support that their claim was filed according to timely filing guidelines and/or exception guidelines for it to be reviewed by Provider Network Services.

The Health Plan will communicate the decision in writing to the requesting provider, specifying the reason(s) for the decision and advising the provider of their right to discuss the decision. The Health Plan shall have the right to uphold or overturn a timely filing denial, based on the documentation provided and final review. The results of the final review by the Health Plan shall be considered final and binding upon Health Plan and the provider.

PROVIDER PORTAL APPEALS

Claims that have been processed with a finalized status (denied-paid) can be appealed online through the Health Plan Provider Portal, Availity Essentials or via paper submission with consideration for payer ID of the member's plan type. In-network providers are encouraged to submit claim appeals electronically through the Claim Appeals application of the Medica Provider Portal for payer ID 39113 or Availity Essentials.

Claim Appeal Types

- ***COB***
  This appeal type is used to request reconsideration of a coordination of benefits (COB) denial. The primary payer's explanation of payment (EOP) is required, if it was not submitted with the original claim.
- ***Additional Payment***
  This appeal type is used to request reconsideration of a Health Plan payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is incorrect is also required.
- ***Recoup***
  This appeal type is used to request a recoupment or refund. Include both the amount originally billed as well as the recoupment/refund amount. The reason for the recoupment/refund is also required.
- **Timely Filing**
  This appeal type would be used to request reconsideration of a timely-filing denial. Providers are required to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Documentation to support the timely filing appeal request

is required.

- **Code Review Request**
  This appeal type is used to request reconsideration of a coding-related claims-denial. Denials may include frequency/maximum units, code bundling, inappropriate modifier, global surgery, and diagnosis. A brief statement explaining why the claim edit should be overturned and corresponding supporting documentation is required.

- **Authorization Appeal**
  This type is used to request reconsideration of a failure-to-prior-authorize denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.

- **Medical Necessity**
  This type is used to request reconsideration of a medical-necessity denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.

- **Unlisted Codes**
  This type is used to request reconsideration of an unlisted code denial. A description of the unlisted procedure, a brief statement explaining why the unlisted code denial should be overturned, and supporting documentation is required.

UTILIZATION MANAGEMENT

Failure to follow **Health Plan's** Utilization Management guidelines may result in claim payment denials or reimbursement of a claim at a lesser benefit. Because Health Plan has multiple products and benefits, some Health Plan benefit plans may require authorization for some services, while others may not. As such, the guidelines contained in this section are general and should be confirmed. Verify a member's benefits via the Eligibility functionality available on the Availity Essentials Portal confirm the authorization requirements as noted in the member's certificate of benefit , and consult the Medica Medical Policies.

- For Missouri —
  - Authorization Priority Statuses and Determination Turnaround Times
  - Chiropractic Copayment
  - Provider Authorization Appeals

Utilization Management Hours of Operation

Health Plan staff are available to members and providers seeking information through the Provider Service Center from 8:00 A.M. to 5:00 P.M. (CST) Monday through Friday, except for recognized national holidays (e.g., Labor Day, Memorial Day, Christmas Day, etc.) The Provider Service Center is the first contact for general inquiries, but callers with questions regarding specific utilization management matters that cannot be addressed by the Provider Service Center are directed to Utilization Management staff by the Provider Service Center.

Utilization Management staff is available via voice message outside the standard business hours and will contact the requester within one business day of receipt of the voice message, provided the voice message contains the requester's return contact information.

The Provider Service Center handles general inquires, but callers with questions that cannot be addressed by the Provider Service Center regarding specific Utilization Management decisions are directed to Utilization Management staff by the Provider Service Center. Utilization Management staff identifies themselves by name, title, and the organization when receiving or initiating calls to providers regarding Utilization Management issues.

Access to TTY/TDD services are available to members via the Telecommunications Relay Service (TRS) number of 711 which is communicated via any correspondence provided to the member from the Utilization Management Department. Translation services are also available to members and providers through a collaborative process between the Provider Service Center and the Utilization Management Department.

REFERRALS

Referral

A Referral is the process between a Primary Care Provider and/or Woman's Principal Health Care Provider when they have determined that a member requires care with an in-network specialist. A referral **does not** require approval by Medica prior to the receipt of services by the in-network specialist, but to receive benefits for treatment from a physician or provider other than a Primary Care Provider or Woman's Health Care Provider, a member must be referred by their Primary Care Provider and/or Woman's Health Care Provider.

Medica expects that in-network Primary Care Providers or Woman's Health Care Providers coordinate with specialists to obtain necessary referrals for members needing specialist care. Referrals are **not** required for urgent/emergent services, treatment for behavioral health, and substance use disorder services.

Standing Referral

A Standing Referral is a referral from a Primary Care Provider or Woman's Health Care Provider for an ongoing course of

treatment pursuant to a treatment plan specifying needed services and time frames developed by a Specialist in consultation with the Primary Care Provider or Woman's Health Care Provider. Standing referrals can be made for up to one year.

Ongoing Course of Treatment

An ongoing course is the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a physician because of the potential for changes in the therapeutic regimen.

AUTHORIZATIONS

A prior authorization is a written request submitted to the health plan by an in-network primary care provider or in-network specialist requesting authorization approval of a specific service(s) with another in-network provider or, in some cases, an out-of-network provider. An approved prior authorization is required when a service is indicated in a Health Plan Medical Policy as requiring prior authorization, when a rendering provider is out-of-network for some plans, or the service is an elective inpatient admission.

High-Quality, Cost-Effective Care Through Authorization

Medica's goal is to provide members with high-quality, cost-effective care at the right time and in the right setting for members. The UM Department maintains processes to ensure: (a) equitable access to care across the network, and (b) the most appropriate use of medical services in accordance with member benefit coverage. The health plan achieves this through our contracts with in-network providers and our Utilization Management Program by monitoring authorizations and through ongoing evaluation.

The scope of UM activities includes but is not limited to the following major categories:

- Authorization management through prior authorization, concurrent review, retrospective review, and evaluation/discharge planning
- Monitoring quality of care through clinical indicators and service satisfaction data obtained from provider and member surveys
- Quality assurance monitoring and tracking and follow-up of sentinel events and quality of care issues is accomplished through the review process and regular meetings of the Medical Peer Review Committee

Refer to the Medica Medical Management page for services requiring prior authorization and their specific requirements. Authorizations should be sought to correspond with the appropriate timeline of care:

Prior Authorization

A request submitted by a provider for approval of services before they are rendered. This authorization type is sometimes referred to as an initial authorization request or pre-service authorization request.

Concurrent Authorization

Authorizations submitted by a provider for a member who is receiving ongoing care. Concurrent authorizations are generally related to members who are inpatient in a hospital or skilled nursing facility (SNF) and are actively receiving services at the time the authorization request is made.

Post-Service Authorization

Post-service authorizations are authorizations that are submitted after a member's care has been received or completed. Post-service authorizations are only considered for coverage in limited and specific circumstances given that authorization policy is based on a provider obtaining written authorization approval ***prior*** to services being rendered.

AUTHORIZATION INFORMATION AND RESOURCES

Formal Approval

Prior authorization approval is written, documented approval from the health plan's Utilization Management Department, or in some cases for certain services from one of the health plan's authorization vendors. A verbal or written request for services does not constitute an approved prior authorization. A prior authorization request determines only the medical necessity of the service and does not guarantee payment of services received.

Online Authorization Resources

Providers can access the health plan's authorization requirements in specific medical policies and in the Medica Master Services List (MSL), both accessible from the Medica Medical Management page.

Is Authorization Required (IAR) toll in Availity Essentials

When submitting an authorization in the Availity Essentials portal, you may use the IAR tool to determine if a code requires authorization. This service can be bypassed, if necessary, but is intended to render guidance without additional calls on whether an approved authorization might be required for claim payment. This determination applies only to CPT codes based on the health plan Medical Prior Authorization Service List found on our Medical Management page. Please note that this tool can't be used for determination on authorizations that may be required by location Medical Injectable (J-Codes), services that need to be submitted to Carelon or Navitus, transplant codes, or those that might be required by certain products. The tool should be used the day of submission for accuracy, as polices are subject to change.

In-Network Providers

For most products, only Medica in-network providers can submit authorization requests to the health plan. An in-network provider is one that is contracted with Medica to provide services and is listed in our provider directory. An out-of-network provider is either not contracted with Medica or is contracted differently than an in-network provider. Out-of-network providers are not listed in our provider directory. The health plan has no liability or responsibility for services provided by out-of-network providers without a contract with Medica.

In-network providers are responsible for completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically necessary. The in-network provider who submitted the authorization request is also responsible for ensuring the approved prior authorization is in place prior to services being rendered.

Member Benefit Considerations for Authorizations

Approved authorizations indicate only that the service(s) are considered medically necessary. If a member's benefits have been exhausted or the requested service is not a covered benefit under the member's plan, the claim for the service will deny. The same is true if a member has a change in enrollment status and becomes ineligible for the service. In this case the claim will deny, indicating that the member is not eligible for coverage.

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Prior authorization requests should be submitted as soon as the determination is made to recommend or schedule a service. This facilitates determinations being made and communicated in advance of the member's scheduled date of service. Electronic submissions can be submitted via the Availity Essentials Portal.

If an authorization request is processed and denied, a written denial for the requested services will always be provided to the member that includes the reason for the denial or redirection and appeal information. The provider who submitted the authorization request and the servicing providers are also notified of the denial or redirection via Availity Essentials, or in writing if access to Availity Essentials portal is not available to the provider(s). The member and the provider make the final decision regarding whether the member will receive any services, despite a denial from the health plan.

Authorization Submission

Providers with Availity Essentials access are strongly encouraged to submit authorization requests electronically through the Availity Essentials. Availity Essentials is a 24/7 direct line between your organization and our self-service applications to exchange electronic transactions. Additionally, the health plan sends an electronic response to authorization requests that come through Availity Essentials.

