(formerly WellFirst Health)

PROVIDER MANUAL

TABLE OF CONTENTS

REVISION LOG

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

Description of Change	Link	Page
Added: Information regarding new payer ID 41822		All
Updated: WellFirst Health's relationship with Medica.	Welcome	5
Updated: Provider information components to ensure current and accurate provider information is in the Provider Directory.	Updating Provider Information	10
Updated: SSM Health Employee Health Plan information.	Products and Service Areas	12
Updated: Features the online Medica Member Resources Reference Guide for Providers as a one-stop resource for information regarding member programs and services.	Member Information for Providers	21
Updated: Clarified 277 Claim Acknowledgement response and Confirmation Reports Portal information; available tools to help prevent billing gaps and payment delays.	Acknowledgement of Submitted Claims	27
Added: Table showing Medica contracted entities for the review and prior authorization of certain services. In these cases, prior authorization requests should be submitted to the contracted vendor, not Medica.	Electronic Authorization Submission	37
Added: Section regarding cancelled prior authorization requests.	Cancelled Prior Authorization Requests	41
Added: Concert Genetics as the Health Plan's contracted vendor for genetic testing.	Medical Management	47
Updated: Locations to access for medical benefit drug policies and pharmacy benefit drug policies.	Pharmacy	59
Updated: Case management information throughout to reflect current program offerings.	Case Management	63

WELCOME!

Welcome to the Medica Central (formerly WellFirst Health) provider network. Thank you for participating in our network of physicians, clinics, hospitals, and other health care professionals. We are delighted for the opportunity 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 link located at the top of Medica web pages. You also have access to our Provider Network Consultants, who are personnel dedicated to supporting our in-network providers.

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 (formerly known as WellFirst Health) to provide services to Medica members. Request to join the network by submitting an online Provider Network Application, located at the bottom of the Medica Provider page at MO-Central.Medica .com/Providers. Our Provider Network Services team contacts interested providers upon receipt of the request.

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. 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.

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 communications 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

ABOUT THIS MANUAL

This Medica Provider Manual is a resource regarding policies and practices for claim submission and procedural expectations to support in-network providers serving patients enrolled in Medica ACA Individual plans. It also includes important phone numbers, website URLs, and references to provider resources as well as how to access them. This manual is intended as an extension of the provider contract. As such, providers should also refer to their contract agreement, the member's benefit certificate, medical policy, and applicable state and federal laws for specific coverage information.

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

In most cases, Medica policies and procedures are the same for Illinois and Missouri. However, in compliance with state laws and regulations, there are variations that are indicated in this manual.

For more information about the SSM Health Employee Health Plan Administrative Services Only (ASO) plan, refer to that Provider Manual accessible from the Medica Providers web page at MO-Central.Medica.com/Providers

Medica began transitioning to a new claims processing platform in January 2024. As a part of this multi-year migration, payer ID 41822 was created to gradually transition our business to this new platform by member plan type. The information in this manual is meant to apply broadly across all plans and payer IDs but will indicate when different processes are required based on the use of payer ID 41822 or 39113, the payer ID used most commonly in our legacy business platforms. Beginning with our Individual and Family Business (IFB/ACA plans) on January 1, 2024, those that have transitioned to our new claims platform and processes will utilize payer ID 41822. Plans utilizing legacy ID 39113 will remain the same, using processes and resources that were effective prior to January 1, 2024. As new plan types set to make the transition and use payer ID 41822 will be broadly announced and documented. Medica offers a separate, supplemental provider manual for Medica Advantage.

Please note that the processes outlined in this, and our supplemental manual apply to Medica Central Networks.

*These processes do not apply or carry over to our affiliate Medica, with a home office in Minnetonka, MN.

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 reflect on the members ID card as applicable.

DIRECTORY

CUSTOMER SERVICE	
Customer Care Center Hours of Operation: Monday – Thursday| 7:30 am to 5:00 pm Friday| 8:00 am to 4:30 pm	• **Payer ID 39113** 1-866-514-4194 • **Payer ID 41822** 1-800-458-5512 **Medica Advantage:** 1-877-301-3326 (TTY 711) **Medica EHP:** 833-942-2159 **SSM EHP**: 877-274-4693 For business platforms under our new payer ID 41822, we've implemented an 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
Nurse Advice Line	866-668-6548 or follow link Nurse advice line - Medica
Language Assistance Line for In-Network Providers Available 24 hours a day, 7 days a week	844- 526-1386
HEALTH SERVICES	
Utilization Management	Refer to CCC number on member card
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 - HIPAA transactions - Benefits & Eligibility: 270/271 - Claims Submission: 837 - Claims Status Inquiry and Response: 276/277	**For electronic Payer ID 39113**, navigate to https://mo.central.medica.com/Providers/Hipaa-transactions or contact EDI support Team at edi@deancare.com **For electronic Payer ID 41822**, 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
Drug Denial Appeals (Formulary, Non-Formulary, and Medical Injectables)	855-847-3554
GRIEVANCE AND APPEALS	
Grievance and Appeals Address	Medica Route CP595

	P.O. Box 9310 Minneapolis, MN 55440-9310
WEBSITES AND MAILING ADDRESSES	
Provider Resources	Illinois: Central.Medica.com/Individuals-and-Families Missouri: Mo-Central.Medica.com/Individuals-and-Families
Business Office	Medica Corporate Saint Louis Office 12800 Corporate Hill St. Louis, MO 63131
Mailing Address	Medica PO Box 56099 Madison, WI 53705
PROVIDER NETWORK CONSULTANTS	
Email	ProviderRelations@medica.com
Phone	314-994-6262

VISIT OUR WEBSITE

The Medica website at MO-Central.Medica.com is the gateway to provider-related health plan information for all Medica products. For provider ease, most provider resources and information can be accessed from our Providers home page at MO-Central.Medica.com/Providers. From MO-Central.Medica.com, select the Provider link near the bottom of the MO-Central.Medica.com home page to go directly to the Providers page. Or, once past the home page and on the website, click the Providers link located on the top of any Medica web page to get to the Providers home page for provider information at MO-Central.Medica.com.

Providers

Our patient-focused, locally driven health plan creates a better kind of health insurance experience that makes providers' lives easier.

Essential tools for providers

Alert: COVID-19 Health Plan Information for Providers. See the latest information.

Provider portals

Sign in to any of the provider portals:

Sign in

Manuals

Find out more about policies and procedures that affect claim submissions.

See manuals

Medical management

Pharmacy services

PROVIDER NETWORK SERVICES

Medica's Provider Network Services' main purpose is to support in-network providers. This includes maintaining provider files, administering the provider contracting process, updating provider manuals, and issuing Provider Communications

PROVIDER NETWORK CONSULTANTS

The Provider Network Services department includes Provider Network Consultants, who are responsible for educating and supporting all new and existing in-network Medica providers. Provider education includes:

- Updating providers on new policies and procedures distributed via email, Provider News newsletters, provider mailings, or workshops.
- Orientations for new practitioners and facilities, as requested.
- Ongoing education for in-network providers on topics such as Quality Improvement, Utilization Management, or processes for day-to-day interaction with the health plan.

Contact a Medica Provider Network Consultant by email at ProviderRelations@medica.com or by phone at 314-994-6262.

NETWORK SETUP AND PROVIDER STATUS

Medica closely manages networks comprised of contracted providers to administer quality care and cost savings to our members. Providers are either contracted with the status of Plan or Non-Plan with Agreement.

- **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.

Contracted providers service Medica members for specific products and services across wide variety of in network locations. It's important for providers to be familiar with their provider agreement and always check member eligibility prior to providing services in order to prevent claims payment issues.

Providers must fully complete Medica credentialing and have an active contract before they can provide services to Medica members and be eligible for reimbursement. 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 Medica network by completing and submitting our online Provider Network Application, located at the bottom of the Medica Provider page at MO-Central.Medica.com/Providers. For information on credentialing and recredentialling, refer to the credentialing section in this document.

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 Network Consultant 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 Network Consultant with 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 mo-central.medica.com/Find-A-Doctor 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 Medica's network of contracted providers by completing and submitting our online Provider Network Application, located at the bottom of the Medica Health Plan Providers page at MO-Central.Medica.com/Providers.

Our Provider Network Services team contacts interested providers upon receipt of the request. Requests are reviewed

internally by Medica and may take extended time to review and make a determination. The determination will be communicated to you by the Provider Network Consultants.

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 Medica' system. Once these are all completed, the provider will be notified, generally via email, of when they are approved to begin providing services to Medica 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 Medica Provider Network Consultants at ProviderRelations@medica.com.

