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Medica | PROVIDER NEWS

Your monthly Medica Provider News

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Teamwork in action — Using our Provider Service Center + self-service resources together

Getting the right information at the right time in health care is a big task, and our Provider Service Center's only goal is to help you achieve that. Last year, this team managed about 58,000 calls/month. Interested in understanding how you can help them help you? Here are a few tips that will lead to a smoother transaction when you call:

- Have the name of your office/facility, your tax ID number (TIN) and the member's first/last name + ID number available.
    - Pro tip – Don't have the member's ID card or ID number upfront? Use the appropriate provider portal (Availity Essentials or the health plan's portal) to do an eligibility and benefits (270/271) transaction using member first/last name and date of birth. This will return the member's ID number for future use.
- Take note of the member's plan type (Commercial, IFB, Medicare Advantage, etc.) and payer ID (39113, 41822, etc) and refer to resources on

the Provider Communications Page for newsletters, portal information, policies and more to save you a call or a few minutes of time.

- Our interactive voice response (IVR) service can help in more ways than one.
    - If you're looking for another way to verify eligibility and benefits independently, you can do so through prompts on the IVR system without having to wait for a representative. Our Provider Service Center leadership encourages providers to listen to the full prompts on the line and then make a selection to avoid unintentional menu options.
    - The IVR also routes incoming calls when you call into the main phone number: **1 (800) 458-5512**. Calls are directed based on the member ID number you enter.

- As we move from the health plan's provider portal to Availity Essentials by member plan type, some functions and information may be on one or the other. Be sure you're using the correct portal for your member or claim inquiry, and when possible, capture screen snapshots to save time with Provider Service Center staff as they research your question. Getting accustomed to finding your way in our self-service portals means no hold time for taking care of many transactions.

We appreciate your time and partnership in both obtaining and providing valuable information that betters our community's care.

Appeals submission + status now available from Availity

The appeals submission and status transaction is now available in Availity Essentials. **Log in** to start using it today.

The new Availity appeals application serves member plan types administered by payer ID 41822. Please continue using our health plan's provider portal for member plan types administered by payer ID 39113.

Effective Jan. 1, 2025:

CMS makes drug changes to Medicare Part D formulary for 2025

There are several medications that lost Medicare Part D coverage status starting Jan. 1, 2025, due to their manufacturers not participating in the Centers for Medicare and Medicaid Services (CMS) Part D Manufacturer Discount program. Effective Jan. 1, CMS removed several brand-name drugs from the Medicare Part D drug formulary, and we will mirror these changes for all of our Medicare plans that use the Part D drug formulary. We are also notifying our affected members.

See the full list of Part D drug removals.

Effective Jan. 1, 2025:

Credentialing process changes for in-training behavioral health providers

As of Jan. 1, 2025, behavioral health providers with in-training (IT) designations do not require full credentialing with the health plan. This applies to the following provider types: LPC-IT, LCSW-IT, LMFT-IT, and SAC-IT. Provider offices will need to notify their Provider Network Consultant (PNC) when the IT professional is first added to the clinic for proper claims processing, and then once again when they near completion of their formal behavioral health licensure so that full credentialing can be completed prior to the behavioral health providers independently treating health plan members.

This change aims to allow members broader access to qualified behavioral health professionals while ensuring that the health plan has the information needed at the right time. We appreciate your partnership!

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:

See Provider News Policy Notice for Feb. 1, 2025

Drug policies

Drug policies are applicable to all of our 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 **1 (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 certificate (or evidence) of coverage 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've partnered with Carelon, a utilization management (UM) program vendor, to support the provider submission and medical necessity review process for select musculoskeletal (MSK), cardiovascular and radiology services, as well as those for interventional pain management. Submissions and review by Carelon replace those previously managed by NIA Magellan (for MSK and radiology). Refer to our Medical Management Master Services List to find which services need Carelon review before providing the service. Submit requests to Carelon **using this portal** or by calling **1 (833) 476-1463**.

For help with the Carelon provider portal, contact Carelon at **1 (800) 252-2021**, option 2, weekdays from 7 a.m. to 6 p.m. Central Time. Or contact them at **WebCustomerService@carelon.com**.

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