April 1, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

Preventive care for your patients

We offer annual preventive visits, tests, and screenings to help prevent, find, and treat medical problems or diseases before they become major health concerns. Our **Preventive care page** highlights preventive care services for your Dean Health Plan patients at every age.

In this edition:

New Availity Essentials functionality for Medica providers

New applications are now activated in Availity Essentials, the provider portal for plan types under payer ID 41822. This means that in addition to eligibility and benefits (E&B) inquiries, you can now check claim status, submit prior authorization requests, and check prior authorization status through Availity Essentials. These new applications replace interim processes established while long-term functionalities were being activated. We're not changing processes for plan types under payer ID 39113 at this time.

Below are process snapshots for available applications.

Claim status

Previously, status for claims submitted under payer ID 41822 could only be obtained by calling us. You can now get claim status in Availity Essentials for dates of service on or after Jan. 1, 2024. While you can still call us and talk to a call agent to get claim status, this information is available through Availity Essentials 24/7.

New/Permanent Functionality for Payer ID 41822	Interim Process Being Replaced	Alternative Option to New Functionality for Payer ID 41822	Equivalent Process for Payer ID 39113
Claims status application (276/277) in Availity Essentials	Calling Customer Care	Calling Customer Care:* 1-800-458-5512	Claim Status application in Medica provider portal.

** Claim status can only be retrieved from a call agent and not through the IVR system.*

Prior authorization submission

Starting on April 1, 2024, you can submit prior authorizations for payer ID 41822 through Availity Essentials, replacing the interim electronic prior authorization form submission in the Medica provider portal. You can also continue to email or fax the prior authorization forms on our Medical Management page for both payer IDs 41822 and 39113.

New/Permanent Functionality for Payer ID 41822	Interim Process Being Replaced	Alternative Option in Addition to New Functionality	Equivalent Process for Payer ID 39113
PA submission application via Availity Essentials *View a recorded webinar from your secure Availity Essentials account.*	PA form in Medica provider portal through the Payer ID 41822 tile*	PA forms on our Medical Management page	Authorization Submission application in Medica provider portal

** In late April, this option will no longer be available.*

Prior authorization status

Starting on April 1, 2024, you can get prior authorization status for payer ID 41822 in Availity Essentials. While you can still call us and talk to a call agent to get authorization status, this information is available through Availity Essentials 24/7. Authorization status in the inquiry tool lists all authorizations submitted on and after Jan. 1, 2024. The real-time dashboard only lists authorizations submitted through Availity Essentials.

New/Permanent Functionality for Payer ID 41822	Interim Process Being Replaced	Alternative Option in Addition to New Functionality	Equivalent Process for Payer ID 39113
Authorization status inquiry tool or dashboard in Availity Essentials *View a recorded webinar from your secure Availity Essentials account.*	Calling Customer Care	Calling Customer Care:* 1-800-458-5512	Authorization View application in Medica provider portal

** Authorization status can only be retrieved from a call agent and not through the IVR system.*

Eligibility and benefits

As a reminder, you can obtain E&B information through Availity Essentials for members enrolled in plan types under payer ID 41822. Remember, these members all have 10-digit ID numbers starting with a “3.” We recently enhanced E&B search criteria in Availity Essentials so that this information can be retrieved using only a member’s first and last name and date of birth.

New/Permanent Functionality for Payer ID 41822	Interim Process Being Replaced	Alternative Option in Addition to New Functionality	Equivalent Process for Payer ID 39113
E&B transaction application in Availity Essentials	N/A	Calling Customer Care:* 1-800-458-5512	Eligibility application in Medica provider portal

** E&B information can only be retrieved from a call agent and not through the IVR system.*

Claim appeals

At this time, electronic claim appeals for payer ID 41822 must be submitted through the Medica Provider Portal using the same application as claim appeals for plans under payer ID 39113.