The request process to add new practitioners, office or practice locations, and services/specialties is as follows:

1. Submit a written request in advance to the Medica Provider Network Consultants at ProviderRelations@medica.com to request a new practitioner, location, or specialty.
    - If adding a new practitioner to replace a practitioner in the organization, include the name, specialty, degree, and termination date of the practitioner who has left or is leaving.
2. The Provider Network Consultant working on the request may ask the submitter of the request for additional information or documentation to ensure that the request includes all of the information needed for health plan review. Please respond promptly to any requests for additional information.
3. Medica reviews and makes a determination on the request.
    - If denied:
        1. The Provider Network Consultant will notify the provider of the denial. The determination notice will be returned to the sender unless otherwise detailed on the form submitted. Denials remain on file for 12 months and therefore providers must wait for that time period to pass before submitting a new request.
    - If approved:
        1. The Provider Network Consultant will notify the provider of the approval and advise on whether the new practitioner must undergo credentialing.
            - If credentialing is not required, the new practitioner's effective date will be 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 Medica 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 Medica members and claims can be submitted for the new practitioner, location, or service.

Mid-Level Practitioners and Locum Tenens Physicians

The Medica network is comprised of many practitioner types, including locum tenens physicians, 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.
- Medica requires our in-network providers to send **advance** notification to the Medica Provider Network

Consultants to request a locum tenens physician. Include in the request the expected time frame for needing the locum tenens physician.

- Mid-level practitioners must have a supervising physician. Include in the request 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

If any of the following changes or updates apply for your organization, please provide as much **advance notice** as possible to the Medica Provider Network Consultant to avoid potential claims payment issues:

Practitioner-Related

- Name change
- Adding or discontinuing specialty
- Moving locations
- 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 Medica 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 Consultant 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 Consultants 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 Consultant in writing.

MORAL AND RELIGIOUS OBJECTIONS

In-network providers who refuse to provide a service to members based on moral or religious objections must notify the Medica Provider Network Consultants in writing of the objection and its basis in a timely manner. Medica will notify the member so that the member can seek another like in-network provider who is available to provide the service in question.

TERMINATION OF PATIENT/PRACTITIONER RELATIONSHIP POLICY AND PROCEDURE

In-network providers are required by Medica to send copies of member termination of care notification letters to their assigned Provider Network Consultant.

Practitioners may terminate a member's care only with good cause. The following are examples of member actions that constitute good cause:

- 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 Medica 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-cancelled 3 or more scheduled appointments with practitioner after having received a written warning.
- Communicated to the practitioner that they would like to select a different practitioner.

The following information should be included in the termination of care letter, per Medica guidelines:

1. Member's full name, including full middle name (not just initial)
2. Member's date of birth (optional)
3. Member's address (satisfied by listing in the address block in the letter)
4. Clinic/facility name
5. Practitioner name
6. Notice in the body of the letter stating that the member may see the practitioner for 90 days from the date the

member received the termination notice if the member presents for urgent or emergent care.

7. Reason for the termination
    a. If reason is due to the member missing or late-canceling appointments, include when their initial warning letter was sent to them and documentation of dates missed.
    b. If reason was due to non-payment, include proof of attempts to collect payment.
8. 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. Please note. Sample ID cards are provided when available, but this manual may not contain every possible variation.

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. WellFirst by Medica IFB products offer multiple plans with Single or Family options and a variety of deductible and benefit levels. For specific information regarding WellFirst by Medica IFB Information and resources for Medica providers are available from the Medica Providers web page at Mo-Central.Medica.com/Providers. As of 1/1/2024 these plans started utilizing payer ID 41822.

Medicare Advantage

Medica Medicare Advantage is a Medicare replacement product. With the exception of hospice claims, no claims go to Medicare. Each plan allows members access to Medica's in-network providers and includes value-added coverage and designated supplemental benefits.

For more information about Medica Advantage, visit the Medica Medicare web page at Central.Medica.com/Medicare. This website also can be accessed from the Mo-Central.Medica.com page by selecting the Missouri & Illinois Medicare Plans link.

Employee Health Plan (EHP) Administrative Services Only (ASO)

The SSM Health EHP ASO plan is the self-funded product for ***SSM Health employees and their dependents*** in Illinois, Missouri, Oklahoma, and Wisconsin. Refer to the SSM Health Employee Health Plan Administrative Services Only Provider Manual accessible from the see manuals link on the providers web page at Mo-Central.Medica.com/Providers.

Medica Employee Health Benefit ASO Plan is also a self – funded product and eligible to Medica Employees and their dependents in Illinois, Missouri, Oklahoma and Wisconsin. Members formerly covered under the WellFirst Health SSM EHP Plan, are now Medica employees covered under the Medica Employee Benefit Plan, effective January 1, 2024. Refer to the Medica Provider Manual accessible from the Manuals link on the Plan Providers web page at Mo-Central.Medica.com

Note: Medica EHP ASO is also applicable to Dean Health employees, formerly covered under the WellFirst Health SSM EHP Plan effective January 1,2024. Refer to the Dean Health Plan Provider Manual accessible from the Manuals link on the Dean Health Plan Providers web page at DeanCare.com/Providers.

AUTOMATIC ASSIGNMENT OF PRIMARY CARE PRACTITIONER (PCP)

Many of the Medica products allow members to choose their primary care practitioner or primary care site. If a member does not choose a primary care practitioner or primary care site, Medica will automatically assign one based upon the member's residence. In these situations, Medica will send a letter to the member informing them of their assigned primary care practitioner and primary care site. If the member has additional questions, the Customer Care Center can be reached at the number listed on the back of member card.

EXAMPLES OF MEMBER IDENTIFICATION CARDS

The WellFirst by Medica IFB member ID cards list "Medica" as the network and are differentiated by product type. Members who have a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount also have their deductible/coinsurance maximum amount listed on their member ID card. Additionally, Medica member ID cards have the First Health Network logo on the back. First Health is the health plan's wrap provider network. This means that through First Health, Medica members have access to a robust provider network when they are outside of the Medica service area. First Health is a wrap network only and does not affect the Medica network of providers as listed in our online provider directory.

- *Please see Appendix on last page of provider manual for examples of Member ID Cards*

CHECKING MEMBER ELIGIBILITY

Providers should verify member eligibility for each date of service. In the event the provider fails to verify eligibility, the member cannot be held responsible for the cost of services rendered. Because Medica 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 Medica Provider Portal accessible from the Provider Portal page for payer ID 39113. For payer ID 41822, use the Availity Essentials Portal or when necessary, contact the Customer Care Center. The information in these transactions also includes real-time details about a member's cost share, deductible, copay, and coinsurance amounts.

For Payer ID 41822, Member health plan benefit information, including certificate of coverage, member policy, or certificate can be viewed at MemberBenefits.MO-Central.Medica.com by entering the full member ID or group number.

HEALTH PLAN COMMUNICATIONS FOR PROVIDERS

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

- **Medica Provider News** —*A* monthly health plan newsletter specifically for Medica providers. The Medica *Provider News* informs providers of changes to health plan procedures, benefits, and other areas of interest involving Medica products and services. This newsletter is the primary means by which providers may receive formal notification of policy change or other pertinent updates.
- **As-Needed Communications** —Is an interim process for self-service, a method to communicate changes outside of the monthly newsletter scheduled but in advance of the date for which the planned implementation will occur, as well as for larger initiatives that require more detail.
- **Policy Updates Provider Notifications** – emailed monthly to communicate select medical benefit drug policy and medical policy updates, as well as Health plan initiatives when applicable. Monthly provider notifications are also published to the Provider Communications Page.
- Provider Communications - Links to a variety of our past and current provider notifications that were originally communicated via postal mailings or emails to serve as an on-demand communications repository. Examples of the notifications that are available from this page are monthly policy update provider notifications and the annual plan and benefit changes notices. Published communications contain information that was accurate when the notification was originally released and may not reflect current information. 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.
- **Portal Flash Messages** — accessible from the Medica Provider Portal (relevant for payer ID 39113) to temporarily communicate general messaging regarding topics such as system outages or directing providers to resources or more detailed communications for full information. These messages are archived in the provider portal and available for review after acknowledgement.

In most cases, we communicate to providers through email. To enable this more efficient method of communication, providers are encouraged to select the opt In option to receive direct and expedited provider email communications from Medica. Opt In is available in the Medica Provider Portal during the Provider Portal registration process and can also be selected after registration through Account Settings. The opt-in captures contact information for providers providing services for all plan types, including those utilizing payer ID 41822.

MEMBER INFORMATION FOR PROVIDERS

While most provider resources and information can be accessed from our Providers home page at Mo-Central.Medica.com/Providers, information for members is available on the Medica members page.