In the case of an unexpected outage, a paper request form may be submitted by faxed or email in for review, for both inpatient and outpatient service requests. Authorization request forms are found on the Medical Management Page under Prior Authorization Forms and then General. Please be sure to fill out the form in its entirety, attach supporting documentation, and provide a dedicated fax number and contact for return messaging or follow-up. Authorization determination notifications will be faxed to providers and not mailed.

Forms can be submitted via fax, email, or USPS:

- For Commercial (Fully Insured/Self-funded) and IFB Members: Fax to 952-992-2836 or email to IFBHealthManagement@Medica.com.
- For Post-Acute (All plans/products): Fax: 952-992-1428 or email postacute@medica.com
- For Behavioral Health (SSM Health Employee Health Plan): Fax to 952-992-1428 or email IFBHealthManagement@Medica.com.
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440

The Availity Essentials portal will indicate determination (approved/denied) and a letter will be sent to the member. If the request is submitted on the paper form, determinations will be sent to the provider via fax.

Paper Form Submission Guidelines

- Providers must follow the guidelines below when submitting a paper authorization request form Submit the request using the applicable Prior Authorization Request Forms accessible from the Health Plan Medical Management page.
- Authorization request forms should be submitted on the date the request has been completed to ensure timely processing of the authorization request.
- A dedicated fax number for provision of the determination notification is required for both the referring and servicing providers if they are different. Determination notifications will be faxed and not mailed via USPS.
- Complete **all** fields on the form in their entirety, otherwise the Utilization Management Department will return it to the submitting physician for completion.
- When an authorization is requested for the services of an out-of-network provider, include as much information as possible regarding why the request is being submitted and a list of in-network providers who the member has already seen. The Utilization Management Department will review these authorization requests to ensure that medically necessary care has been requested and that the services requested are not available with in-network providers. *Note*: Only services that are NOT provided within the Health Plan provider network are considered for approval with a non-contracted provider.

Use of Other Entities for Authorization Services

Health Plan contracts with other entities for the review and prior authorization of certain services. In these cases, prior authorization requests should be submitted to the contracted vendor, not Health Plan, as shown in the table below.

Service	Whom to Submit	How to Submit
Pharmacy Benefit Drug Authorizations	Navitus/Navi-Gate	Authorization forms and submission through the Navitus Prescriber Portal at Prescribers.Navitus.com or via fax information on the form.
Medical Benefit Drug Authorizations	Health Plan	Authorization forms are available through the Navitus Prescriber Portal at Prescribers.Navitus.com, but should be submitted to the Health Plan via the portal that corresponds with your member's plan type and payer ID or via fax, mail, or phone information on the form.
Medical Injectables * *For benefit classifications and submission information, see our Medical Injectables List.*	Health Plan (for Medical Benefit medications) or Navitus/Navi-Gate (for Pharmacy Benefit medications)	Authorization forms are available through the Navitus Prescriber Portal at Prescribers.Navitus.com. Submit Medical Benefit medications through the portal that corresponds with your member's plan type and payer ID, or via fax, mail, or phone information on the form. Submit Pharmacy Benefit medications through the Navitus Prescriber Portal or via fax information on the form.
Services/Procedures requiring authorization per Health Plan Medical Policies ** See our Master Service List to know if authorization is required and where and how to submit authorizations.*	Health Plan via Availity Essentials	Authorization can be submitted via the Availity Essentials provider portal. Authorizations can be submitted by fax or email by using the authorization form available on the Medical Management page.
Musculoskeletal, Interventional Pain Management, Cardiology & Radiology Prior Authorizations * *For more information, see our Musculoskeletal, Interventional Pain Management, Cardiology, and Radiology web page.*	Carelon	Authorizations can be submitted through the Carelon portal.

*If the plan/product does not use Navitus as the Pharmacy Benefit Manager please visit https://partner.medica.com/providers/pharmacy for Pharmacy and Medical Injectable information.

SUPPORTING DOCUMENTATION

Providers must submit all relevant documentation along with the authorization request submission in order for the Utilization Management Department to review and decide on the request. Providers can electronically attach supporting documentation when submitting their authorization requests through the Availity Essentials Portal. If there are issues with submitting supporting documentation on the portal, additional information can be submitted via fax, email or USPS.

- For Commercial (Fully Insured/Self-funded) and IFB Members: Fax to 952-992-2836 or email to IFBHealthManagement@Medica.com.
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440
- If an authorization request is submitted with insufficient information, the Utilization Management Department adheres to the following process to obtain missing documentation. A phone call is made to the provider office to request the additional information. Health Plan Utilization Management will advise of:
    - Member name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required
    - Fax number and name of individual that the information should be made attention to
- If the requested information is **not** provided within the initially requested 2 business days, Utilization Management will contact the provider office again within 1 business day and advise of the following:
    - This is the second request for additional information
    - Date of the original request for information
    - Member name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required
    - Fax number and name of individual that the information should be made attention to
- The provider will be advised that if the information is not received within the second new time frame, the authorization will be submitted to the Medical Director for review based on the information that is available on the first business day after the second requested time frame has ended.
- Authorization and any available information will be directed to the Medical Director for review no later than the first business day following receipt of the information or expiration of the second provided time frame.
- If the authorization is denied a **new** authorization request with new objective medical documentation must be submitted for consideration of the services. The required information **cannot** be provided via the peer-to-peer process for the authorization denial.
- Resubmission of an authorization request **must** contain **new** objective medical documentation for it to be considered. New authorizations should not be submitted simply to re-open the peer-to-peer process.
- Authorizations without new objective medical documentation will be cancelled back to the provider if entered through the Provider Portal or will not be entered if submitted on paper and the requesting physician's office will be contacted to advise why the authorization is not being processed.

CANCELLED PRIOR AUTHORIZATION REQUESTS

Not all services require prior authorization approval. If an authorization request is submitted when prior authorization is not required, the request is "Cancelled" and returned to the provider indicating the authorization is not required. Authorizations submitted via the Availity Provider Portal that don't require a prior authorization will not be accepted and indicate authorization is not required when a procedure code not requiring prior authorization is entered. Health Plan offers a variety of resources to help providers determine when prior authorization is required and where to submit the request:

- Check the Master Service List (MSL). In addition to listing policies and services that do require authorization, the MSL also includes a number of services that do not require prior authorization, denoted in the purple-colored sections.
- Check the Document Library to search for specific policies.
- Check the Medical Injectables List for commonly prescribed drugs and whether prior authorization is required.
- Use the "Is Auth Required?" tool in Availity Essentials prior to submitting your prior authorization
- Authorizations submitted via the Availity Essentials portal that don't require prior authorization maybe rejected. Providers will receive a notification advising that the CPT code submitted does not require an authorization.

AUTH PRIORITY STATUSES & DETERMINATION TURNAROUND TIMES - FOR MISSOURI

The authorization priority status refers to the urgency of the authorization. This is required information for authorization submissions.

In compliance with Missouri state law, Medica adheres to specific time frames for authorization determinations. Refer to the Missouri — Authorization Determinations and Notification Time Frames table below for an at-a-glance reference of designated time frames. Contact the Customer Care Center for the status of authorization requests if you have not received a determination within the designated time frame.

Missouri — Authorization Determinations and Notification Time Frames

TYPE OF REVIEW	DECISION TIME FRAME	FIRST NOTIFICATION, RECIPIENT, AND TIME FRAME	REQUIRED FORMAT	SECOND NOTIFICATION, RECIPIENT, AND TIME FRAME	REQUIRED FORMAT
Initial Determinations					
Determination to Certify an Admission, Procedure, or Service	36 Hours, including 1 Business Day	Provider – 24 Hours	Telephone or Electronically	Provider and Member – 2 Business Days	Written or Electronic
Adverse Determination	36 Hours, including 1 Business Day	Provider – 24 Hours	Telephone or Electronically	Provider and Member – 1 Business Day	Written or Electronic
Concurrent Review Determinations					
Determination to Certify an Extended Stay or Additional Services	Within 1 Business Day	Provider – 1 Business Day	Telephone or Electronically	Provider and Member – 1 Business Day	Written or Electronic
Adverse Determination	Within 1 Business Day	Provider – 24 Hours	Telephone or Electronically	Provider and Member – 1 Business Day	Written or Electronic
Retrospective Review Determination					

Retrospective Review Determination	Within 30 Business Days	Member – 10 Business Days	Written	N/A	N/A

PEER-TO-PEER REVIEW PROCESS

The peer-to-peer review process offers the requesting provider an opportunity to discuss the denial determination of an authorization request with a Medica Medical Director. It is NOT considered a provider authorization appeal. The peer-to-peer review process is intended to give the requesting physician an opportunity to discuss the denial determination when they believe that the submitted documentation supported an approval determination. A request for a peer-to-peer review can be initiated by calling the number listed on the denial notification. This information is also included in the denial determination notice.

The peer-to-peer review process should not be used as a means for the provision of additional information that should have been provided with the initial authorization request. All applicable medical documentation should be provided or available to Medica UM when an authorization is originally submitted for review and/or a determination is in progress. If additional objective medical information is obtained following the denial determination, a new authorization request must be submitted with that additional information. New authorization requests submitted without additional objective medical information will not be accepted.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten calendar day window has elapsed include filing a formal provider appeal, directing the member to the appeals and grievance process outlined in their letter, member benefit certificate, or by contacting the Provider Service Center.

AUTHORIZATION APPEALS

Medica providers can appeal medical necessity denial determinations through the health plan's appeals process for authorizations. We strongly recommend that providers complete the peer-to-peer review process before submitting a provider authorization appeal as resolution may be reached with a verbal discussion between the physician provider and a Medica Plan Medical Director through that process.

Medica members may file an appeal or grievance relating to any aspect of the health plan by following the formal grievance procedure outlined in their member certificate. The Customer Care Center is responsible for the research and resolution of the grievance.

PRIOR AUTHORIZATION GUIDELINES

Because Health Plan has multiple products and benefits, some Health Plan benefit plans may require authorization for some services, while others may not. As such, the overview guidelines contained in this section are general and should not be construed as a description of coverage for members. Verify a member's benefits via the Eligibility functionality available on Availity Essentials Confirm the authorization requirements in the member's Certificate of Coverage and consult the Health Plan's Medical Policies.

