Provider News

February 1, 2024

Your monthly Medica (formerly WellFirst Health) Provider News.

Be heart smart

February is American Heart Month. Our February preventive health toolkit highlights how blood pressure, stress, and other factors play a part in overall heart health. It also includes information about risks that can be controlled versus those that can't be controlled.

We invite you to share our monthly preventive health toolkits with your patients, when appropriate. Each toolkit includes education and awareness for many national observances and seasonally appropriate topics.

In this edition:

Why payer ID matters

Over the last several months, we've frequently referred to payer ID in our provider communications. Since our new payer ID 41822 became effective for Individual and Family Business (IFB)/Affordable Care Act (ACA) plans for dates of service on and after Jan. 1, 2024, we've been asked: **Why is payer ID so important?**

Our answer: Payer ID is important because it's an indication of which resource to use or process to follow specific to your Medica patient's benefit plan.

- Payer IDs are unique numbers assigned to health plan carriers for the purpose of transmitting electronic claims to the appropriate claims processing platform. Currently, we have two payer IDs, with each applying to specific Medica benefit plans:
    - **Payer ID 41822 was implemented this year for our new claims platform and currently applies to 2024 IFB/ACA plans only. In**

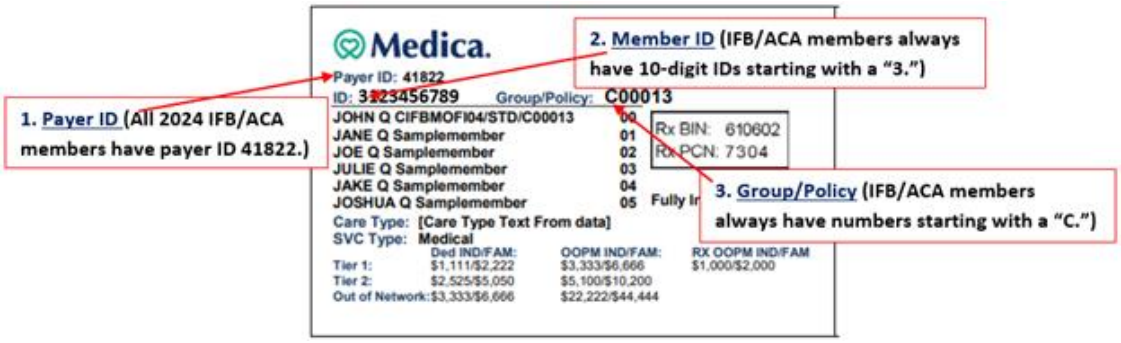
the future, we'll move other benefit plans to our new claims platform under this payer ID.

- **Payer ID 39113 applies to:**
  - Medica Advantage plans
  - SSM Health Employee Health Plan (now under the Medica brand)
  - Medica Employee Health Plan

- With the addition of payer ID 41822, we introduced processes and resources that currently apply to 2024 IFB/ACA plans only that are different than those for our other payer IDs.
- Resources and processes for our benefits plans under payer ID 39113 are *not* changing at this time. For these benefit plans, continue to submit authorizations, send claims, use the provider portal, etc. as you do today until further notice.

See the Medica (formerly WellFirst Health) Provider Quick Reference by Payer ID for which resources to use and processes to follow based on the payer ID, date of service, and patient's benefit plan.

Payer ID on member ID cards
We list the applicable payer ID for the member's benefit plan on all of our member ID cards. Here's three ways to quickly identify Medica 2024 IFB/ACA members from their ID cards and know to use the resources and processes that apply to payer ID 41822:



See more information online
Visit our Provider communications web page to see:

- Medica Provider Just in Time – preparational checklist and "how to" steps for a variety of processes timely to the start of 2024.
- Medica Advantage Quick Reference – for providers contracted to deliver care to Medica Advantage (formerly WellFirst Health) members in Illinois and Missouri for plan year 2024.
- Medica (formerly WellFirst Health) Provider Quick Reference by Payer ID – identifies resources and processes with the addition of payer ID 41822.
- How to submit IFB/ACA authorizations for 2024 dates of service – interim steps to submit authorizations while the Availity Essentials authorization functionality is being activated.
- Links to 2023 and recent 2024 articles and communications regarding our new business platforms for IFB/ACA plans, effective Jan. 1, 2024. **Just added:** Are you using the correct resources for your 2024 Medica patients?

Note: Interim processes are denoted in documents when applicable.

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, please consider providing this information so that 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.

Member rights and responsibilities

To promote effective health care, Medica clearly states its expectations for the rights and responsibilities of its members to foster cooperation among members, practitioners, and Medica.

To view these rights and responsibilities, visit the Member rights and responsibilities web page.

Termination of doctor/patient relationship

Practitioners sometimes feel it is necessary to terminate a relationship with a patient. Medica has an established policy for this, as part of our contract with providers, while assuring continuity of care for the member.

A practitioner may terminate such care only for good cause, as determined by Medica. Information regarding this process is in the Medica Provider Manual under the section titled “Termination of Patient/ Practitioner Relationship Policy and Procedure.”

Provider network consultants

While online self-service resources and the Customer Care Center are your first sources of information, Provider Network Consultants (PNCs) are health plan personnel who assist with more in-depth inquiries, when necessary. (And, always, contact your PNC to report changes or updates to your demographic information.)

Contact the Medica PNC team at ProviderRelations@Medica.com.

Medical Policy Committee updates

Highlights of recent 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, Feb. 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 NIA Magellan for authorization of physical and occupational therapy, 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 Monday-Friday from 7 a.m. to 7 p.m. CST or by email at RadMDSupport@MagellanHealth.com.