Medica offers a wide range of programs and services to improve the overall health of our communities and support providers caring for individuals enrolled in Medica benefit plans. Available member services and programs are intended for members who are enrolled in Medica benefit plans (and some are even available regardless of insurance). Providers are encouraged to be familiar with member resources and promote them to their patients when appropriate.

A wealth of details regarding member programs and services are featured on the Medica web pages ranging from behavioral health resources, nutritional programs, health and wellness webinars and events, preventive care, and more. Medica has designated websites for members based on their benefit plan or residency. To assist providers in finding this online information, the Medica Member Resources References Guide for Providers is published on the Provider Communications page.

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

USING MEDICA PLAN PROVIDER PORTALS

Medica uses two provider portals to ensure providers have access to 24/7 self-service. For payer ID 39113, our health plan-specific provider portal registration and functionality is described in detail below. Beginning January 1, 2024, multi-payer solution Availity Essentials will serve as the main location to exchange clinical and administrative data for members in plans under payer ID 41822, indicating they have transitioned to our new claims platform. Please note that providers will need to continue to do business out of both portals until all of our membership has transitioned off of legacy systems. While full functionality is being activated within Availity Essentials, interim processes may be utilized and will be detailed on our Provider Communications page.

.

OVERVIEW AND RESOURCES FOR AVAILITY ESSENTIALS

Availity Essentials enables provider teams to perform transactions for multiple payers from their single account. Essentials will be available for all member transactions as their plan type transitions tor payer ID. Availity Essentials is a widely utilized provider portal between payers and providers. If your organization uses Availity Essentials for another payer, our new payer ID 41822 for Medica Health Plan 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. Regardless of plan, Availity Essentials is the primary platform for Prior authorization submission for all payer ID's.

LOGGING-IN, TRAINING AND TROUBLESHOOTING WITH AVAILITY

Availity's Medica Health Plan provider set-up and resource **page can be found** ***HERE*** **or from** availity.com/medica-health-plans. This page also allows you to sign up for live webinars or play a Medica 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 during our member transition, but updates on additionally available functionality will be available from our *Provider Communications page*.

OVERVIEW OF THE HEALTH PLANS PORTAL FUNCTIONALITY

The Medica 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. Work pertaining to members in plan types utilizing payer ID 41822 is available in Availity Essentials.

We strongly encourage providers to establish a Provider Portal Account!

If you are not interacting with the health plan through the Provider Portal, we strongly encourage you to establish a Portal account. Once a Portal account is created, users can access information and perform tasks specific to their assigned Portal role(s). Individuals need to register in order to create a secure Provider Portal account. Refer to the Medica Provider Portal Registration User Guide for the simple step-by-step process on how to create Individual and Organizational Provider Portal accounts. The User Guide is accessible from the Provider Portals link on the Medica Providers page at Mo-Central.Medica.com.

ACCESS PROVIDER PORTALS

There are two ways to access the Provider Portal:

1. From the Provider's Home page at Mo-Central.Medica.com and selecting the 'Provider Portals' link located under the Provider Resources section.
2. Medica Plan Provider Portal - Directly at Mo-Central.Medica.com/Providers
    - Eligibility and benefits for members under payer ID 39113
    - Claim Appeals for payer ID 39113 and 41822
3. Availity Essentials Portal – directly at Availity Essentials
    - Prior Authorization Submissions for all plans/player IDs
    - Eligibility and benefits for payer IDs 41822
    - Claims Appeals for payer IDs 41822

PROVIDER PORTAL APPLICATIONS

This section details options available in the Medica Provider Portal applicable to business using payer ID 39113. As we transition business to payer ID 41822, check the Provider Communications page to verify availability of the applications listed here in the Availity Essentials and any applicable interim solutions.

Eligibility (270/271 EDI) Transactions

This application will provide 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.

Authorization

Submit electronic prior authorization requests through the Provider Portal's Authorization application for most services. There are some exceptions to the type of authorization requests that can be submitted through the Provider Portal. Medica contracts with the following entities for authorization review and approval of certain services, applicable to both payer ID 39113 and 41822.

- Navitus/Navi-Gate — for pharmacy benefit drug authorization requests.
- Carelon — for authorization of high-end radiology services, musculoskeletal services (MSK) pain management and cardiovascular services.

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

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

Authorization View

See your authorizations that have been started and saved in the Provider Portal, and authorizations that have been completed and submitted through the Provider Portal.

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. Note: Claims cannot be submitted via the Medica Provider Portal

Claim Payments

This application will allow users to view electronic remittance files or search by a variety of criteria including a keyword search.

- For Payer ID 39113 - This application is only available for historic Change Healthcare prior to claims processed on or before February 9, 2024. For claims processed after February 9, 2024, claims payment can be viewed in the Instamed Portal.
- For Payer ID 41822 claims payment can only be viewed in the Instamed Portal.

Claim Appeals

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

Provider Admin

Allows Provider Portal Site Administrators to make updates to Individual user or Organization account information.

Provider Resources page

Repository of convenient links to provider resources such as medical policies, user guides, provider manuals, and partner portals.

For more information on applications, refer to the Medica Provider Portal User Guide for Payer ID 39113 available on the Provider Resources page once you have established your Portal account. For payer ID 41822 resources are available with Availity Essentials.

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

The Opt In for electronic communications option is available in the Medica 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 Medica in the Availity Essentials portal, so please ensure that your Medica portal account reflects this preference to ensure that your email is collected for this purpose.

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

Medica 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. Medica 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 Medica 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.

Electronic Data Interchange (EDI) TRANSACTIONS

Electronic Data Interchange (EDI)

Medica offers HIPAA-compliant electronic transactions to provide consistent documentation, handling and privacy standards, as well as for efficiency. Go to the HIPAA Transactions page to view the Medica-supported transactions, companion guides, a EDI setup form , and additional information. The HIPAA Transaction Page is organized by payer ID. Please be sure to establish new payer ID 41822, access through the Availity gateway, with your clearinghouse to ensure that transactions can be performed our Individual and Family Business (IFB/ACA plans) transition effective January 1, 2024.

Eligibility and Benefit Inquiry and Response (270/271)

The most timely and accurate way to confirm a member's benefits and coverage amounts is to submit an eligibility request transaction. Medica supports this transaction in either real-time or batch. To engage in EDI transmission, please complete an EDI setup form; if you utilize a clearinghouse or billing service have them reach out to us to arrange transmission.

Health Care Claim Submission (837)

Electronic claim submission allows for standardized transmission of claims data, resulting in fewer rejections and more streamlined claims adjudication. Medica accepts both the 837 Health Care Claim: Professional (837P) and Institutional (837I) transactions. To submit claims electronically, please complete an EDI setup form; if you utilize a clearinghouse or billing service have them reach out to us to arrange transmission.

Claim Acknowledgment (277CA)

Electronic claim acknowledgment files are a response to the electronic claim submission (837) files we receive. Each claim is identified individually as to whether or not it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

Health Care Claim Status Request and Response (276/277)

Electronic claim status requests allow inquiry and response to quickly know the status of a claim that has been accepted for adjudication. Medica supports this transaction in either real-time or batch. The provider should wait a minimum of 30 days after claim submission to send a claim status request to allow for the known payment processing time. To engage in EDI transmission, please complete an EDI setup form; if you use a clearinghouse or billing service have them reach out to us to arrange transmission.

Health Care Claim Payment/Remittance Advice (835) and Electronic Funds Transfer (EFT)

Medica contracts with Instamed to manage payment services (i.e, remittance advice, Explanation of Payments

(EOP),electronic funds transfer (EFT) and paper checks. Providers can visit Instamed.com/eraeft to register.

EDI Help Desk

If you have questions related to EDI setup, data content, or other EDI issues please contact our EDI team directly edi@deancare.com.

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. Families share the first nine digits of their subscriber number; for payer ID 39113. For payer ID 41822 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 payer ID 41822 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.
- Medica requires that all services billed be appropriately documented in the patient's medical records in accordance with the Medica Medical Records Policy. If the services billed are not documented in the patient's medical record in accordance with the policy, they will not be considered reimbursable by Medica. The Medica Medical Records Policy can be found in the Quality Improvement section of this manual.

- 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 Medica 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 with the published Medica Companion Guides. Only the latest published versions of the claim forms will be accepted for processing. If necessary, providers can mail claims to Medica, PO Box 56099, Madison, WI 53705 for payer ID 39113. For Payer ID 41822 claims can be mailed to Medica - PO Box 211404, Eagan, MN 55121.
- 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.

