To view this email as a web page, go here.

October 2022

NEWS FOR MEDICA NETWORK PROVIDERS

General News

Medica makes over $1 million in charitable contributions in Nebraska

Funding of social determinants of health supports providers, communities

This year, Medica has provided over $1 million in funding to support Nebraska organizations throughout the state that address social issues affecting the health of people living in low-income communities. Of that funding, $370,000 is supporting health care providers across the state, including:

- Bryan College of Health Sciences (Lincoln, Neb.) – to support the "Focus Program" at Northwest High School that consists of a medical career pre-pathway for 9th and 10th graders, and the pre-med/pre-physician assistant pathway programs for 11th and 12th graders
- CHI Healthy Communities, Maternal Health Equity/Doula Program (Omaha, Neb.) – to improve maternal and infant health rates for women of color in Nebraska by having a doula onsite, increased opportunities for doula services, scholarships for additional doula training, and increased access to specialty care services through tele-specialty care
- Children's Hospital Foster Care Clinic (Omaha, Neb.) – to help meet the medical and behavioral health needs of children placed in foster care, providing physical examinations, psychosocial assessments, developmental screenings, dental assessments, visual evaluations, and nutritional evaluations as needed
- Great Plains Health Center (North Platte, Neb.) – to support the Salvation Army backpack program that provides school supplies and trauma prevention information
- Nebraska Methodist Hospital Foundation (Omaha, Neb.) – to eliminate barriers to behavioral health care and meet students where they are by expanding the counseling program to two additional Omaha Public High Schools opening in fall 2022
- OneWorld Health Center (Omaha, Neb.) – to meet the increased need for behavioral health services due to the disproportionate effects of the pandemic by providing integrated care through the "Warm Handoff" model
- Ponca Health Services (Norfolk, Neb.) – to help individuals of the Ponca Tribe of Nebraska receive support services in Norfolk, Lincoln, Omaha and Niobrara as a result of domestic violence; address a variety of social determinants of health; and provide emergency assistance via a food pantry
- Santee Health & Wellness Center (Santee, Neb.) – to support the incorporation of cultural traditions into community outreach efforts focused on prenatal and postpartum education to support young families; and to conduct community outreach to promote health, wellness, and disease prevention

Medica health insurance covers about 130,000 lives in Nebraska. "Medica made a commitment to be a part of the Nebraska community when we began making health coverage available in the state in 2016," said Patrick Bourne,

vice president and market leader for Nebraska. “These contributions will address underlying causes that impact health and make health care more accessible to people who need it most.”

Effective January 1, 2023:

Medica makes Medicare product, benefit changes for next year

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica’s Medicare product offering continues to expand, and Medica is making changes to its Medicare Cost and Medicare Advantage plan benefits for next year as well.

Medicare Cost plans

Effective January 1, 2023, Medica Prime Solution® (Medicare Cost) will grow by 20 counties within the Cost plan’s service area. States seeing county expansions include Kansas, Nebraska, Oklahoma and Wyoming. In Minnesota, the Prime Solution Enhanced plan offering will be consolidating the Rx and Rx2 plans. Members on the Prime Solution Enhanced Rx plan are moving over to the Prime Solution Enhanced Rx2 plan. Medica members who are affected will receive a description of the benefit changes in their Annual Notice of Changes (ANOC) mailing.

Medica’s Cost plans continue to focus on the health and well-being of members. Many Cost plans cover an annual full physical exam as well as access to health education coaching, One Pass™ fitness benefits and telehealth services are provided by Amwell. In addition to annual reimbursement allowances for dental, hearing and vision, these plans will also continue to include a quarterly allowance for over-the-counter (OTC) health and wellness products through CVS OTC Health Solutions.

Medicare Advantage plans

Medica will continue to offer multiple plan options in its Medica Advantage Solution® (Medicare Advantage) service area in Minnesota for 2023. One of Medica’s Medicare Advantage plan designs, Medica Advantage Solution H8889-005 (PPO), will have a premium reduction from $45 to $0 and expand its service area from seven counties in the Twin Cities metro area to an additional 34 counties in northern Minnesota. Medica will also reduce the premium from $39 to $19 on its lower-premium plan as part of the Medica Advantage Solution product offering in southern Minnesota.