Furthermore, some of the Health Plan clinical guidelines used by the Health Services Division (such as the MCG Care Guidelines) are accessible to the provider upon request. Contact the Provider Service Center to request clinical guidelines.

MEDICAL MANAGEMENT

The following pages contain an overview of some common services designated by the outpatient- "OUTPATIENT/AMBULATORY CARE SERVICES" or inpatient- "HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS" nature of the service. These descriptions are intended to provide only an overview of when a provider should seek authorization through Health Plan and the guidelines by which to do so. This information should not be used as a description of specific coverage for members. When reviewing this section, please also refer to the online Health Plan medical management information and other resources.

Resources and Requirements

- Once on the Medical Management page, access the following:
  - **Medical Prior Authorization Service List**, also referred to as the Master Service List (MSL), lists medical policies with links, prior authorization requirements, and applicable coverage limitations, as well as information for some services that do not require authorization. When authorization is required, submission method information about where and how to submit authorizations is also listed.
  - **Medical Injectables List** This is a list of drugs that are covered under the medical benefit.
  - **Medical and Drug Policies** Health Plan policies are reviewed at least annually and updated based on technology assessment resources and in-network provider feedback.
  - **Prior Authorization web pages** detailing certain services, including, but not limited to:
    - Radiology, Interventional Pain Management and Cardiology —Health Plan contracts with Carelon for authorization of high-end radiology service, interventional pain management and cardiology services. Authorization requests should be submitted through the Carelon portal.
    - Musculoskeletal (MSK) Care Management Program —Health Plan contracts with Carelon for review and authorization of non-emergent MSK, including hip, knee, shoulder and spine surgeries. Authorization requests for MSK services should be submitted through the Carelon portal.
- Provider Communications webpage – Keep up to date on Medical and Drug Policy updates and updates to processes.
  - **Prior authorization forms** for certain services to be used by those providers without the ability to submit authorization requests electronically through the Availity Essentials Portal.
  - **Provider Service Center** Call the number on the member ID card with questions about policies, authorization requirements, member coverage, or the maximum number of visits in a member's certificate.

OUTPATIENT/AMBULATORY CARE SERVICES

AUTISM SERVICES

Medica expects that providers will indicate autism as the primary diagnosis code on claims benefits to be administered accurately and in adherence with state-specific autism mandates.

For successful claim adjudication, the primary diagnosis must be a recognized autism diagnosis for the rendered service to be eligible for coverage without a prior authorization. If the service is for a primary diagnosis other than a recognized autism diagnosis, the service may be subject to prior authorization requirements.

MENTAL HEALTH & SUBSTANCE USE DISORDER (SUD) – OUTPATIENT

Medica manages behavioral health services for all members who have behavioral health benefits. For providers Without Availity Essentials access authorization requests may be faxed to 952-992-3556. All services must be medically

necessary.

Outpatient Mental Health and Substance Use Disorder (SUD)

- Some outpatient services require prior authorization to determine medical necessity. These include but are not limited to: Outpatient care with an out-of-network provider, including group, family, and individual therapy

See Medica's Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers. These brief training slides, available from the Behavioral Health Prior Authorization web page, behavioral health medical policies, and prior authorization information.

Court Ordered Care

Court-ordered services may not be covered unless the services are a result of an emergency detention or received on an emergency basis and Medica is notified within 72 hours of the initial service.

OUTPATIENT SURGERY/OUTPATIENT PROCEDURE

Definitions of Surgical Day Care Services and Ambulatory Surgery Center (ASC)

Surgical Day Care Services (SDC)/Surgical Day Care with Overnight (SDCON) are services generally more invasive than ambulatory/minor surgery and usually require incision or excision procedures. General anesthesia and recovery room services are frequently required. SDC services are usually performed either in a hospital setting or ambulatory surgical center (ASC) and can frequently require an overnight stay (not expected to exceed 23 hours post procedure) as part of the recovery period.

Note: members who do not have an acute medical need which meets inpatient medical necessity criteria guidelines **cannot** be admitted as an inpatient status either prior to or following 23 hours of post procedural care.

SDC/SDCON procedures that are converted to an inpatient admission due to an unforeseen complication and meet inpatient criteria guidelines are considered urgent/emergent and require authorization as outlined in the Urgent/Emergent Inpatient Admission section of this manual.

- **Ambulatory/Minor Surgery Service (ASC)** are surgical services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.
- **Outpatient Surgery/Outpatient Procedures** are services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.

Some outpatient procedures require authorization prior to the services according to Health Plan Medical Policy. If the service requires an authorization, providers are responsible for obtaining an approved authorization **prior** to the services being received.

Providers with Provider Portal access to authorizations **must** submit the required information through the Availity Essentials Provider Portal. All providers without Provider Portal authorization access have two options to provide the required admitting information:

- For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- For Post-Acute (All plans/products): Fax: 952-992-1428 or email postacute@medica.com
- For Behavioral Health (All plans/products: Fax to 952-992-3556 or email HPShealthmanagement@medica.com
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440

The applicable medical policy for the service being requested should be reviewed prior to submission of an authorization. Refer to the Medical Policies on the Medical Management page accessible from the Health Plan's

website.

EMERGENT AND URGENT CARE SERVICES

Emergent/Emergency Care

An emergency medical condition is one brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or part
- Inadequately controlled pain
- With respect to a pregnant woman who is having contractions:
    - Inadequate time to complete a safe transfer to another hospital before delivery, or
    - A transfer to another hospital may pose a threat to the health or safety of the woman or unborn child

Emergency services are covered services given by any qualified provider, and are services needed to evaluate or stabilize an emergency medical condition. A prior authorization is NOT required for emergency services.

Emergency Care from Medica Providers

Most of the time, members will get emergency care from a Medica in-network provider. If members are unable to reach an in-network provider, they should go to the nearest medical facility to receive care.

Emergency Care from Out-of-Network Providers

If your patient must go to an out-of-network provider for care, call the Provider Service Center as soon as possible after they have received care to notify us of where they received emergency care. A prior authorization is not required for emergency care services. Applicable emergency room copayments apply whenever emergency services are received at an emergency room.

Non-emergent/non-urgent follow up care with an out-of-network provider is not covered unless this care is prior-authorized by the Health Plan Utilization Management Department or unless use of an out-of-network provider is allowed under the member's benefit plan.

Urgent Care

Urgent care is care that is needed sooner than a regular physician's office visit (ex. broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding). A prior authorization is not required for services in an urgent care setting.

Urgent Care from In-Network Providers

If the member is in the Medica in-network service area and has a sudden illness or injury that is not a medical emergency, the member should call their Primary Care Practitioner. Medica expects that members receive urgent care from in-network providers. In most cases, Medica will not pay for urgently needed care that a member receives from an out-of-network provider while the member is in the Medica in-network service area.

Urgent Care from Out-of-Network Providers

Authorization is not required for services provided in an urgent care setting. If the member is outside of the service area, the member should call their Primary Care Practitioner or the 24- hour nurse advise line to see if their condition needs immediate attention. Urgent care should be received at the nearest appropriate medical facility unless the member can

safely return to the in-network service area to be seen by their Primary Care Practitioner.

There are no available benefits for follow-up care with an out-of-network provider unless such care is necessary to prevent further health risks. **Such care must be prior authorized through the Medica Utilization Management Department**.

NEW TECHNOLOGIES

Procedures not commonly accepted as a standard of care within the health profession are not a covered benefit of the member's plan. New technology services are reviewed by the Medica Health Services Division for medical appropriateness and efficacy by Medical Directors. Updated information about new technology assessments, when determined, is published in editions of the monthly Medica Provider Newsletter or Connections Newsletter.

CHIROPRACTIC CARE

Medica provides coverage for chiropractic care with in-network providers with the exception of long-term and maintenance therapy. For urgent/emergent chiropractic care by an out-of-network provider, refer to Urgent and Emergent Care Services in this manual. A prior authorization request from a member's Primary Care Provider is not required in order to see an in-network chiropractor. Services are **not covered** if the member seeks chiropractic care at an out-of-network provider, unless it is urgent or emergent. If you need further assistance in understanding chiropractic benefits, contact the Provider Service Center.

Therapy Types

- **Active Therapy —** regular care with an established patient to resolve a particular ailment. An AT modifier is required for Active Therapy and must be in the first modifier position.
- **Long-Term Therapy —** therapy extending beyond two months that is determined, by our Medical Affairs Division, to be primarily maintenance therapy.
- **Maintenance Therapy** — ongoing therapy delivered after the acute phase of an accident or illness has passed. It begins when a patient's recovery has reached a plateau or improvement in their condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by the health plan after reviewing an individual's case history or treatment plan submitted by a health care provider.

The determination of what constitutes "maintenance/long-term therapy" is made by the chiropractor. The health plan will review the case history or treatment plan of the patient if a questionable situation would arise. When a member reaches the long-term/maintenance therapy phase, providers can give them a copy of the "Chiropractic Handout for Medica Members" information on the next page of this manual. This is designed to give members a brief description of benefits that are not available for long-term/maintenance therapy.

CHIROPRACTIC COPAYMENT – MISSOURI

Per Missouri legislation, Missouri members who receive chiropractic care from an in-network chiropractic provider cannot be charged with a copay that is more than 50% of the total cost of a single chiropractic service. This applies to Missouri residents who are enrolled in the IFB plan, regardless of whether they received chiropractic services from a network provider in Missouri or from a network provider in another state.
In adherence to the legislation:

- Medica will determine if a copay amount is more than 50% of the total allowed amount for the service
- If amount is more than 50%, Medica will adjust the copay so that it does not exceed the limit and will pay the provider up to the remaining allowed amount
- Adjustments will be on the Remittance Advice

- Providers will owe the member the difference between the charged and adjusted amount

CHIROPRACTIC HANDOUT FOR MEDICA MEMBERS

Medica covers chiropractic services when the services are provided by a Medica in-network provider to a Medica member with applicable coverage. As a Medica member, we encourage you to refer to your benefit certificate to determine your coverage and see if you are required to pay an office copayment each time you visit your chiropractor. Also, check your benefit certificate to see if items supplied by your chiropractor are covered under your member benefit.