- To check the status of a claim, use the Claim Status application in the Provider Portal or 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.**

ACKNOWLEDGMENT OF SUBMITTED CLAIMS

Medica offers acknowledgment of electronic claim submissions through the following:

- 277 Claims Acknowledgment (277CA) transaction
- Confirmation Reports Portal * only available for claims submitted under payer ID 39113

277 CA

Providers can sign up from the our HIPAA Transactions web page. to receive 277CA responses for each electronic 837 claim file submitted to the health plan. In the 277CA, each claim is identified individually as to whether it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

Confirmation Reports Portal – (Applicable for payer ID 39113 only)

The Confirmation Reports Portal is still an option to providers who sign up to receive 277CA responses. Confirmation reports show all claims that were successfully accepted for processing as well as all claims that were rejected and not accepted for processing. Confirmation reports are available within 48 hours of when Medica receives a claim. This includes claims submitted electronically or on paper.

Providers must contact the Medica Provider Network Consultant Team to sign up for the Confirmations Report Portal. A link to the Confirmation Reports Portal can be found on the Account Login page at Mo-Central.Medica.com/Account-Login.

Providers should review each report received to confirm that all claims were received by Medica as well as work to resolve rejected claims. The rejected claims portion of the report will include error codes to explain the specific reason a claim was not accepted. Based on the error codes provided, please resubmit the claims with the necessary changes. **Providers are required to make corrections and resubmit the claim within the allotted time frame agreed upon in the contract beginning with the date of receipt.**

The following shows examples of the Confirmation Reports Portal for accepted and rejected claims:

Accepted

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	DOB
[redacted]	[redacted]	[redacted]	10/20/2016	1	164.00	12/01/2016	[redacted]	M	[redacted]

Rejected

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	REJECT REASON	DOB
[redacted]	[redacted]	[redacted]	11/10/2016	4	1034.00	12/01/2016	[redacted]	M	Member not on file.	[redacted]

For electronic claims submission, a 999 Acknowledgement transaction will be used to indicate whether or not your

transaction sets (ST/SE) passed SNIP types 1 and 2 compliance. Please work directly with your clearinghouse or EDI team to validate claim transaction acceptance. In cases of rejected 999s, please use the content of the transaction to understand the errors and resubmit the entire transaction.

For electronic claims enrollment and responses, go to the HIPAA Transactions web page.

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 Consultant.
- 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.

GRACE PERIOD FOR ADVANCED PREMIUM TAX CREDIT SUBSIDY

ACA mandates a three-month grace period before terminating coverage for members who purchased their health plan on the Marketplace *and* who also meet certain income thresholds to qualify for the Advanced Premium Tax Credit (APTC) subsidy. The grace period applies after the enrolled member has paid at least one month's premium within the benefit year and the next payment is not received by the due date for the following month.

Medica will process claims incurred during the first month of the APTC grace period but will suspend processing of claims for services rendered during the second and third month of a member's grace period. If the member makes all outstanding payments by the last day of the third month of the APTC grace period, Medica will process all pending claims. If the member fails to make all outstanding premium payments by the last day of the third month of the APTC grace period, Medica will deny claims for services rendered during the member's second and third month.

Medica will issue a notification to the billing provider when a claim is submitted for services rendered during a member's grace period. Additionally, providers may submit a 270 Health Care Eligibility electronic request to confirm the status of members who may be in an APTC grace period. If a member is in the second or third month of their grace period, the 271 responses will indicate that the member is "pending investigation" in EB01 with a value of 5.

GRACE PERIOD FOR NON-ADVANCED PREMIUM TAX CREDIT SUBSIDY

For members who purchased their health plan on the Marketplace but do not qualify for the APTC subsidy, Medica will allow a 31-day grace period. Medica will process claims for these members during the 31-day grace period.

END OF GRACE PERIODS

If payment of all premiums due is not received from the member at the end of the grace period, the member policy will terminate to the last date through which premiums were paid.

EXPLANATION OF PAYMENT

Medica produces Explanation of Payments (EOP) information on a weekly basis. Providers are encouraged to receive remittance information electronically, free-of-charge through the Medica Provider Portal claim payments application for Payer ID 39113 for claims processed prior to February 9,2024 or by our Health Care Claim Payment/Remittance Advice (835) transaction. For claims processed after February 9, 2024 for payer ID 39113 and for Payer ID 41822 providers can review EOPs through Instamed.com.

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:

- Complete the Claim Review Request form available in the Claim Appeals Application of our Provider Portal at Mo-Central.Medica.com.
- Include a brief 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.).

If any questions, please contact the applicable Customer Care Center referenced on the Directory page of this Provider manual.

PROVIDER CLAIM APPEALS

PROVIDER APPEALS PROCESS

If Medica denies a claim or benefit that 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 to be considered by an appropriate representative of Medica and should be submitted using the Claim Appeals Application in the Medica Provider Portal for efficiency. This instruction applies to appeals filed both for claims submitted under payer ID 39113 and payer ID 41822, as the application in the health plan provider portal will apply to both payer IDs. Decisions are communicated in writing to the requesting provider specifying the reason(s) for the and advising the provider of their subsequent appeal rights should they be dissatisfied with the decision made by the Medica representative.

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

TIMELY FILING APPEALS

If a claim is specifically denied for timely filing, please reference the process below.

If the timely filing guidelines and/or exception guidelines were not met and the claim or claims deny, the provider may appeal the timely filing denial. The provider must submit additional documentation to support that their claim was filed timely in order for it to be reviewed by Provider Network Services.

The Provider Network Consultant 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 appeal the decision. The Provider Network Consultant 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 Provider Network Services shall be considered final and binding upon Medica and the Provider.

PROVIDER PORTAL APPEALS

Claims that have been processed with a finalized status (denied-paid) can be appealed online through the Medica Provider Portal or via paper submission. In-network providers are encouraged to submit claim appeals electronically through the Claim Appeals Application of the Provider Portal.

Claim Appeal Types

- **COB**
  This appeal type would be used to request reconsideration of a coordination of benefits (COB) denial. The primary payer's EOP is required if it was not submitted with the original claim.

- **Additional Payment**
  This appeal type would be used to request reconsideration of a Medica payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is believed to be incorrect is also required.

- **Recoup**
  This appeal type would be 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 Timely filing limit stipulated in your Provider Agreement/Contract. Documentation to support the timely filing appeal request is required.

- **Code Review Request**
  This appeal type would be used to request reconsideration of a coding-related claim denials. Reasons for denial 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.

- **No-Authorization Appeal**
  This appeal type would be 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 appeal type would be 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 appeal type would be 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 Medica's Utilization Management guidelines may result in claim payment denials or the reimbursement of a claim at a lesser benefit. In many instances, Medica Health's Utilization Management policies and procedures are the same for Illinois and Missouri providers, but differences between states are indicated where applicable. This section contains the following state-specific information for payer ID 39113 and the Availity Essentials Portal for payer ID 41822. Confirm the authorization requirements as noted in the member's certificate of benefit, and consult the Medica Medical Policies.

- For Illinois —
  - Referrals
  - Authorization for WellFirst by Medica Individual IFB Plans in Illinois
  - Authorization Priority Statuses and Determination Turnaround Times
  - Infertility
  - Provider Authorization Appeals
- For Missouri —
  - Authorization Priority Statuses and Determination Turnaround Times
  - Chiropractic Copayment
  - Provider Authorization Appeals

Utilization Management Hours of Operation

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

Members may access Medica via a toll-free number to the Customer Care Call Center or via a toll-free number to the Utilization Management Department. 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 Customer Care 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.

REFERRALS — FOR ILLINOIS ONLY

Medica requires that members choose a Primary Care Provider or Woman's Health Care Provider. The Primary Care Provider or Woman's Health Care Provider acts as a "gatekeeper" to ensure members receive appropriate, high-quality care in a cost-effective manner.

If the Primary Care Physician or Woman's Principle Health Care Provider believes specialty care is medically necessary, they may refer the member to an in-network specialty Provider. Physicians, hospitals, and other health care providers are listed in the Provider Directory accessible from the Find a Doctor page, by specialty or location.

The Primary Care Physician or Woman's Principle Health Care Provider will determine the number of visits needed for specialty care. If the member has a medical condition that requires ongoing specialty care, the member may apply to the Primary Care Physician or Women's Principle Health Care Provider for a standing referral.

If you are an in-network specialty provider, it is your responsibility to make sure a referral from the Primary Care Physician or Woman's Principle Health Care Provider is in place prior to rendering services, or the services may be denied.

If the specialty services are not available from an in-network provider, a referral from the Primary Care Physician to the out-of-network provider **and** an approved prior authorization from Medica is required for coverage of the out-of- network specialty services.

