January 1, 2025

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

New year, new opportunities

Dear valued providers:

I want to start this edition of Provider News with a sincere “Thank you!” for your partnership and your enduring patience as we worked to deliver the functionality you deserve from our systems. Our health plan’s goal is always to strive for effective, efficient and time-saving tools so that you can focus on providing excellent care for our members, but the journey hasn’t always been straightforward. Despite our best intentions, we acknowledge that the implementation of some new tools has not gone as smoothly as we had hoped.

We see 2024 as a year of evolution toward bigger and better things, and appreciate your ongoing feedback, engagement and collaboration as we move into 2025. Our team members are your patients, community and friends, and we genuinely value the work you and your teams do every day to keep us all healthier.

Thank you again for your continued partnership. We wish you a successful new year in 2025.

Sincerely,

Jeni Alm
Vice President of Provider Partnerships + Solutions

Happy new year! Reminder to verify member information

The start of the year is a busy time as many patients switch health plans and/or coverage. Changes and updates can happen due to employer groups customizing their health plan, and product offerings can change. In addition, our health plan periodically makes changes to claims addresses, member ID numbers, payer IDs or other details. Having up-to-date member information helps to ensure accurate and timely claims processing.

To confirm a member's coverage eligibility, please use our real-time resources for the payer ID applicable to your patient's benefit plan and date of service. Here's a quick rundown of which portals to use for which payer IDs.

270/271 Eligibility and Benefit Inquiry + Response transactions

- **Medica Central Provider Portal**
  - Payer ID 39113 – SSM Employee Health Plan, Medica Employee Health Plan, Medicare Advantage
- **Availity Essentials**
  - Payer ID 41822 – Individual & Family Business (IFB) + transitioned commercial groups

Resources are available to help you navigate these transactions on our **Provider communications webpage**, including our Quick Reference by Payer ID guide.

Medicare telehealth flexibilities extended through March 31, 2025

In November, the Centers for Medicare and Medicaid Services (CMS) issued the Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule, which included several provisions impacting telehealth under Medicare. While the Rule finalizes a number of updates related to telehealth services under Medicare for 2025, it also

announced the intention to end several of the temporary telehealth flexibilities that were in effect for Original Medicare during the COVID-19 Public Health Emergency (PHE). However, in late December, a short-term funding package was signed into law that allows continuation of existing PHE-era telehealth flexibilities through March 31, 2025. For providers, this means that there is no need to change the administration and billing of telehealth services for a Jan. 1, 2025, effective date.

Our health plan is reviewing the latest information and intends to align with Original Medicare policy on its requirements. We will publish additional information on our implementation of the CMS policy in future communications as needed. Providers are encouraged to **refer to CMS**, under "Telehealth Services under the PFS," to prepare for parts of the policy that could impact their work with patients.

Appeals submission + status trainings coming soon from Availity

To prepare for the upcoming release of the appeals submission and status application in Availity Essentials in January 2025, be sure to sign up for trainings intended for Dean Health Plan, Prevea360 and Medica Central Health Plan (formerly WellFirst Health) network providers.

You have two upcoming dates to choose from:

1. **Jan. 9, 2025**, at 10-11 a.m. CST: Log in to Essentials and **register for this session** on the Availity Learning Center enrollment page
2. **Jan. 16, 2025**, at 10-11 a.m. CST: Log in to Essentials and **register for this session** on the Availity Learning Center enrollment page.

The new Availity appeals application will serve member plan types administered by payer ID 41822, as well as Wisconsin Medicaid plans using payer ID MEDM1 as of Jan. 1, 2025. Please continue using our health plan's provider portal for member plan types administered by payer ID 39113.

Reminder:

Accessibility of Services standards

It is important for network providers to understand the Accessibility of Services standards. Our health plan is committed to ensuring that members using the provider network for their care have appropriate appointment accessibility. The Accessibility of Services standards for members pertain to services provided by primary care, specialty

care and behavioral health care clinic locations and can be found in the Quality Improvement section of our **Provider Manual**.

Reminder:

Notify us of changes to your demographic details

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

Review your directory information regularly on our website to verify it reflects current and accurate information for you and your organization. Notify your Provider Network Consultant of any updates to your information on file with us, including changes to any of the following:

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	

Also notify us of terminations for individual practitioners, clinics, facilities and any other locations under your organization. Terminations need to be communicated in writing to your assigned Provider Network Consultant with as much advance notice as possible.

While our vendor BetterDoctor conducts quarterly outreach to validate that our on-file information for you is accurate, don't wait for these reminders to update your information.

NPPES information
We encourage you to also review and update your National Plan and Provider Enumeration System (NPPES) information and keep it updated. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format and serves as an important resource for provider information. **Refer to NPPES online**.

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 Jan. 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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