Examples of covered supplies include:

- Slings
- Rib Belts
- Lumbar-Sacral Orthosis
- Wrist Cock-Up Splint
- Cervical Collars
- Sacroiliac Support
- Elbow Orthoses
- Air Cast

Examples of non-covered supplies include orthopedic pillows, cushions, and other convenience items.

Services not covered for chiropractic care are:

- Long-term and/or maintenance therapy
- Chiropractic care (non-urgent/emergent) provided by a non-contracted chiropractor

    - **Long-Term Therapy** – means therapy extending beyond two months which is determined by the health plan to be maintenance therapy.
    - **Maintenance Therapy** – means ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in their condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by your chiropractor and/or Medica after reviewing your case history or treatment plan.

The determination of what constitutes "maintenance therapy" is made by the chiropractor and/or Medica Plan after reviewing the case history or treatment plan. Services are **not covered** if you seek chiropractic care with a provider who is out of the Medica Plan network, unless it is urgent or emergent.

We are here to help! If you need assistance in understanding your chiropractic benefits or have questions, please call the Medica Customer Care Center located on the member ID card.

HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS

MENTAL HEALTH AND SUBSTANCE USE SERVICES – INPATIENT

Medica manages behavioral health services for all members who have behavioral health benefits. For providers without Availity Essentials Portal access authorization requests may be faxed to 952-992-3556. All services must be medically necessary.

Inpatient Mental Health and Substance Use Disorder (SUD)

- For urgent/emergent inpatient hospital admissions, a prior authorization is not required. However, the admitting facility must notify Medica of the admission within 48 hours or when it is medically feasible (whichever is longer).
- Prior authorization is required for all elective or non-emergency inpatient and residential treatment center stays *before* admission.

URGENT/EMERGENT INPATIENT ADMISSION NOTIFICATION

In-network hospitals are responsible for notifying the Medica Utilization Management Department within 48 hours or when it is medically feasible (whichever is longer) of an urgent/emergent inpatient admission. A member may require urgent/emergent inpatient admission to an acute hospital from any of the following settings:

- Home
- Doctor's office
- Emergency room
- Observation bed
- Surgical day care (SDC) unit
- Transfer from another facility *(including neonatal intensive care unit admission from another facility)*

Hospital observation admissions **do not require authorization** by Medica. They are considered an extension of the emergency care [that the member received while in the emergency room.

Notifying the Health Plan of an Emergent Inpatient Admission

Notifying the Health Plan of an Emergent Inpatient Admission

We encourage providers to establish an Availity Essentials Provider portal account and submit their emergent inpatient authorization requests through Availity Essentials. Member eligibility can also be confirmed in Availity Essentials.

If not working through the Availity Essentials Portal, the process for notification and submitting authorization requests for emergent inpatient admissions by phone varies depending on whether the request is made during standard business hours or outside of standard business hours. Standard business hours for the Utilization Management Department are Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding federal holidays.

Providers should be prepared to provide all the following information when submitting an authorization request:

- Member name *(middle initial if available)*
- Member date of birth (DOB)
- Member ID number
- Admission date *(must be the actual date the member was admitted to inpatient status)*
- Admitting/attending physician name and phone number
- Facility name and phone number

- Admitting diagnosis
- Type of admission: ER, direct admit, day of surgery

Hospital inpatient admissions require authorization from Health Plan whenever a member is admitted from an emergency room. In urgent and emergency situations, Health Plan must be notified of any inpatient admissions resulting from emergency room services within 48 hours or when it is medically necessary (whichever is longer).

All hospitals without Availity Essentials Portal access have two options to notify Health Plan of the inpatient admission:

- Fax the required admitting information to 952-992-3555
- Phone the required admitting information to 800-987-2459

Urgent/emergent inpatient admissions with the exception of labor and delivery will be reviewed by Health Plan Utilization Management to confirm that the inpatient level of care is medically necessary. The medical necessity criteria utilized by Health Plan Utilization Management is nationally recognized and evidence based.

Concurrent Review

Urgent/emergent inpatient admissions that meet medical necessity requirements will be approved for the date of admission only, pending concurrent review and ongoing medical necessity determinations for facilities that do not have a Diagnosis Related Group (DRG) contract with Medica. Hospital facilities that do not have a DRG contract with Medica are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Concurrent review information is required to be provided to the Medica Utilization Management department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Medica are not required to provide concurrent review to the Medica Utilization Management Department, but they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the inpatient admission and discharge dates provided by the DRG hospital facility.

ELECTIVE INPATIENT ADMISSION AUTHORIZATION

NOTE: This section is specific to non-urgent/emergent conditions ONLY.

Notification of an elective inpatient admission by the servicing hospital or specialist provider is required as soon as the procedure is scheduled or **a minimum of five to seven days prior** to the scheduled admission date.

Elective Admissions are defined as non-urgent/emergent inpatient services that are planned and are able to safely be scheduled at a future date and are not being admitted from one of the settings indicated in the "Urgent/Emergent Admission Notification" section above. Notification of elective inpatient admission by the servicing hospital or specialist provider is required **a minimum of five to seven days prior** to the scheduled admission date.

Elective inpatient services that were scheduled but were not prior authorized in the indicated minimum time frame are not considered an urgent/emergent service. Plan providers who fail to follow the indicated prior authorization requirements for Elective Admissions may be responsible for services denied as not medically necessary.

Provider Portal Authorization Submissions for Inpatient Admission Authorization

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.

Elective Inpatient Prior Authorization Requirements

The following information is required for the prior authorization of an elective admission:

- Patient name *(middle initial if available)*
- Subscriber number and date of birth
- Admitting physician/specialist's name
- Hospital's name
- Diagnosis and clinical information
- Service requested *(i.e., admission, procedure, etc.)*
- CPT code(s) appropriate to the type of admission (medical or surgical) **must** be provided
- Admission/Procedure date

Providers with Availity Essentials portal access to the authorization application must submit the required information through the Availity Essentials portal. All providers without Availity Essentials authorization access have two options to provide the required information indicated above:

- Inpatient Hospital: Fax the required information to 952-992-3555 or phone the required information to 800-987-2459.
- For Post-Acute: Fax: 952-992-1428 or email postacute@medica.com

Concurrent Review

Elective inpatient admissions that meet medical necessity requirements will be approved for the date of admission only. Hospital facilities that do not have a DRG contract with Medica are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Concurrent review information is required to be provided to the Medica Utilization Management Department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Medica are not required to provide concurrent review to the Medica Utilization Management Department, but they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the admission and discharge dates provided by the DRG hospital facility.

If the elective date of admission is rescheduled or cancelled, please notify the Medica Utilization Management Department at 800-987-2459

TRANSFERRING PATIENTS

If it is medically necessary that a patient receiving inpatient hospital services be transferred to another inpatient hospital facility, a plan facility should be used whenever possible. Plan benefit design may affect these requirements.

When transfer to an out-of-network facility is determined to be appropriate for emergency and/or specialty care that is unavailable in-plan, the admission is authorized. However, Medica must be notified prior to the transfer, within 24 hours, or when it is medically feasible (whichever is longer). For all other transfers to out-of-network facilities, prior authorization is required to be obtained from Utilization Management before the transfer to the out-of-network facility occurs. A member's plan may require transfer to a plan facility once they are medically stable. If you have any questions about, please contact our Customer Care Center.

For all non-emergent transfers to out of state network facilities, prior authorization is required to be obtained from Utilization Management before transfer to the out of network facility occurs.

OBSERVATION STAYS

Observation care is a defined set of specific, clinically appropriate services which include ongoing short-term treatment, assessment, and reassessment that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency room who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

An observation stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member to determine if they may require an inpatient stay or follow-up care in another setting. An observation stay should not exceed 48 hours.

Examples considered appropriate for observation stay include, but are not limited to:

- Abdominal pain
- Asthma
- Back pain
- Bronchitis
- Chest pain
- Croup
- Concussion
- Dehydration
- Drug overdose
- False labor
- Gastroenteritis
- Migraine headache
- Pneumonia
- Renal colic/calculus
- Seizure
- Sepsis
- Syncope
- Upper limb closed fracture or dislocation

Providers are NOT required to notify or receive authorization for any observation stay in a facility. Reimbursement for observations stays is limited to a maximum of 48 hours. Observation stays that are converted to an inpatient admission are considered urgent/emergent and require authorization as outlined in the Urgent/Emergent Inpatient Admission Notification section.

PROGRAM OBJECTIVES AND EVALUATION

The purpose of the UM Program is to ensure that health care resources are used efficiently and effectively to provide the best value to individuals and organizations purchasing health care and services. The UM objectives include, but are not limited to the following:

- Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards
- Monitor potentially avoidable admissions and address identified areas of concern
- Focus inpatient or outpatient review activities on opportunity areas as determined by various data sources
- Monitor data to identify areas of possible over and under-utilization. Areas may include but are not limited to procedure utilization, pharmacy utilization (certain medications and classes of medications), emergency room utilization, inpatient utilization, laboratory utilization, and physician practice utilization
- Assess provider and member satisfaction with UM activities and address areas of dissatisfaction, when appropriate
- Integrate UM with Disease and Case Management as appropriate when identified during UM activities
- Monitor and analyze variations in the delivery of care in the network for which evidence-based standards of appropriate care exist, and consider opportunities to improve quality of care and reduce medical costs
- Implement or maintain policies and procedures in accordance with regulatory and accreditation requirements
- Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence
- Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness
- Maintain a process to ensure that relevant information is collected to review medical necessity for coverage
- Employ qualified health professionals to assess the clinical information used to support UM decisions
- Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations in accordance with federal and state requirements as well as accreditation standards
- Provide access to staff for members and providers seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers
- Implement and maintain processes for objective and systematic monitoring, evaluation, and improvement of UM processes and services
- Implement and maintain processes, policies, and procedures to assist in monitoring the quality of UM decisions. These mechanisms include, but are not limited to, inter-rater reliability and manageability, case audits, and the identification of potential adverse events

The UM Department annually evaluates the UM Program and submits their UM Program Evaluation to the UM Committee for review and approval. The evaluation includes a review of the UM Program using member complaints, grievance and appeal data, the results of member satisfaction surveys, practitioner complaint, grievance, and appeal data, and the results of practitioner satisfaction surveys, as appropriate. The evaluation includes both program accomplishments and limitations/barriers. Recommendations from the annual Program Evaluation are incorporated into the next year's UM Program Description and QI Work Plan as appropriate.