Out-of-network provider services are covered only when an in-network provider cannot provide the requested medically necessary services, except emergency and behavioral health services. Female members may obtain services from an in-network Woman's Principle Health Care Provider without a referral from a Primary Care Physician.

The health plan will not cover services rendered by an out-of-network provider, except for emergency and behavioral health services, unless the Primary Care Physician or Woman's Principle Health Care Provider refers the member **and** the member receives an approved prior authorization from Medica.

AUTHORIZATIONS

A prior authorization is a written request submitted to the health plan by an in-network Primary Care Provider (PCP) 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 Medica Medical Policy as requiring prior authorization, when a rendering provider is out-of-network, or the service is

an elective inpatient admission. As you review the information below, please note that while the health plan transitions business platforms, submission methods for authorization review may change according to payer ID and provider portal status.

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.

If the authorization request was submitted via the Provider Portal, the notification will be delivered electronically through the Portal in real-time when the authorization is processed. Medica will provide written confirmation of a telephone or electronic notification of an adverse determination to the provider and the member within one business day of making the adverse determination.

AUTHORIZATION INFORMATION AND RESOURCES

Formal Approval

Prior authorization approval is written documented approval from the health plans 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 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. If a service is not found in a medical policy or listed in the MSL, providers are encouraged to also refer to the Medica Non-Covered Medical Procedures and Services list, also accessible from the Medica Medical Management page, to verify that the service is not on that list.

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 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.

AUTHORIZATIONS: WELLFIRST BY MEDICA IFB - ILLINOIS ONLY

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 services(s) with an in-network provider or, in some cases, an out-of-network provider.

In compliance with Illinois-mandated requirements, Medica authorization approvals for members enrolled in a Medica Individual IFB plan in Illinois will remain valid for the lesser of either 12 months from the date the health care provider received the prior authorization approval or the length of treatment, as determined by the patient's health care provider.

For newly enrolled members who have received a prior authorization approval for services prior to their enrollment in a Medica Individual ACA plan, the services will be approved if all of the following circumstances apply:

- The prior authorization date span falls under the member's new eligibility with Medica
- The member/provider is able to provide the written approval documentation from their previous plan
- The services are a covered benefit under their current plan

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 the Provider Portal, or in writing if access to the Provider 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 unexpected delays or outages, a paper request form may be faxed or email in for review, found on the Medical Management page under Prior Authorization Forms and then General, which applies to both inpatient and outpatient service requests. 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 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 (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 Availity Essentials portal will indicate determination (approved/denied) and a letter will be sent to the member. If the request was 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 Medica Medical Management page at Mo-Central.Medica.com/Providers/Medical-Management.
- Authorization request forms should be mailed or faxed 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 that the member has already seen. The UM 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 Medica provider network are considered for approval with a non-contracted provider.

Use of Other Entities for Authorization Services

Medica 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 Medica, as shown in the table below

Service	Whom to Submit	How to Submit
Pharmacy Benefit Drug Authorizations	Navitus/Navi-Gate	Authorization forms are available through the Navitus Prescriber Portal at prescribers.navitus.com and should be submitted through the Navitus Prescriber Portal or via fax information on the form.
Medical Benefit Drug Authorizations	Medica	Authorization forms are available through the Navitus Prescriber Portal at prescribers.navitus.com, but should be submitted to Medica via the Medica Provider Portal or via fax, mail, or phone information on the form.
Medical Injectables * *For benefit classifications and submission information, see our Medical Injectables List.*	Medica (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 Medica Medical Policies ** See our Master Service List to know if authorization is required and where and how to submit authorizations.*	Medica	Regardless of payer ID, authorizations can be submitted via the Availity Essentials provider portal. In addition, 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, go to our Carlon Musculoskeletal - Medica web page.*	Carelon	Authorizations can be submitted through the Carelon MBM provider portal

SUPPORTING DOCUMENTATION

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

- For IFB members: Fax to 952-992-2836 or email to IFBHealthManagement@Medica.com.
- U.S. Mail to Medica Utilization 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 the missing information. A phone call is made to the provider office to request the additional information. Medica Utilization Management will advise of:
    - Member's name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required
    - Fax number and name of the individual that the information should be marked "attention" to
- The provider office will be advised of the time frame in which the additional information must be provided.

- 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's name and DOB
    - Specific authorization request that is missing information
    - Specific information which is required
    - Fax number and name of the individual that the information should be marked "attention" to
- The provider will be advised that if the information is not received within the new second 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.
- Requests that are submitted as pre-service medically urgent or urgent/concurrent will have an accelerated insufficient information process to facilitate a determination no later than 72 hours after the request.
- Authorization and any available information will be sent to the Medical Director for review no later than the first business day following receipt of the information or the 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 office will be contacted to advise as to 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 reviewed and a "Cancelled" determination status is applied. Medica 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.
- Check the Non-covered Services List if you cannot find the service in any of the above resources.

AUTH PRIORITY STATUSES & DETERMINATION TURNAROUND TIMES - FOR ILLINOIS

Authorization Priority

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

Medica adheres to National Committee for Quality Assurance (NCQA)-specified time frames for authorization determinations. Refer to the Illinois Authorization Determinations and Notification Time Frames table below for an at-a-glance reference of designated time frames. Contact the Customer Care Center at number listed on back of member card for the status of authorization requests that you have not received a determination for within the designated time frame.

Illinois — Authorization Determinations and Notification Time Frames

AUTHORIZATION STATUS	TIME FRAME	DEFINITION	STATUS TYPE
Pre-Service Non-Urgent	Determination and notification to member and providers no later than 5 calendar days from the receipt of all necessary documentation to make a determination. If additional information is needed, the provider must supply it to facilitate the determination no later than 15 calendar days from the initial request receipt.	This status is used for outpatient and elective inpatient admission requests.	Outpatient or Inpatient
Pre-Service Medically Urgent	Determination and notification to member and providers no later than 48 hours from the receipt of all necessary documentation to make a determination. A determination will be made within 72 hours of the request.	This status is used for requests when the delay of service could jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without this care or treatment.	Outpatient

Urgent/Emergent Inpatient Admission	Determination and notification to member and providers within 24 hours if all medically necessary information is provided; no later than 72 hours if medical documentation is not provided and must be submitted.	This status is used for inpatient admission to a facility when the member is admitted from either the emergency room, an observation status, or a physician office.	Inpatient
Post-Service	Determination and notification within 30 calendar days of the receipt (unless additional information is required for determination).	This status is used for requests that are received after the member's services have already been received. Most post-service requests will not be accepted. Exceptions will only be considered for request for request that initiate during a weekend or holiday.	Outpatient or Inpatient

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 Medica Customer Care Center at the phone number listed on the member's ID card.

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 Medica has multiple products and benefits, some Medica 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 the Provider Portal for payer ID 39113, and Availity Essentials for payer ID 41822. Confirm the authorization requirements in the member's Certificate of Coverage, and consult the Medica Plan Medical Policies.

Furthermore, some of the Medica's 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 Customer Care Center at the phone number located on the member's ID card to request clinical guidelines.

PROVIDER AUTHORIZATION APPEALS — FOR ILLINOIS

Medica providers in Illinois can appeal medical necessity denial determinations through the health plan's Utilization Management department. We strongly recommend that providers first complete the peer-to-peer review process before submitting a provider authorization appeal, as resolution of a denial determination may be reached with a verbal discussion between the physician provider and a Medica Medical Director through that process.
Providers filing a formal provider authorization appeal may file it on their own behalf or on behalf of a member. If appealing on behalf of a member, the provider must have an Authorized Representative form on file with the health plan.

Medica providers in Illinois can submit an authorization appeal in writing to the following address or fax number. Medica
Route CP595
PO Box 9310
Minneapolis MN 55440-9310
Fax: 608-252-0812

Standard Provider Authorization Appeals

A provider authorization appeal should be submitted as "Standard" in any scenario where the appeal does not meet the definition of an expedited appeal as outlined below. Standard appeals will have a determination within 15 days of all the required information being received and no later than 30 days of the original receipt of the appeal. Medica shall notify the following of the determination verbally and in writing:

- Party filing the appeal and the member
- Member's primary care provider and any health care provider who recommended the health care service related to the appeal of its decision

Expedited Provider Authorization Appeals

A provider authorization appeal should be submitted as "Expedited" if the decision or action by Medica relates to any of the following:

- The denial of health care services (including but not limited to procedures or treatments) which could significantly increase the risk of a member's health who is in an ongoing course of treatment.
- The denial of a treatment, referral, service, procedure, or other health care service which could significantly increase the risk to a member's health.

