November 1, 2024

Medica | PROVIDER NEWS

Your monthly Medica Provider News

In this edition:

Appeals submission using Availity Essentials

You're already receiving eligibility and benefits information, checking claim status and submitting authorizations for health plan members in Availity Essentials — Why not add the ability to submit claim appeals and check their status?

Availity

Arriving this fall, for health plan membership in plan types administered under payer ID 41822, users will be able to submit and track appeals in Essentials as a part of our business platform migration. This process is ongoing, and for our health plan membership in plan types administered under payer ID 39113, you will continue to use the legacy health plan portal as the electronic option for claims status, eligibility and benefits, and appeals submission and status.

Getting ready

Watch our **Communications page** for the go-live announcement and to view resources with more details about how our health plan membership is transitioning between

business platforms by payer ID.

More information, pre-recorded trainings and live webinars will be available in the **Availity Learning Center** on the Essentials portal, accessible through your Availity Essentials login. For example, you can **watch a demo video on Availity's appeals transaction**.

Note: As a reminder, the Availity Essentials portal is *only for medical prior authorization requests*. Prior authorization requests for J-code medications, for example, should be faxed to **1 (608) 252-0814** using the appropriate form found on our provider **Medical management home page**.

Quick Hits

Helpful coding tip for billing of genetic tests
When submitting a claim for a genetic test, providers should include the Concert Genetics "GTU" for the test performed. The GTU is a test-specific code created by Concert Genetics that providers are given when they register their tests with this vendor. Including the GTU on the claim ensures that the claim is processed accurately and in a timely manner. Not including the GTU can result in the claim being denied for lack of information or being denied incorrectly. Also, please make sure your billing office is submitting the codes linked to the GTU to avoid an incorrect coding denial.

Carelon tips + trainings

Effective with Oct. 1, 2024, dates of service, Medica has partnered with Carelon, a utilization management (UM) program third-party vendor, to support the provider submission and medical necessity review process for prior authorizations for certain muskuloskeletal (MSK), cardiovascular and radiology services, as well as those for pain management. As needed, requests should be **submitted online directly to Carelon** or by calling Carelon at **1 (833) 476-1463**.

Helpful tips for working with Carelon

- To confirm which service requires prior authorization through Carelon, please refer to the Medical Prior Authorization Service List on our Medical management home page (see above) prior to providing services.
- For the most optimal turnaround times and to avoid request denials, providers should fill out the Carelon intake form completely and accurately. Be sure to

submit documentation, as needed, as part of the intake steps for Carelon's program. **Note:** The order request checklist found on the **Carelon Resources page** is a good resource to prepare for prior authorization submission.
- If a request is not auto-approved, Carelon has up to 10 days to review; please plan accordingly when scheduling services.

Trainings
Carelon offers ongoing training for providers, in both live Q&A sessions as well as recorded sessions that are posted online.

Reminder on upcoming live Q&A sessions from Carelon:

Service type/topic	Date	Time (CT)	Registration
MSK (Q&A only)	Nov. 7	2:30-3:30 p.m.	**Click to register**.
Radiology/Cardiology (Q&A only)	Dec. 3	2-3 p.m.	**Click to register**.

Or view these previously recorded trainings from Carelon, available online 24/7:

Service type/topic	Recording
Radiology/Cardiology (full training)	**Click to view**. (Password: MwsYykv4)
MSK (full training)	**Click to view**. (Password: Musculoskeletal1)

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**.

Notify us of changes to your demographic information

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. Additionally, Centers for Medicare & 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:

<table>
<tr><th>Practitioner Data Elements</th><th>Location Data Elements</th></tr>
<tr><td>Practitioner Name</td><td>Location Name</td></tr>
<tr><td>Degree/Title</td><td>Address</td></tr>
<tr><td>Specialty</td><td>Phone Number</td></tr>
<tr><td>Ability to Accept New Patients</td><td>Handicap Accessible</td></tr>
<tr><td>Board Certification</td><td>Website URL</td></tr>
<tr><td>Gender</td><td>Accepted Plan Types at Location</td></tr>
<tr><td>Language(s) Spoken by Practitioner</td><td>Language(s) Spoken at Location</td></tr>
<tr><td>Telehealth Available
○ Telehealth Optional / Telehealth Only
○ Modalities (chat, phone & video)
○ 3rd Party Caregiver</td><td>Handicap Accessible</td></tr>
<tr><td>Language(s) Spoken by Practitioner</td><td rowspan="3">Services</td></tr>
<tr><td>Participating Hospital Affiliation(s)</td></tr>
<tr><td>Practice Locations</td></tr>
</table>

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.

National Plan and Provider Enumeration System (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.

Screening patients for diabetic retinopathy

To best care for patients, the American Diabetes Association recommends that those with diabetes be screened or monitored for diabetic retinopathy (DR). Diabetes is the leading cause of new cases of blindness in adults, the vast majority of which is caused

by DR. A recent study, supported by the CDC, found that the prevalence of DR was high, affecting almost one-third of adults over 40 years of age with diabetes, and more than one-third of African Americans and Mexican Americans with diabetes.

Diabetes-related blindness costs the nation about $500 million annually. While people with diabetes are clearly at a higher risk of vision loss and eye diseases, 60% do not get annual eye exams. Impaired vision and blindness caused by DR may be prevented through good glycemic and blood pressure control, and by early detection and treatment of eye diseases.

At least annually, ask your diabetic patients about their eye health and educate about symptoms to watch for. Ensure understanding by asking them to repeat back what they heard.

We recommend medical eye exam screenings for:

- Patients with type 1 diabetes – an initial comprehensive examination by an ophthalmologist or optometrist within the first five years of diagnosis
- Patients with type 2 diabetes – an initial comprehensive examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes is made

Follow-up examinations should be individualized, but completed at least once annually, in patients who have abnormal findings or if retinopathy is progressing.

If your patients have an eye exam at an outside facility, ask them to bring in a printout of their evaluation and scan it into their medical record or MyChart to help comprehensively manage their diabetic care and ensure they are staying up-to-date on their screenings. You can also encourage members to take our eye exam form with them to an outside facility. The form can be found on our **Managing your diabetes** webpage.

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 Nov. 1, 2024

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 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.

Starting with Oct. 1, 2024, dates of service, 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 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**.

This email was sent by: **Medica**
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