STATEMENT OF CONFIDENTIALITY

Medica has a Corporate Confidentiality policy that states that employees have a responsibility to ensure that all personal, member, and employee information remains confidential. Earning the trust and confidence of our members and fellow employees is a responsibility each employee shares. Every employee has an obligation to comply with Medica policies on confidentiality and with laws and regulations that apply to us and our industry. Disclosure of confidential information at work or elsewhere about members or employees violates a valued trust and that individual's legal right to confidentiality. If an employee is found to have violated any confidentiality policy, disciplinary action up to and including immediate termination of employment may result.

STATEMENT OF CONFLICT OF INTEREST

Employees and consultant practitioners are prohibited from reviewing cases and requests that pertain to themselves, family members, or acquaintances in which the case/request that is being reviewed and the decision reached would be influenced by personal knowledge. Employees are also prohibited from reviewing cases in which they have provided care. The case/request must be deferred to another reviewer.

Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Employees are prohibited from working for other companies while employed with Medica, where that employment may be construed as a conflict of interest.

PHARMACY

PHARMACY MANAGEMENT

Medica provides a comprehensive drug benefit for those members in a plan with prescription drug coverage. The member's identification card will identify those members with a drug benefit.

A pharmacy benefit drug is a medication covered and paid for under the pharmacy benefit, oftentimes self-administered by the member. A medical benefit drug is defined as a medication that is covered and paid for under the medical benefit, oftentimes administered to the member by another healthcare professional.
Pharmacy Management includes but is not limited to:

- Formulary Tiering
- Prior Authorization and Step Therapy Requirements
- Quantity Limits
- Specialist Restrictions
- Mandatory Specialty Pharmacy
- Mandatory Generic Substitution

**For plans using Express Scripts as the Pharmacy Benefit Manager please refer to resources on Medica's Pharmacy webpage.

Medica provides pharmacy information including medical benefit drug policies, pharmacy benefit drug policies, formulary coverage, a listing of prior authorized drugs, and pharmacy program information for members on the Medica website on the Medical Management webpage. Medical benefit drug prior authorization forms and policies can be accessed via the Pharmacy webpage. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms that can be accessed through the Navitus Prescriber Portal at Prescribers.Navitus.com.

Health Plan notifies clinics of new pharmacy information through provider notifications including:

- The monthly Provider Newsletter a newsletter specifically for Health Plan providers
- Policy updates provider notifications – issued monthly to communicate medical benefit drug policy updates, in addition to certain medical policy updates and Health Plan initiatives, outside of the monthly newsletter

DRUG PRIOR AUTHORIZATION PROCESS

Pharmacy Benefit Drug Prior Authorization

Health Plan contracts with Navitus to manage pharmacy benefit drug prior authorizations Providers can view instructions on how to submit a prior authorization and log into the Navitus Prescriber Portal at Prescribers.Navitus.com to access the prior authorization forms. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms. Please note that the listed fax and phone numbers on the forms for submission and Customer Care can vary.

Medical Benefit Drug Prior Authorization

Health Plan manages medical benefit drug prior authorizations requests with support from Prime Therapeutics for oncology and oncology-related drugs. Medical benefit drug prior authorization forms and policies can be accessed via the Pharmacy webpage or links from deancare.com under 'Medical Management'.

PEER-TO-PEER REVIEW PROCESS

Providers are encouraged to take advantage of the peer-to-peer review process before submitting a prior authorization appeal. The peer-to-peer review process offers the requesting provider an opportunity to discuss the denial determination of a pharmacy authorization request with a Medica Medical Director.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten-calendar day window has elapsed include filing a formal provider appeal, directing the member to the appeals and grievance process outlined in their letter or member benefit certificate, or by contacting the Medica Customer Care Center.

AUTHORIZATION APPEALS

Medica providers can appeal medical and pharmacy benefit drug denial determinations, including denials for oncology and oncology-related drugs. We strongly recommend that providers complete the peer-to-peer review process before submitting a provider authorization appeal as a resolution may be reached with a verbal discussion.

Prior authorization appeals must be submitted to Medica, regardless of the entity that processed the prior authorization request. To submit an appeal for an authorization request that was submitted to Medica or Navitus, providers may submit a letter of necessity by fax to 608-252-0812 or by paper mail to: Medica, Route CP595, PO Box 9310, Minneapolis MN 55440-9310.

When submitting an appeal, review the reason for denial and provide supporting documentation for the request (e.g., medical records, medication history, medical journals, etc.). If more information becomes available after the authorization request was initially denied, the authorization request may be submitted again to be reconsidered. Ultimately, the prescriber or member has the opportunity to pursue the grievance process for any drug prior authorization request that is redirected to other covered drugs or denied.

DRUG FORMULARIES

Health Plan has developed pharmacy benefit drug formularies specific to our benefit plans to help providers choose the appropriate drugs based on their member's needs, coverage plan, and cost of each drug. Our drug formularies are published on the Pharmacy webpage.

Formularies are available as Adobe PDFs. Users can scroll through the list or type in "Ctrl + F" to bring up the search

bar to type in the name of the drug. All formularies contain the Drug Name, Special Code, Tier level, and Category the drug is listed under.

***Note*:** Self-Funded Plans has its own unique formulary and drug prior authorization process. Please reach out to the Pharmacy Benefit Manager listed on the back of the member's ID card for more information.

PREVENTIVE DRUG LIST

Health Plan publishes a Preventive Drug List of covered drugs to assist providers in choosing the right drugs for their patient's needs. This resource details certain preventive medications that are available at $0 to members. For the up-to- date list of $0 preventive drugs, refer to the Preventive Drug List available under the Covered drugs / formulary section on Pharmacy webpage under Member pharmacy programs.

SPECIALTY PHARMACY

Medica uses Lumicera Health Services for specialty pharmacy services. Lumicera is experienced in managing specialty medications and coordinating personalized support for members affected by chronic illnesses and complex disease states. Lumicera offers free delivery, same day service, medication consultations, and refill reminders. Refer to our Specialty Pharmacy Program web page for more information about Lumicera and available support for members.

Contact information for Lumicera is the following:

- Phone: 855-847-3554
- Fax: 855-847-3558
- Address: 310 Integrity Rd. Madison, WI 53717
- Website: lumicera.com

MAIL ORDER PHARMACY

Costco is Medica's preferred mail order pharmacy. Members do not need to have Costco membership to use this service.

EXCLUDED OR NONFORMULARY DRUG POLICY

Medica has an established policy for handling requests for drugs excluded from the formulary (notated as NC on the formulary). Physicians may request consideration for excluded drugs on an exception basis. Exception requests should be submitted using the Exception To Coverage form, which can be found on the Navitus Prescriber Portal at Prescribers.Navitus.com. Exception requests will be considered for approval **only after all formulary alternatives have been tried and failed.**

A contraindication to a specific formulary alternative drug constitutes a failure of that formulary alternative drug without a trial of that drug. **All drugs are excluded from the formulary until they have been reviewed and approved by the Medica Medical Policy Committee.**

In the case of denials for exception requests, a denial letter will be sent and will outline appeal options available to physicians, members, and their representatives. Pharmacy appeals for coverage under a Commercial product are reviewed by Medica's Grievance and Appeals Team**.**

OTHER PHARMACY INFORMATION

- When a member requests a brand name prescription when a generic is available, the member will be responsible for the brand name copayment along with the difference in cost between the generic and brand drug.
- Generic substitutions will be made by the pharmacy when Food and Drug Administration (FDA) approved generics are available.
- Insulin and diabetic supplies are a covered benefit for all members, including groups that do not have a drug benefit. The amount of coverage varies depending on the member's benefit.
- Only retail pharmacies with an active Health Plan Pharmacy Agreement may provide outpatient drugs to Health Plan members. Discharge medications or emergency room/urgent care take-home drugs are considered outpatient prescriptions. These medications are not a covered benefit unless dispensed by the institution's retail pharmacy who is an in-network pharmacy provider.
- When a member has more than one insurance carrier, coordination of benefits for pharmacy claims shall occur. If Health Plan is the member's primary carrier, all pharmacy charges should be submitted according to the Health Plan filing guidelines.

In situations where Health Plan members treated for urgent/emergent care require medications and they do not have access to a plan pharmacy, the following guidelines apply:

- The member should be given a quantity of medication to last until they are able to access an in-network pharmacy (usually a one-day supply).
- The member should be given a written prescription for the remaining medication needed and instructed to have the prescription filled at an in-network pharmacy.

CASE MANAGEMENT

CASE MANAGEMENT PROGRAM DESCRIPTION

Health Plan 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, network providers, 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 Case Management.

Health Plan's Case Management team includes nurses, 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 outcomes and working to reduce the burden of illness. A comprehensive assessment of the member's health and wellness needs informs development of an individualized plan of care with member-centric goals. Licensed Case Management staff adhere to NCQA standards for complex case management.

Case Management team members:

- Educate members on how to self-manage their diagnosis.
- 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 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.
- Assist in guiding members to the best-in-class location for the type of transplant they need, utilizing Optum- designated transplant centers (Centers of Excellence).
- Support members with breastfeeding and pumping.

Case Management is not able to answer or resolve issues for questions 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

Advanced Illness and Advance Care Planning

Dean Health Plan's Advanced Illness program provides comprehensive care for members facing life-limiting illness, generally defined as the last twelve months of life. The model is focused on reducing the burden of illness impacting the physical, psycho-social, emotional, spiritual and environmental well-being of our members while supporting and honoring their unique traditions, culture and goals of care.

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. Dean 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.