Expedited provider authorization appeals will have a determination as soon as possible, but no more than 24 hours after the submission of all information that Medica requires to evaluate and make a determination on the appeal.

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 Medica 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 Medica Medical Management information and other resources, listed below, to navigate the health plan policies, requirements, and member coverage.

Access

- From the Medica Medical Management web page by following these step-by-step instructions:
    1. Go to the Medica home page at Mo-Central.Medica.com.
    2. Click the Provider link near the bottom of the page.
    3. Click the Medical Management Home link under Medical Management to view the Medica Medical Management page.

Resources and Requirements

- Once on the Medica Medical Management page, you may access the following:

- **Medical Prior Authorization Service List**. Also referred to as the Master Service List (MSL), this resource lists medical policies and services that require authorization as well as information for some services that do not require authorization. It also contains links to medical policies that require prior authorization and/or have coverage limitations. When authorization is required, the 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**. Medica policies are reviewed at least annually and updated based on technology assessment resources and in-network provider feedback.

- **Prior Authorization web pages.** These pages detail certain services including but not limited to:

- Carlon Musculoskeletal - Medica- Medica contracts with Carelon for authorization of high-end radiology services, interventional pain management and cardiology services. Authorization requests should be submitted through the Carelon MBM provider portal.
- Musculoskeletal (MSK) Care Management Program — Medica contracts with Carelon for review and authorization of non-emergent MSK procedures: inpatient hip and knee and inpatient and outpatient shoulder and spine surgeries. Authorization requests for MSK services should be submitted through the Carelon MBM provider portal.

- Provider Communications webpage – Keep up-to-date on Medical and Drug Policy updates and processes.
- **Prior authorization forms.** Available for certain services to be used by those providers without the ability to submit authorization requests electronically through the Medica Provider Portal or Availity Essentials Portal.
- **Member benefit plan information**. **(for payer ID 39113 only**) Access online member health plan benefit information, including certificate of coverage, member policy, and certificate at MemberBenefits.central.medica.com. by entering the full member or group number.(Note: You must use Google Chrome to access this page)
- **Customer Care Center** Call the Customer Care Center 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 for 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.

BEHAVIORAL HEALTH & SUBSTANCE ABUSE – OUTPATIENT

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

Outpatient Behavioral 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, highlight the Illinois Generally Accepted Standards of Behavioral Health Care Act of 2021, behavioral health medical policies, and prior authorization information.

Refer to the Medica in Illinois authorization approval timeframes and information regarding newly enrolled members.

Behavioral Services Out-of-Network — For WellFirst by Medica Individual IFB Illinois

Authorizations for behavioral health services with out-of-network providers will be approved in the event of the following:

- Members are unable to obtain an appointment with an in-network behavioral provider within 10 business days of request initiation.
- Members are unable to obtain a repeat or follow-up appointment with an in-network behavioral provider within 20 business days of making the request.
- Member resides more than 60 miles or 60 minutes from a an in-network behavioral provider.

Substance Abuse Services Notification of Admissions and Discharges— For WellFirst by Medica Individual IFB Illinois

In compliance with Illinois-mandated requirements, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the

contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization.

Substance use disorder treatment providers and facilities must provide Medica with at least 7 days of advance notice of a planned discharge date from substance use disorder treatment for WellFirst by Medica Individual IFB members. Additionally, the substance use disorder treatment provider or facility must provide notice to Medica on the day that the member is discharged.

Refer to the WellFirst by Medica Individual IFB plan in Illinois authorization approval timeframes and information regarding newly enrolled members.

Psychiatric Collaborative Care Programs — For Illinois

We provide coverage for services provided to patients with behavioral health and substance abuse disorders who are participating in psychiatric collaborative care programs. These services do not require a prior authorization with network providers. Services with an out-of-network provider require an approved prior authorization.

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 being received according to the Medica 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 the below options to provide the required admitting information:

- For 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 the submission of an authorization. Refer to the Medical Policies on the Medical Management page accessible from the Medica website at Mo-Central.Medica.com.

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 Customer Care 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 Medica Utilization Management Department.

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**.

INFERTILITY SERVICES — FOR ILLINOIS

Infertility services require prior authorization from the Utilization Management Department.

- Infertility treatment rendered to dependents under the age of 18

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 quarterly Medica *Provider News*.

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 Medica Customer Care Center on member ID card.

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 WellFirst by Medica Individual 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

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES – INPATIENT

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

Inpatient Behavioral Health and Substance Abuse

- 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.

Substance Abuse Services Notification of Admissions and Discharges — For WellFirst by Medica Individual IFB Illinois

In compliance with Illinois-mandated requirements, the substance use disorder treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization.

Substance use disorder treatment providers and facilities must provide Medica with at least 7 days of advance notice of a planned discharge date from substance use disorder treatment for WellFirst by Medica Individual IFB members. Additionally, the substance use disorder treatment provider or facility must provide notice to Medica on the day that the member is discharged.

Refer to the WellFirst by Medica Individual IFB Plan in Illinois authorization approval timeframes and information regarding newly enrolled members.

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

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 the health plan's Provider Portal through the Eligibility application. For Payer ID 41822 use the Availity Essentials Portal.

If not working through the health plan's Provider 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 Availity whenever a member is admitted from an emergency room. In urgent and emergency situations, Medica 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 Provider Portal access have two options to notify Medica of the inpatient admission:

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

Hospital inpatient admissions require authorization from Medica whenever a member is admitted emergently. In urgent and emergent situations, Medica must be notified of any inpatient admissions resulting from emergency room services within 48 hours or when it is medically feasible (whichever is longer).
Urgent/emergent inpatient admissions (with the exception of labor and delivery) will be reviewed by Medica Utilization Management to confirm that the inpatient level of care is medically necessary. The medical necessity criteria utilized by Medica 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 da

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 Care Management, Pharmacy, and Utilization Management Departments annually evaluate their respective programs. The Utilization Management and Pharmacy Departments submit their program evaluations to the Utilization Management Committee for review and approval; Care Management Program evaluations are reported to the QI Committee. Recommendations from the annual Program Evaluations are incorporated into the next year's Program Description and QI Work Plan as appropriate.

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 and 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 as well as 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 and accreditation standards
- Provide access to staff for members and providers seeking information about the UM process, authorization of care, and the 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

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 at Mo-Central.Medica.com/Providers/Medical-Management. Medical benefit drug prior authorization forms and policies can be accessed via the Gateway page, or Mo-Central.Medica.com under Medical Management. 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.

Medica notifies clinics of new pharmacy information in the quarterly https:Mo-central.medica.com/Providers/Provider-news

- A newsletter specifically for Medica providers. Provider Communications
- Policy update provider notifications are issued monthly to communicate medical benefit drug policy updates in addition to certain medical policy updates and health plan initiatives outside of the quarterly newsletter schedule.

DRUG PRIOR AUTHORIZATION PROCESS

Pharmacy Benefit Drug Prior Authorization

Information about the prior authorization process for pharmacy benefit drugs is available at Navitus.com. From this website, providers can go to the Prescribers Section, choose more information for prescribers, then refer to the prior authorization area. 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 authorizations 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 Center can vary.

Medical Benefit Drug Prior Authorization

Medica manages medical benefit drug prior authorization requests with support from Prime Therapeutics for oncology and oncology-related drugs. Medical benefit drug prior authorization policies and forms can be accessed via the policy page at Gateway or Mo-Central.Medica.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

Medica has developed pharmacy benefit drug formularies specific to our benefit plans to help providers choose the appropriate drugs based on their patient's needs, coverage plan, and the cost of each drug. Our drug formularies are published on the Medica website at Mo-Central.Medica.com/Individuals-and-Families/Pharmacy-benefits/Drug-Formulary. If providers are unsure which drug formulary applies to a given member, consult our online member health plan benefit information at MemberBenefits.central.medica.com.

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 of the drug.

***Note*:** Medica SSM Employee Health Plan and the Medica Employee Health Plan has its own unique formulary and drug prior authorization process. Refer to the Navitus website at Navitus.com or call Navitus Customer Service at using the phone number on the member's ID card for formulary and benefit information for this member population.

PREVENTIVE DRUG LIST

Medica 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 from the Pharmacy Services for Health Care Providers page on the Medica Plan Specialty Pharmacy Program web page.

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 a Costco membership to use this service. Refer to the mail order information on our website for more information.

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-name drug.
- The pharmacy will make generic substitutions 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.
- Take-Home Drugs: only retail pharmacies with an active Navitus Pharmacy Agreement may provide outpatient drugs to Medica 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 a contracted pharmacy provider.