New/Permanent Functionality for Payer ID 41822	Interim Process Being Replaced	Alternative Option in Addition to New Functionality	Equivalent Process for Payer ID 39113
Appeals application in Availity Essentials	N/A	Mailing an appeal: Medica PO Box 211404 Eagan, MN 55121	Claim Appeals application in Medica provider portal

Register now! Availity is offering live trainings the first week of April! Plus, visit the **landing page in the Availity Learning Center** (from your secure Availity Essentials account) to view previously recorded trainings to learn more about these applications.

Race and ethnicity during provider recredentialing

As part of our National Committee on Quality Assurance (NCQA) accreditation, Medica follows credentialing and recredentialing processes to select and maintain a high-quality provider network.

We recognize that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. As such, we are deeply committed to Health Equity and the **CLAS standards**.

Understanding the race, ethnicity, and language demographics of our provider network is an important part of our ability to support our members. While race and ethnicity fields are optional fields in the recredentialing process, consider providing this information to us so we can better connect members to practitioners that meet their cultural needs and preferences. For more information about Health Equity, visit our **Cultural Awareness & Health Equity web page**.

Support depression screening and follow-up

The U.S. Preventive Services Task Force (USPSTF) recommends that providers screen adolescents ages 12–18 and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be done with adequate systems in place to ensure accurate diagnosis, treatment, and appropriate follow-up.

Screening

We recommend that providers screen all members annually for depression. An age-appropriate validated screening tool should be used to identify depression symptoms. To support screening efforts, consider setting flags if available in the electronic health record (EHR) or develop a tracking method for patients who may need screenings and follow-up visits.

Follow-up

Identifying patients with depression is important, but it is also critical they get follow-up care on a positive screen. Follow-up could include further evaluation of symptoms (i.e., administering a PHQ9 on a positive PHQ2 screening), prescribing an antidepressant medication, making a referral to a mental health specialist if the patient is open to those services, or a supplemental outpatient visit for a diagnosis of depression. Be sure to document in the patient's medical record your efforts.

We provide case management services for patients with mental health needs, including finding and scheduling a follow-up appointment with a contracted mental health provider. Email **caresupport@medica.com** or contact Provider Customer Care to refer a patient.

Mothers and Babies Program

The Medica Behavioral Health Case Management team facilitates a nine-week program called Mothers and Babies. It's an interactive program that shares useful tools and skills to help pregnant women and new moms manage stress and/or reduce symptoms of depression. To learn more or refer a patient, email **caresupport@medica.com** or contact Provider Customer Care.

Process for annual CMS-based fee schedule updates

Last fall we **announced** that beginning this year, we're implementing annual Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) and Relative Value Unit (RVU) fee schedule updates to be effective annually on April 1. This applies to provider agreements with Commercial products reimbursement terms based on RBRVS and RVUs established by CMS for our Commercial products (fully insured, self-funded administrative services only [ASO], ACA individual and family, and ACA small group plans). Medicare Advantage products will continue to implement CMS's RVU changes using the effective date CMS established for its updates.

We've made this change to accommodate the release of RVU updates by CMS each year. There is considerable analysis that goes into capturing the impact of these RVU changes in advance of fee schedule updates. The change lets us continue to pay claims without having to implement claim holds. It also aligns with overall payor practices and the timing of Medica's standard fee schedule updates as we continue to migrate to our new, shared claims processing platform.

Have questions? Contact your Provider Network Consultant.

Kidney health evaluation for patients with diabetes

Why is the HEDIS® KED measure important?
The Healthcare Effectiveness Data and Information Set (HEDIS) measure for kidney health evaluation for patients with diabetes (KED) objective is to improve kidney disease testing and kidney health for people most at risk — those with diabetes. Kidney disease affects 37 million American adults — one in three of those adults with diabetes also have chronic kidney disease (CKD). However, 90% of people are unaware they even have it. Clinical guidelines recommend people with diabetes should be routinely tested to detect kidney disease.