Advanced Illness case managers and 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, health care and other providers
- Work to align member goals and coordination of goals with health care team and family
- 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

Behavioral Health Case Management

Behavioral health and substance use case management provides an individualized approach for members with mental health and substance use disorders to enable them to manage their health and improve their quality of life. For members with medical and behavioral needs, Dean Health Plan offers an integrated program that supports members with depression, anxiety, stress, and other mood disorders.

A behavioral health case manager can help members to:

- Understand individual health care plans to self-manage health conditions.
- 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.
- Transition back to home after an inpatient behavioral health or substance use hospitalization.

Complex Case Management

Health Plan's complex case management program is a multi-disciplinary approach to the coordination of care and services provided to adult and pediatric members who have a chronic or acute medical condition 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.

Pregnancy Program

Health Plan provides case management services to birthing parents enrolled in our Pregnancy program to promote healthy outcomes for mother and baby. The pregnancy case management team provides outreach, education, and complex case management on a continuum through the pregnancy and post-partum period.

The pregnancy case management team supports birthing parents:

- Navigate the complex health care system.
- Coordinate appointments with their provider and specialists, including connecting to transportation resources as needed.
- Assess for stress and markers of depression, integrates with behavioral health care as appropriate.
- Assesses for social determinant of health needs and connects to appropriate community-based support resources.
- Develop a plan for services and supports after the birth of the baby.
- Make healthy changes – like quitting tobacco.
- Connect with local resources and find pregnancy education classes.
- Get support with breastfeeding and pumping.
- Receive support with any health concerns or chronic conditions, including behavioral health and substance use.

Transplant Case Management

Transplants are life changing and complex, not only affecting the member but involving their family as well. Health Plan's 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. This includes guiding members to the best-in- class location for the type of transplant they need, utilizing Optum designated transplant centers through the Centers of Excellence (COE) Program.

Transplant case mangers complete both utilization management and case management functions to provide members with a seamless relationship and key points of contact with Health Plan.

A transplant case manager and engagement coordinator help members:

- Understand and manage the complex disease that is leading toward transplantation.
- Coordinate care with providers, clinics, and programs through the transplant process.
- Navigate the evaluation and listing process and help them to maintain transplant readiness while awaiting transplant.
- Navigate and understand health coverage and benefits before, during, and after transplant.
- Ensure appropriate prior authorizations for transplant services are in place.
- Connect with an advance care planning social worker, if desired.

All transplant services except for cornea requires prior authorization. For CAR-T services please submit prior authorization requests directly through the pharmacy department using the medical benefit prior authorization form found on the Medical Management Webpage

Social Work Resources

Health Plan social workers help members to meet their goals and have a good quality of life with a focus on physical, emotional, social, and spiritual well-being.

A social worker helps members:

- Connect with housing, food and employment resources
- Find transportation resources
- Locate resources for caregiver support

- Understand how to access public benefits
- Connect socially through support groups, peer groups, and spiritual communities
- Identify resources to stay safe and report abuse, neglect, harassment and discrimination

CASE MANAGEMENT REFERRALS

Members may refer to Car Management by calling the Medica Customer Care Center at (866) 905-7430 or by emailing caresupport@medica.com.

Providers may refer a member to Case Management via:

The provider referral line at (866)-905-7430. Providers should have the following information when calling in a member referral:

- Provider name/office information
- Member name
- Member date of birth
- Reason for referral, including pertinent diagnosis
- E-mail caresupport@medica.com

- Guide patients to Health Plan Case Management websites for more info or to self-refer

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

- Discharge Planners and nurse navigators
- Pharmacy data
- Claims data
- Hospital discharge data
- Health Assessments
- Internal referrals from other departments
- Health Plan's Utilization Management

CASE MANAGEMENT OUTREACH PROCESS

Health Plan's Case Management standard hours of operation are 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday excluding nationally recognized holidays.

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

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

MEMBER APPEALS & GRIEVANCES PROCESS

MEMBER COMPLAINT, APPEAL & GRIEVANCE PROCEDURE

The Complaint, Appeal, and Grievance Procedure is used to resolve member issues. We ask that our providers familiarize themselves with this process and refer all complaints to Dean Health Plan with consent from their patients. This process may also be used by providers to file appeals or grievances on behalf of their patients.

When a complaint, appeal, or grievance has been submitted, Health Plan may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from Health Plan. This will assist us in providing a timely response and resolution to complaints, appeals, or grievances filed with our office. To ensure a fair decision, Health Plan gives our practitioners the opportunity to discuss decisions that are based on medical necessity with a Health Plan Medical Director, through our peer-to-peer process. The treating physician will be informed at the time of the denial by the Medical Affairs Division of how to initiate the peer-to- peer process should they want to discuss the decision. It is recommended, when available, to first exhaust the peer- to- peer process prior to pursuing the Appeal and Grievance process.

The procedure for filing a complaint, appeal, or grievance is defined below. This information is also located in the Member Certificates. Your understanding of this process will assist us in resolving member issues in a timely manner.

Complaint

Health Plan takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner. If a member has a complaint regarding any aspect of care or decision made by you or the health plan, please contact the Customer Care Center using the phone number listed on the member's ID card. We will document and investigate the member complaint and may notify the member of the outcome of the complaint. Complaints regarding the quality of service or quality of care of a physician, clinic, or staff are considered confidential and the outcomes are not shared with members. If the complaint is not resolved to the member's satisfaction, they can file a grievance. Because most concerns can be addressed informally, we encourage either you or the member to contact the Customer Care Center first for discussion before taking any formal action.

Grievance/Appeal

Any written expression of dissatisfaction will automatically be addressed as a grievance and/or appeal as required by the product type and applicable regulations. Medica does not require that a provider or member use a specific term in order for a review to begin.

A member or their authorized representative can file a grievance/appeal in writing to the following address or fax number:

Medica Central
Route CP595
P.O Box 9310
Minneapolis, MN 55440-9310
FAX 608-252-0812

Expedited grievances/appeals, or situations that may seriously jeopardize the member's life, health, or the ability to regain maximum functionality, may also be submitted by calling Customer Care. In most cases, standard grievances/appeals will be researched and responded to within 25 business days, while expedited grievances/appeals will be resolved and responded to within 72 hours.

Upon receipt of the grievance, Medica's Plan's Grievance and Appeal Department will acknowledge it within five business days. Our acknowledgment letter will advise the member of their right to:

- Submit additional written comments, documents, or other information regarding their grievance/appeal
- Be assisted or represented by another person of their choice
- Appear before the Grievance and Appeal Committee if they wish to do so, if eligible; and, the date and time of the next scheduled meeting, which will not be less than seven calendar days from the date of their acknowledgment and within a 30-calendar day timeframe of receiving the grievance

If the member chooses to appear before the committee, they **must** notify us. If they are unable to appear before the committee, they do have the option of scheduling a conference call.

The member or the member's authorized representative have the right to request a copy of documents, free of charge, relevant to the outcome of the grievance by sending a written request to the address listed above.

Their grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt.

Independent External Review

A member may be entitled to an independent external review (IER) of a final adverse determination involving care which has been determined not to meet the Plans' requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care, or where the requested services have been found to be an experimental treatment. Determinations involving pre-existing conditions and Policy Rescissions are also eligible for IER. A member must exhaust all appeal/grievance options before requesting an independent external review.

However, if we agree with the member that the matter should proceed directly to independent review, or if they need immediate medical treatment and believe that the time period for resolving an internal grievance/appeal will cause a delay that could jeopardize their life or health, they may ask to bypass our internal grievance/appeal process. In these situations, the request will be processed on an expedited basis.

If the member or the member's authorized representative wish to file a request for an independent review, the request must be submitted in writing to the address listed above in the "Grievance/Appeal" subsection, or submitted directly to the IER if specified in the grievance/appeal decision letter, and received within four months of the decision date of the grievance.

Upon receipt of the request, a URAC accredited IER will be assigned to the case through an unbiased random selection process, unless the policy is subject to the Federal IER process in which case Maximus will be the selected IER. The assigned IER will also deliver a notice of the final external review decision in writing to the member or the member's authorized representative and Medica Plan within 45 calendar days of their receipt of the request.

A decision made by an IER is binding for both Medica and the member with the exception of pre-existing condition exclusions and the rescission of a policy or certificate. The member is not responsible for the costs associated to the IER. The decision is binding on both the insurer (the Plan) and the insured.

Requests for benefits beyond those defined in the benefit package are not eligible for independent external review. Please contact our Customer Care Center for information regarding availability, and the process for initiating the review.
Appeals filed on behalf of a Medicare member will be automatically forwarded to Maximus if a final adverse determination is issued.

Second Level Grievance/Appeal — For Missouri

If the outcome of the internal grievance/appeal procedure is not favorable, the member also has the right to file a grievance/appeal with the Missouri Department of Insurance (MDI) Consumer Complaints Division at the following address:

Missouri Department of Insurance
Consumer Complaints
PO Box 690
Jefferson City, MO 65102-0690

Following the review completed by the MDI, any grievance/appeal not favorably resolved and involving an adverse determination that is medical in nature will be referred to an Independent Review Organization (IRO). The IRO review procedures may take up to 45 calendar days for standard grievances/appeals, and 72 hours for expedited grievances/appeals. The outcome of the IRO is binding on the health plan. The IRO procedures are free of charge to the member.

QUALITY IMPROVEMENT

It is the mission of Medica to promote members' health by ensuring the right care, at the right place, at the right time, and with the right person. The Quality Improvement Program provides an overview of how the health plan assesses and improves the quality of clinical care and quality of service delivered to its members. The Quality Improvement Department is involved in reviewing relevant reports on several subjects, including those that follow.

There are two types of quality issues - quality of service and quality of care, which are outlined in this section.

QUALITY OF SERVICE ISSUES

Medica identifies and investigates all instances of concern for the quality of service provided to Medica members. Medica typically identifies quality of service issues through member complaints.