In situations where Medica 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 a plan pharmacy (usually a one-day supply).
- The member should be given a written prescription for the remaining medication needed.
- The member should be instructed to have the prescription filled at an in-network pharmacy.

CASE MANAGEMENT

CASE MANAGEMENT PROGRAM DESCRIPTION

Medica offers case management to optimize the overall health of our members across their health care continuum by engaging them in population-informed programs and services available through the health plan, network providers, and community. Core objectives of case management programs are to help members self-manage complex or chronic conditions, promote the relationship between the member and their primary care, 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.

Medica'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 the development of an individualized plan of care with member-centric goals. Licensed Case Management staff NCQA National Committee for Quality Insurance, standards for complex case management.

Case Management staff will:

- 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 the services and community resources necessary to self-manage their health care needs
- Serve as an advocate to help members achieve their optimal physical and mental health
- Help members learn how to navigate the complex health care system
- Assist in guiding members to the best-in-class location for the type of transplant they need, utilizing Optum designation 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

Medica'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 an illness, accident, or sudden medical event. Medica wants to ensure that members' health care wishes are known and respected. Social workers are available to help any member over the age of eighteen begin or continue the process of advance care planning.

Advanced Illness nurses and Advance care planning social workers will help members:

- Explore personal values, beliefs, and the meaning of quality of life
- Weigh options for the kind of care and treatment members would or would not want to receive
- Consider who members should appoint to speak on their behalf
- Start the conversation with family, friends, clergy, and 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 the current advance directive to ensure it continues to reflect the member's wishes

For more information, go to Medica's Advanced care planning web page at Central.Medica.com/Individuals-and-Families/Wellness/Care-Management/Advance-Care-Planning

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, we offer an integrated program that supports members with depression, anxiety, stress, and other mood disorders.

Behavioral health case management help members:

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

For more information, go to Medica's Behavioral health web page at Central.Medica.com/Individuals-and-Families/Wellness/Care-Management/Behavioral-Health-and-Substance-Use

Complex Case Management

Medica complex case management takes 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 the appropriate delivery of care and services.

The complex case management team helps members:

- 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, and in the right place
- Identify self-care needs, including arranging referrals to therapeutic services and community-based support resources

For more information See Medica's Complex case management web page at: Central.Medica.com/Individuals-and-Families/Wellness/Care-Management/Complex-Case-Management-and-Care-Coordination

Pregnancy Program

Medica provides case management services to birthing parents enrolled in our pregnancy program to promote healthy outcomes for mother and baby. The case management team provides outreach, education, and complex case management on a continuum through pregnancy and the 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.

For more information, go to the Medica Maternal and child health web page.

Transplant Case Management

Transplants are life-changing and complex, not only affecting the member but involving their family as well. The Medica Case Management team offers support before, during, and after the procedure, providing education and coordination of services to ensure members receive the care they need. 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 managers complete both utilization management and case management functions to provide members with a seamless relationship and key point of contact with Medica.

A transplant case manager and engagement coordinator helps members:

- Understand and manage the complex disease that is leading toward transplantation

- Coordinate care with providers, clinics, and programs through the transplant process
- Navigate 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 the 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 here: Medica.com/wellness/care-management/transplant-case-management/care-management-enrollment-form.

For more information, go to Medica's Transplant Case Management web page at Medica.com/wellness/care-management/transplant-case-management.

Social Work Resources

Medica 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

For more information, go to Medica's Social Work web page at
Wellness - Medica

CASE MANAGEMENT REFERRALS

Members may self-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 CareManagement@medica.com
- or any Individual & Family Business/Marketplace IFB members, e-mail ifbhealthmanagement@medica.com

- Guide patients to the health plan Case Management websites for more info or to self-refer:
  - Care management – Medica (Central.Medica.com)

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

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

CASE MANAGEMENT OUTREACH PROCESS

Medica'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: Medica's Case Management team **does not** provide urgent or emergent services.

LIVING HEALTHY

In partnership with WebMD, Medica offers certain plans to members over the age of 18 years condition management health coaching for those with one or more of the following conditions; asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure and coronary artery disease (CAD) through its Living Healthy Program.

WebMD Health Coaches provide support online and by phone around three key aspects of condition self-management:

- Medication — education and goal setting around medication adherence for long-term health outcomes.
- Monitoring — help members understand their "health numbers" and healthy ranges, how often to have tests done, and the factors that can influence these key markers of their condition.
- Lifestyle — telephone support from a registered nurse or certified health coach on healthy behaviors, goal setting, development of healthy habits, and optimization of self-care.

For more information, go to the Living Healthy Wellness Programs - Medica.

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 Medica, 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, Medica may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from Medica. This will assist us in providing a timely response and resolution to complaints, appeals, or grievances filed with our office.

The procedure for filing a complaint, appeal, or grievance is defined in the following subsections. Detailed information is also included in the member's benefit certificate. Your understanding of this process will assist us in resolving member issues in a timely manner.

Complaint

Medica 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 a decision made by you or the health plan, please contact the Customer Care Center. 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 Illinois

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 Illinois Department of Insurance IDOI) Office of Consumer Health Insurance at the following address:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767

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: • Physical exams/preventive health visits • Follow-up visits	Within 30 days
Urgent care appointments	Within 48 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 days
Urgent care appointments	Within 48 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 48 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 Find a doctor | Missouri individual + family plans, Medica/SSM Health employee plans - Medica.
- 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 Wellness - Medica.
- 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.

Complaints

Complaints about how we manage your health information can be submitted in writing to our Privacy Officer, at the mailing address listed below. Medica will not hold any complaint you submit against you in any way. In addition, if you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

If you have questions, complaints, or want to exercise any of your health information rights, call the Customer Care Center or contact us at the following address:

Privacy Officer
PO Box 56099
Madison, WI 53705

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

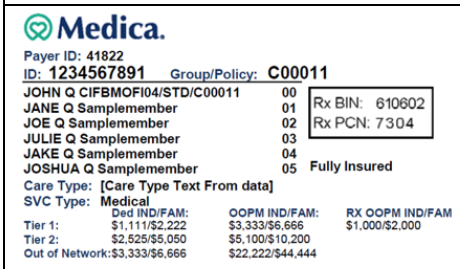
Updated: Member identification card description regarding deductible amount, deductible/coinsurance maximum amount, and out-of-pocket maximum amounts listed on member ID cards for members who have a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount.	June 2022
Updated: 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

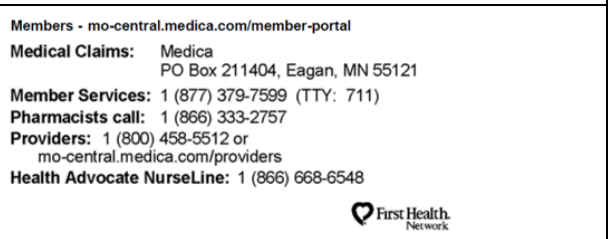
Appendix

IFB – INDIVIDUAL & FAMILY (MO & IL)

FRONT



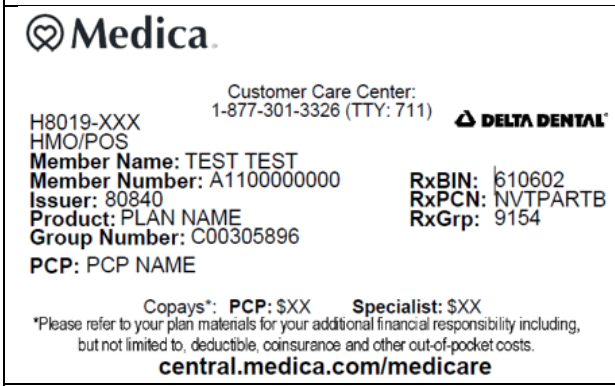
BACK



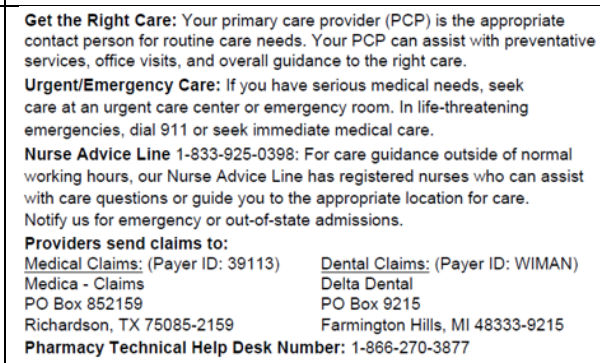
MEDICA ADVANTAGE

Medica Advantage with SSM Salute (MA Only)