While the tests associated with kidney disease detection and diagnosis are inexpensive and widely available for routine clinic visits, **less than 50% of people with diabetes get both tests**. The test results give physicians and patients the critical information they need

to identify CKD and develop a treatment plan that may include additional testing, lifestyle changes, medicine, and a referral to a nephrologist for further evaluation. Because kidney disease is asymptomatic in its earliest stages, routine testing of patients at the highest risk for developing the disease is the best way to diagnose it early and help stave off its life-threatening complications.

KED measure description

The KED measure assesses the percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin-creatinine ratio (uACR), during the measurement year.

Provider best practices

- The member must receive at least one eGFR in the measurement year.
- The member must also complete at least one uACR in the measurement year.
    - This can be satisfied by ordering a uACR (urine microalbumin/creatinine ratio lab) or separate quantitative urine albumin and urine creatinine tests within four days of each other. (A urine albumin test is not sufficient.)
- The member can receive the eGFR and uACR on the same date or different dates of service.

Please remember to order these important tests annually for your patients with diabetes.

Go to **NCQA's Kidney Health Evaluation for Patients with Diabetes (KED) web page** for more information.

Humira to be removed from Medica formulary

Effective June 1, 2024, Humira will be moved to not covered for all Medica Commercial and Individual + Family Business (IFB) formularies. Humira is being removed as numerous adalimumab biosimilars have recently entered the market that provide alternatives to the reference product Humira.

A biosimilar is a biological product that is highly similar to, and has no clinically

meaningful differences from, a biologic product already approved by the U.S. Food and Drug Administration (FDA). Biosimilars are safe and effective treatment options for many illnesses such as cancer, psoriasis, ulcerative colitis, or rheumatoid arthritis. They also have no clinically meaningful difference in safety, purity or potency compared to the reference product.

Effective June 1, 2024, the following biosimilars will be available on the Medica Commercial and Individual + Family Business formularies:

- ADALIMUMAB-ADAZ INJ
- ADALIMUMAB-ADAZ PFS INJ
- ADALIMUMAB-FKJP AUTO-INJECTOR KIT
- ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML
- ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML
- HADLIMA INJ 40MG/0.8ML
- HADLIMA PUSH INJ 40MG/0.8ML

Members must transition to a biosimilar agent to ensure continuation of therapy. A new prescription for the biosimilar must be submitted; however, a new prior authorization request isn't required for those members already on Humira therapy. In those instances, Navitus will transfer the prior authorization to the biosimilar through the end date of the original approved Humira authorization.

Members newly starting biosimilar therapy will need a new prior authorization. If none of the biosimilar agents are clinically appropriate for the member, the prescriber can submit an Exception to Coverage (ETC) form to Navitus.

Termination of doctor/patient relationship

Practitioners sometimes feel it's necessary to terminate a relationship with a patient. As part of our contract with providers, Medica has an established policy for this which assures continuity of care for the member. You can find information about this process in the Provider Manual under the "Termination of Patient/ Practitioner Relationship Policy and Procedure" section.

Medical Policy Committee updates

Highlights of recent medical and drug policy revisions, new policies, and formulary updates approved by the Health Plan's Medical Policy Committee, as well as information on how to locate policies and criteria are published as part of our newsletter, linked below.

See Provider News Policy Notice, April 1, 2024

Drug policies

Drug policies are applicable to all Health Plan products, unless directly specified within the policy. **NOTE: All changes to the policies may not be reflected in the written highlights in our Provider News Policy Notice. We encourage all prescribers to review the current policies.**

Medical policies

In addition to our medical policies, all other clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at 800-356-7344, ext. 4012.

Coverage of any medical intervention in a medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note that prior authorization through the Health Services Division is required for some treatments or procedures.

Prior authorization requirements for self-funded plans (also called ASO plans) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

We contract with National Imaging Associates (NIA) (also referred to as Magellan Healthcare) for authorization of **high-end radiology services** and **musculoskeletal services** . A link to the NIA Magellan portal is available on our Account Login page.

Providers can contact NIA by phone at 866-307-9729, 7 a.m. - 7 p.m. CT, Monday – Friday, or by email at **RadMDSupport@MagellanHealth.com**.