Medica categorizes quality of service issues as follows:

- Access To Care
- Communication/Incorrect Information
- Provider/Staff Behavior
- Privacy Breach
- Facility Physical Accessibility
- Facility Physical Appearance
- Adequacy of Space in Facility
- Adequacy of Treatment Record Keeping

All issues relating to quality of service provided to Medica members are referred to the Quality Improvement Program for investigation. This includes all incoming issues concerning quality of service, noting the date of receipt and the source. Quality Improvement will determine if the individual(s) involved was a Medica member at the time of service. If not, the quality-of-service concern is referred to the practitioner's clinic and/or medical facility for investigation and resolution. This referral is documented in Quality Improvement.

Quality Improvement will investigate the issue and verify the concern for quality of service provided to members. Quality of service issues are investigated by contacting the appropriate Medica staff, as well as medical and administrative staff at practitioner clinics and medical facilities.

Quality Improvement will review the following as they pertain to the service issue:

- Medica complaint and/or grievance documentation

- Prior authorization information
- Utilization review information
- Medical records
- Any documentation of the issue at appropriate practitioner clinics and medical facilities
- Any other available information relevant to the issue

Quality Improvement will document a summary of the investigation which is reviewed by Quality Improvement Management to determine the appropriate disposition of the issue. They will conduct and complete the investigation within 30 business days of receipt of the complaint.

Quality Improvement will update the log of quality-of-service issues, noting the actions taken by Quality Improvement Management. They will monitor and, as appropriate, implement corrective action plans. Quality Improvement will document all activities and the progress of corrective action plans.

QUALITY OF CARE ISSUES

Medica identifies and investigates all instances of concern for the quality of care provided to Medica members. Medica identifies quality of care issues through member complaints, inpatient and outpatient utilization review, case management referrals, studies, reports, and referrals from providers and practitioners.

All incoming issues concerning quality of care, noting the date of receipt and the source (member complaints, inpatient and outpatient review, studies, reports, and referrals from providers and practitioners). Grievance and Appeals will also send any required acknowledgement letter within 5 business days of receipt. Grievance and Appeals then forwards all quality-of-care issues involving a Medica member at the time of service for investigation. If the individual involved in a quality of care complaint was not a Medica member at the time of service, the concern will be sent to the practitioner's clinic and/or medical facility for investigation and resolution.

In investigating a quality-of-care complaint, Medica will follow the Medica Plan MPRC (Medical Peer Review Committee) Workflow process. A Medical Peer Review Committee Case Summary will be prepared for each case investigated. The investigation may include the following information:

- Medica complaint and/or grievance documentation
- Prior authorization information
- Utilization review information
- Medical records
- Any documentation of the issue at appropriate practitioner clinics and medical facilities
- Any other available information relevant to the issue
- Results of an External Independent Review if there is a referral for a second level review recommended by a Medica Medical Director

The Chair of the Medical Peer Review Committee, the Medica Medical Director, or the Medical Peer Review Committee may contact the physician under review in writing to request additional information or clarification. The physician is expected to respond appropriately to the request(s) for additional information.

The Chair of the Medical Peer Review Committee or Medica Medical Director will conduct and complete their investigation of the quality-of-care complaint within 90 business days of receipt. This 90-day period applies only to the investigation by the Chair of the Medical Peer Review Committee or the Medica Medical Director. If the file is referred to the Medical Peer Review Committee for further investigation, that investigation may go beyond the 90-day time period. A summary of the investigation and any actions taken will be documented within the Medical Peer Review Committee. The Chair of the Medical Peer Review Committee, a Medica Medical Director, and/or the Medical Peer Review Committee will determine

the appropriate level of severity and disposition of the issue. Levels of Severity include:

- Level 1 – Standard of care
- Level 2 – Marginal deviation from standard of care – Medical Peer Review Committee review required
- Level 3 – Significant deviation from standard of care – Medical Peer Review Committee review required

If the Medical Peer Review Committee Chair or a Medica Medical Director believes a case has the potential to be leveled at a two or three, the case will be referred to the Medical Peer Review Committee for review, discussion, and final determinations.

The purpose of the Medical Peer Review Committee is to function as an advisory board and to provide a review of medical practitioners by peers in the areas of quality of care and effective utilization of services. The outcome of the review process is to educate practitioners on issues identified as requiring improvement and to initiate any applicable remedial or disciplinary actions. Members of the Medical Peer Review Committee are medical practitioners from various specialties. The responsibilities of Medical Peer Review Committee include:

- Reviewing quality of care issues identified through member complaints, inpatient and outpatient reviews, studies, reports, and referrals from providers and practitioners. Quality of care issues may also be identified through sentinel events monitoring, peer referral, and through the complaint processes of HMOs, hospitals, and other medical facilities.
- Determining appropriate remedial steps or discipline needed.
- Establishing a plan for practitioner education and follow-up to assure future improvements and compliance as needed.
- Monitoring data on identified quality issues.
- Providing recommendations to medical management about individual practitioner and/or group trends or patterns relating to quality issues, if needed.

The Medical Peer Review Committee will review quality of care issues referred by the Chair of the Medical Peer Review Committee or a Medica Medical Director to determine the appropriate corrective actions. Medical Review staff will attend the Medical Peer Review Committee meeting to support the presentation of quality-of-care issues.

The Medical Peer Review Committee will specify the activities, responsible parties, time frame, and reporting requirements for implementing corrective actions, which may include a recommendation for an ad hoc recredentialing if deemed appropriate by the Medical Peer Review Committee members. The Medical Peer Review Committee will update the log of quality-of-care issues, noting the actions taken by the Medical Peer Review Committee. Any actions to reduce, suspend, or terminate a Medica practitioner will follow the process outlined in the Medica Credentialing Committee's policies and procedures.

The Medical Peer Review Committee will, as appropriate, implement and monitor corrective action plans. The Medical Peer Review Committee will document all activities and progress of corrective action plans.

ACCESSIBILITY OF SERVICES

Medica has set standards for member access to services provided by primary care practitioners, behavioral health, and specialty care practitioner clinic locations.

Access to Primary Care

Medica defines the following practitioners as primary care practitioners: Internal Medicine, Family Medicine, General Practice, and Pediatric Medicine. The access standards for primary care practitioner clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 15 business days
Urgent care appointments	Within 24 hours
After-hours care	Primary care clinic locations must have information available and accessible to members regarding after-hours care and 24-hour emergency room access

Access to Specialty Care

Medica assesses specialty care accessibility for practitioners identified as high-volume or high-impact. The access standards for specialty care clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 30 business days
Urgent care appointments	Within 24 hours

Access for High-Risk Obstetrics

Health Plan assesses accessibility for medically necessary high-risk prenatal care. The access standards for high-risk obstetrics are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 14 days
Regular and routine care appointments with practitioners accepting new patients	Within 21 days
Urgent care appointments	Within 24 hours

Access to Behavioral Health Care

Medica does assess behavioral health care accessibility with any of the following providers: Psychiatrists, Psychologists, Other Therapists (e.g., LPC, LCSW, LMFT, MS), and Alcohol and Other Drug Abuse (AODA) Counselors. The access standards for behavioral health clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Non-life-threatening emergency	Within 6 hours
Urgent care appointments	Within 24 hours
Initial visit for routine care	Within 10 business days
Follow-up routine care with Prescribers (e.g., psychiatrists)	Within 30 days

Follow-up routine care with non-Prescribers (e.g., psychologists)	Within 20 days

Appointment Accessibility Assessment Survey

Medica conducts an annual Appointment Accessibility Assessment of all primary care, behavioral health, and specialty care practitioner clinic locations within the Medica network. This is accomplished through a self-assessment appointment access survey sent annually to practitioner clinic locations for completion. The Health plan compiles and evaluates the results from the survey and presents that information to the Access and Availability Workgroup and Network Adequacy Committee.

CLINICAL GUIDELINES

Medica, in cooperation with our providers, is dedicated to continually improving the quality of care for our members. Medica has adopted clinical guidelines for providers to help you make health care decisions for your patients. They are not intended to replace clinical judgment. Refer to the Clinical Guidelines page accessible from the Medica website at Providers - Medica.

HEDIS REPORTING REQUIREMENTS

HEDIS (Healthcare Effectiveness Data and Information Set) is a standardized set of performance measures used to assess plans' performance on a number of elements, including such things as financial stability, access, and quality of care.

Medica annually collects data and reports on performance measures from HEDIS relevant to the commercial populations. Medica uses HEDIS information to assess the quality of care delivered by plan practitioners and providers and to identify improvement projects and studies.

All in-network providers are expected to cooperate with Medica in the accurate and timely reporting, collection of data, and review of medical records. Medica will collect data according to HEDIS specifications and notify practitioners and providers of any additional information requirements. We will also identify and communicate the names of patients for medical record review. All providers are expected to provide Medica with timely access to medical records, as requested, and allow Medica to print and/or make photocopies as necessary.

RISK ADJUSTMENT

The Risk Adjustment Program was established by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) as a requirement of Medicare Advantage Organizations and the Affordable Care Act (ACA). The program requires health plans to submit claims and detailed documentation pertaining to each Medicare Advantage and Commercial ACA member in a specific format for each benefit year. The specific diagnoses of each plan member must be documented in accordance with ICD-10 standards and supported by valid documentation within the patient's medical record **each year**. All current or active diagnoses should be documented by an advanced practitioner or MD/DO that exist at the time of the face-to-face encounter/visit and require or affect patient care.

Medica has created an internal audit process to comply with CMS and HHS requirements of capturing and submitting complete and accurate severity and disease status of their members. We contract with a vendor to identify members for patient medical record review throughout the year. The vendor's medical record review is to support the internal process and ensure that our records properly reflect the clinical condition(s) of our Medicare Advantage and Commercial ACA members.

Annually, Medica must comply with the HHS Risk Adjustment Data Validation (RADV) audit of our Commercial ACA members

by using an independent auditor. The independent auditor must retrieve and review the medical records for the members identified by HHS for the audit. All in-network providers are expected to cooperate with Medica Plan in the accurate and timely collection of data and review of medical records. All providers are expected to provide Medica, and those working on behalf of Medica with a Business Associate Agreement (BAA), with timely access to medical records, as requested, and allow these entities to print and/or make photocopies, as necessary.