FRONT

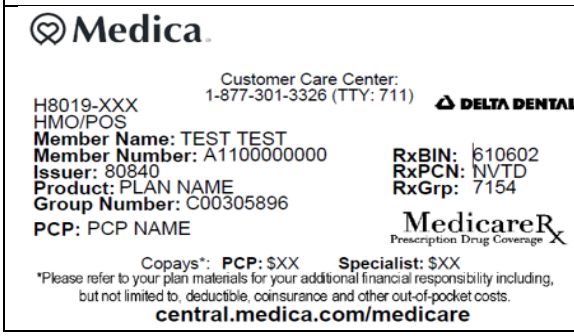


BACK

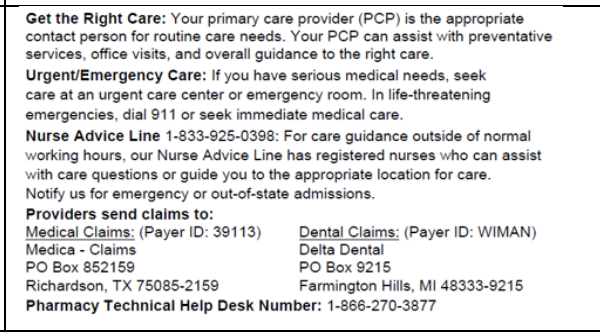


Medica Advantage Value (MAPD)

FRONT



BACK



MEDICA EMPLOYEE HEALTH PLAN (EHP)

EHP STL

FRONT

Medica.

Network: Medica Employee (STL)
Group Number: XXXXXXXXXXX
Product Type: EPO
mo-central.medica.com/medicaemployees

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

Deductible*: Individual $XXXXX Family $XXXXX
Ded/Coinsurance Max*: Individual $XXXXX Family $XXXXX
Out of Pocket Max*: Individual $XXXXX Family $XXXXX
PharmacyQuestions: navitus.com• 844-268-9789 PCN: DHE • BIN: 610602

CustomerCare: 833-942-2159 (TTY: 711) • NurseAdviceLine: 833-925-0398

BACK

Get the Right Care: Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

Urgent Care/Emergency Care: If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

Nurse Advice Line: For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.

Contact us for questions regarding •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

***Please refer to your plan materials for your additional financial responsibility.**
Providers send claims to: Medica • PO Box 56099 • Madison, WI 53705
Electronic Payer ID #: 39113

First Health Network

This card is for identification purposes and does not constitute proof of eligibility.

Form Date: XX/XX/XXXX

EHP WI

FRONT

Medica.

Network: DEAN ASO (WI)
Group Number: XXXXXXXXXXX
Product Type: EPO
mo-central.medica.com/medicaemployees

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

Deductible*: Individual $XXXXX Family $XXXXX
Ded/Coinsurance Max*: Individual $XXXXX Family $XXXXX
Out of Pocket Max*: Individual $XXXXX Family $XXXXX
PharmacyQuestions: navitus.com• 844-268-9789 PCN: DHE • BIN: 610602

CustomerCare: 833-942-2159 (TTY: 711) • NurseAdviceLine: 833-925-0398

BACK

Get the Right Care: Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

Urgent Care/Emergency Care: If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

Nurse Advice Line: For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.

Contact us for questions regarding •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

***Please refer to your plan materials for your additional financial responsibility.**
Providers send claims to: Medica • PO Box 56099 • Madison, WI 53705
Electronic Payer ID #: 39113

First Health Network

This card is for identification purposes and does not constitute proof of eligibility.

Form Date: XX/XX/XXXX

SSM EMPLOYEE HEALTH PLAN (EHP)

EHP IL

FRONT

Medica. SSMHealth.

Network: SSM EHP - IL
Group Number: XXXXXXXXXXX
Product Type: EPO
medica.com/ssmhealth

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

Deductible*: Individual $XXXXX Family $XXXXX
Ded/Coinsurance Max*: Individual $XXXXX Family $XXXXX
Out of Pocket Max*: Individual $XXXXX Family $XXXXX
PharmacyQuestions: navitus.com• 866-333-2757 PCN: 8104 • BIN: 610602

CustomerCare: 877-274-4693 (TTY: 711) • NurseAdviceLine: 833-925-0398

BACK

Get the Right Care: Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits. Find an SSM Health PCP by visiting mo-central.medica.com/employees.

Urgent Care/Emergency Care: If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

Nurse Advice Line: For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.

Contact us for questions regarding •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

***Please refer to your plan materials for your additional financial responsibility.**
Providers send claims to: Medica • PO Box 56099 • Madison, WI 53705
Electronic Payer ID #: 39113

First Health Network

This card is for identification purposes and does not constitute proof of eligibility.

Form Date: XX/XX/XXXX

EHP OK

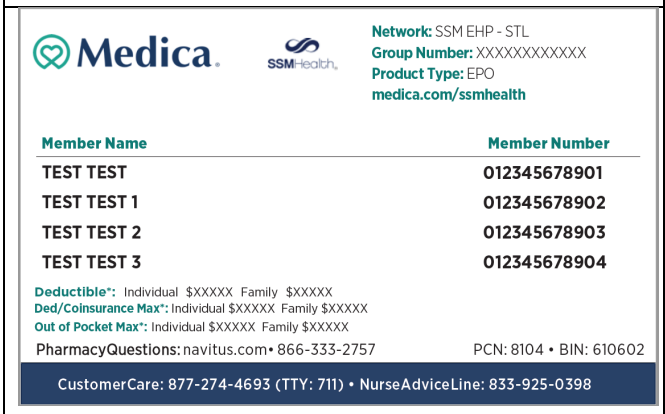
FRONT | **BACK**

MID-MO: Jefferson City

FRONT	BACK

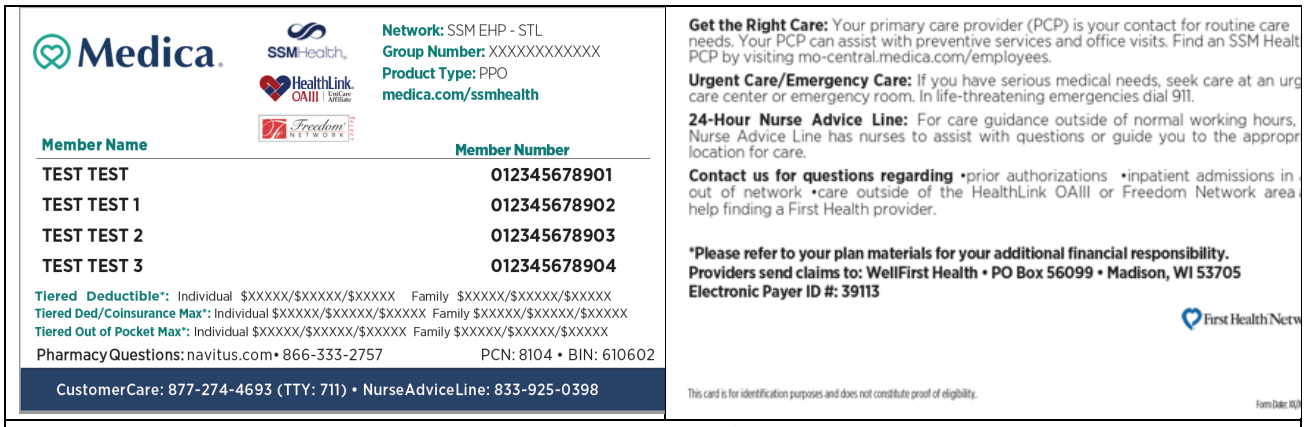
EHP STL

FRONT	BACK



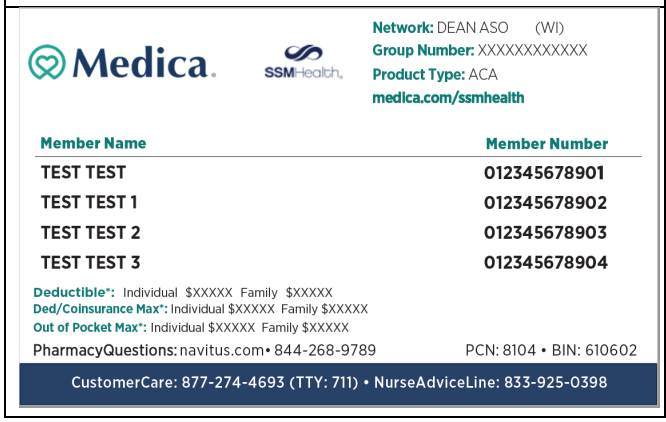
EHP STL (PPO)

FRONT	BACK



SSM EHP WI (ACA/PRN)

FRONT



BACK