MEMBER RIGHTS AND RESPONSIBILITIES

Medica members deserve the best service and health care possible. Medica is committed to maintaining a mutually respectful relationship with its members. Rights and responsibilities help foster cooperation among members, practitioners, and Medica. Member rights and responsibilities are outlined in this section. Medica also publishes member rights and responsibilities for member reference on the Medica website at Member rights and responsibilities - Medica.

Medica members have the right to:

- Be treated with respect and recognition of their dignity and have the right to Privacy policy - Medica.
- Receive a listing of the Medica participating practitioners in order to choose a plan provider.
- Present a question, complaint, or grievance to Medica about the organization or the care it provides without fear of discrimination or repercussion.
- Receive information on procedures and policies regarding their health care benefits.
- Timely responses to requests regarding their health care plan.
- Request information regarding Advance directives.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Receive information about the organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Medica members have the responsibility to:

- Read and understand the materials provided by Medica concerning their health care benefits. We encourage members to contact Medica if they have any questions.
- Present their ID card in order to identify themselves as Medica members before receiving health care services.
- Notify Medica of any enrollment status changes such as family size or address.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed on with their practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Fulfill financial obligations as it relates to any copays and deductibles and/or premiums as outlined in your policy.
- Provide information about any other health plan coverage you have so that Medica can coordinate benefits with other health plan coverage, as applicable.

MEMBER PRIVACY POLICY

Protecting the Privacy of Your Personal Health Information

Medica is required by law to maintain the privacy of your personal health and financial information (collectively referred to as "nonpublic personal information") and to provide you with written notification of our legal duties and privacy practices concerning that information. This notice describes how we protect the confidentiality of our members' (and former members') nonpublic personal information. It includes brief explanations on how we obtain, use, and protect your

nonpublic personal information.

Types of Nonpublic Personal Information Medica Collects About You

We collect a variety of nonpublic personal information needed to administer health coverage and benefits. We collect nonpublic personal information about you from some of the following sources:

- Information we receive directly or indirectly from you, your employer, or your benefits plan sponsor through applications, surveys, or other forms. The information may be received in writing, in person, by telephone, or electronically. Examples include name, address, Social Security Number, date of birth, marital status, and medical history.
- Information from your transactions with us, our affiliates, our providers, our agents, and others. This includes information from health care claims, medical history, eligibility information, payment information, service requests, and appeal and grievance information.
- Information you authorize us to collect from others.

Choices about Your Health Information

We will not use or disclose your health information without your written authorization, except as described in this notice. You have the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

In the following cases we never share your information unless you give us written permission:

- Most uses and disclosures of psychotherapy notes.
- Marketing purposes.
- Sale of your information.

If you do give us written authorization to use or disclose your health information for a particular purpose, you may change your mind at any time. You must let us know in writing if you change your mind.

How Medica May Use or Disclose Your Health Information

We will not disclose your nonpublic personal information unless we are allowed or required by law to do so. The following categories describe the ways that Medica may use or disclose your nonpublic personal information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure we might make will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

***Note**: Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws that are more stringent than Federal laws, including disclosures related to mental health and substance abuse, developmental disability, Alcohol and Other Drug Abuse (AODA), and HIV testing.*

We are allowed to use and disclose information that falls within one of the following categories:

- **Payment**: we may use and disclose your health information to make and collect payment for treatment and services you receive, such as: determining your eligibility for plan benefits, obtaining premiums, determining your health plan's responsibility for benefits, and collecting payment for your health services.
- **Health Care Operations**: we may use and disclose your health information to support our business activities and improve our coverage and services. However, we are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage. Health care operations include such activities as:
    - Underwriting
    - Premium rating
    - Claims
    - Other functions related to plan coverage

- Quality assessment and improvement activities
- Activities designed to improve health and reduce health care costs
- Case management and care coordination

- **Treatment**: we may disclose your health information to a physician or other health care provider that is treating you. We may contact you with information on treatment alternatives and other related functions that may be of interest to you.
- **Distributing Health-related Benefits and Services**: we may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.
- **Disclosure to Plan Sponsors**: if applicable, we may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.
- **Public Safety**: we can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious and imminent threat to the health or safety of a particular person or the public.
- **Research**: under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- **Required by Law**: we will share information about you if laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- **Workers' Compensation, Law Enforcement, and Other Government Requests**: we can use and share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- **Legal Actions**: we may disclose your health information in the course of any administrative or judicial proceeding.

How Medica Protects This Information

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to safeguard your nonpublic personal information. We limit the internal use of oral, written, and electronic nonpublic personal information about you, and ensure that only authorized staff and business associates with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.

Your Health Information Rights

- **Right to Request Restrictions**: you have the right to request restrictions on certain uses and disclosures of your health information.
- **Right to Request Confidential Communications**: you have the right to receive your health information through a reasonable alternative means or at an alternative location.
- **Right to See and Copy**: you have the right to see and copy certain health information about you.
- **Right to Correct Records**: you have a right to request that Medica correct certain health information held by Medica if you think it is incorrect or incomplete.
- **Right to Accounting of Disclosures**: you have the right to receive a list or "accounting of disclosures" of your health information made by us in the past six years. The list will not include disclosures made for purposes of treatment, payment, health care operations, or certain other disclosures (such as those you asked us to make).
- **Right to Copy of Notice**: you have a right to receive a paper copy of this notice at any time.
- **Right to Be Notified of a Breach**: you will be notified in the event of a breach of your unsecured protected health information.

Changes to the Notice of Privacy Practices

Medica may change this notice from time to time and make the new provisions effective for all nonpublic personal information we maintain, including information we created or received before the change. Medica will always comply with the current version of the notice.

HISTORICAL REVISION LOG

The grid below lists recent past revisions to the manual for historical reference.

Description of Change	Revision Date
Added: How to use the Language Line	August 2024
Updated: Availity Essentials Provider Portal Information for payer ID 41822	February 2024
Added: Instamed information to include payer ID 39113	February 2024
Updated: Information regarding new payer ID 41822	February 2024
Added: Customer Service IVR information **Updated:** Customer Care Phone Number	February 2024
Updated: Provider information components to ensure current and accurate provider information is in the Provider Directory.	February 2024
Updated: Sample member ID card images for IFB product	February 2024
Updated: Sample member ID card image for the Medica SSM Employee Health Plan.	February 2024
Updated: Health Plan Provider News as a monthly newsletter.	February 2024
Updated: Credentialing processes.	February 2024
Added: Availity Essentials Portal for payer ID 41822	February 2024
Updated: Case management information throughout to reflect current program offerings and contact information	February 2024
Updated: Contact information for Grievance and Appeals	February 2024
Added: Branding changes to reflect WellFirst Health partnership with Medica. Updates to Wellfirst Health brand as Medica.	October 2023
Added: Customer Care Center phone number and Nurse Advice line phone number for the Medica Employee Health Plan.	January 2023
Added: Health equity section, including information about our new web page.	June 2022

Added: Telephone number for new Language Assistance Line to this manual's Directory.	June 2022
Updated: Member identification card description regarding deductible amount, deductible/coinsurance maximum amount, and out-of-pocket maximum amounts listed on member ID cards for members who have a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount.	June 2022
Updated: Health Plan's provider communication offerings to include monthly policy update provider notifications.	June 2022
Added: Free language assistance interpreter services for in-network providers interacting with WellFirst Health Plan members.	June 2022
Added: Information regarding WellFirst Health's Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers.	June 2022
Updated: Provider types for primary care and behavioral health.	April 2022
Added: Reminder to also update National Plan and Provider Enumeration System (NPPES) when there are changes to provider information.	January 2022
Added: Organizational provider types required to be credentialed under CMS standards.	January 2022
Added: Steps to correct a claim and more information regarding adjustments.	January 2022
Added: Authorization requirements specifically for WellFirst Health ACA in Illinois in compliance with 2022 Illinois-mandated requirements.	January 2022
Updated: Authorization determination and notification timeframes in grid for Illinois in compliance with 2022 Illinois-mandated requirements	January 2022
Added: Information regarding Inpatient Partial Hospital Program Requests Related to Pregnancy or Post-Partum Diagnoses, Behavioral Services Out-of-Network and Substance Abuse Services Notification of Admissions and Discharges for WellFirst Health ACA in Illinois in compliance with 2022 Illinois-mandated requirements.	January 2022
Added: Information regarding Outpatient Partial Hospital Program Requests Related to Pregnancy or Post-Partum Diagnoses and Substance Abuse Services Notification of Admissions and Discharges for WellFirst Health ACA in Illinois in compliance with 2022 Illinois-mandated requirements.	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

Clarified: Where to send prior authorization appeals for denial determinations. In most cases, prior authorization appeals for denial determinations should be submitted to the Health Plan, **including** drug authorization denials from Navitus. Prior authorization appeals for denial determinations from NIA Magellan Healthcare must be submitted to NIA.	January 2022
Updated: Effective January 1, 2022, the mail order pharmacy is Costco.	January 2022
Added: Second level Grievances and Appeals information for WellFirst Health Illinois.	January 2022
Updated: Accessibility of Services for member access to primary care practitioner, behavioral health, and specialty care practitioner clinic locations.	October 2021
Changed: Member ID Card images and new wrap network.	July 2021
Updated: Importance of using real-time eligibility resources (270/271 & Provider Portal) when verifying member eligibility.	July 2021
Added: Advance Care Planning video information, Emmi, and Foodsmart.	July 2021
Added: Failure to comply with credentialing and recredentialing requirements and timelines.	July 2021
Added: Opportunity to correct errors on provider applications when necessary.	July 2021
Added: Automated authorization available in the WellFirst Health Plan Provider Portal for some services.	July 2021
Added: Tips for Submitting Prior Authorization Requests.	July 2021
Updated: Musculoskeletal (MSK) Care Management Program summary to reflect that prior authorization is no longer required for outpatient hip and knee.	July 2021
Added: Specialty Pharmacy	July 2021
Added: Provider Authorization Appeals for Missouri	December 2020
Updated: Provider Authorization Appeals for Illinois	December 2020