Medica will increase the Part B premium buy down to $30 per month on its medical-coverage-only plan, which is a $0 premium Medicare Advantage product available in the entire 66-county Medica Advantage Solution service area in Minnesota. Medica Advantage Solution plans will include $0 copays on diabetic testing supplies limited to specific manufacturers, LifeScan (OneTouch) and Roche (Accu-Chek), and continue to offer $35 monthly copays for select insulins on all plans with Part D coverage. Medica will also offer reward gift cards up to $290 to members on select plans who complete certain health services.

Fact sheets with details on Medica’s Medicare products will be updated soon for 2023.

Effective January 1, 2023:

Medicare Advantage plans to require prior authorization on certain DME, other supplies

(This applies to direct-contracted providers only.)

Effective January 1, 2023, Medica Medicare Advantage plans will require prior authorization of certain durable medical equipment (DME), prosthetics and other supplies, as defined by the Centers for Medicare and Medicaid Services (CMS) in its “Required Prior Authorization List.” The most common items on this list include power wheelchairs, power-operated vehicles and certain prostheses and orthoses. The affected codes include:

- L0648; L0650
- L1832; L1833; L1850
- E0193; E0277; E0371; E0372; E0373
- L5856; L5857; L5858; L5973; L5980; L5987
- All wheelchair and scooter codes

Medica will continue to follow existing National and Local Coverage Determinations, as well as CMS claim payment guidance, supporting prior authorization of items on this list. Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of a Medicare benefit.

More information

- **See Medicare's current Required Prior Authorization List**.
- **See Medica's Prior Authorization List and learn about submitting requests to Medica for prior authorization**. *(Medica's Prior Authorization List will be updated with codes for Medicare prior authorization as of October 1, 2022.)*

Clinical News

Effective November 21, 2022:

Medical policies and clinical guidelines to be updated

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective November 21, 2022, unless otherwise noted.

Monthly update notifications for Medica's UM policies, coverage policies and clinical guidelines are available on an ongoing basis. **Update notifications are posted on Medica.com** at least 60 days prior to their effective date. The medical policy update notification for changes effective November 21, 2022, is already posted. Changes to policies are effective as of that date unless otherwise noted. ("Medical policy updates" notifications are available at Medica.com under For Providers, "Policies and Guidelines," then "Updates to Medical Policies.")

The medical policies themselves will be available online or as a hard copy:

- **View medical policies and clinical guidelines at Medica.com** as of their effective date; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1 (800) 458-5512, option 1, then option 8, ext. 2-2355.

These policies apply to all Medica products including commercial, government, and individual and family plan (IFB) products unless other requirements apply due to state or federal mandated coverage, for example, or coverage criteria from the Centers for Medicare and Medicaid Services (CMS).

Note: The next policy update notification will be posted in October 2022 for policies that will be changing effective December 19, 2022. These upcoming policy changes will be effective as of that December 2022 date unless otherwise noted. The affected policies will then be available as noted above.

Input requested by October 30:

Requesting provider perspectives on patient access to care

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon be asking providers for their feedback on patient access to care, including activities like care coordination, referrals to specialists and availability of clinic appointments. This annual survey is intended only for primary care offices, behavioral health care offices and the following specialty care offices: cardiology, dermatology, ear/nose/throat (ENT), gastroenterology, general surgery, neurology, obstetrics and gynecology (Ob/Gyn), oncology, ophthalmology and orthopedics. The survey should be completed only by office managers, administrators or practitioners since it will ask about care availability across practice sites.

This survey will be coming electronically in early October 2022. Survey responses, due by the end of October, will be confidential and grouped with other results.

Provider surveys like this allow Medica to improve service to providers as well as members. Medica would like to thank providers in advance for giving their valuable feedback.

Due by October 15, 2022:

Quality complaint reports required by State of Minnesota

(This applies to Medica direct-contracted providers in Minnesota only.)

Medica requires its Minnesota-based network providers to submit second-quarter 2022 quality-of-care complaint reports to Medica by October 15, 2022. The State of Minnesota requires that providers report quality complaints received at the clinic to the enrollee's health plan. All Minnesota-based providers should submit a quarterly report form, even if no Medica members filed quality complaints in the quarter (in which case, providers should note “No complaints in quarter” on the form).

Providers can send reports by e-mail to **QualityComplaints@medica.com**, by fax to 952-992-3880 or by mail to:

Medica Quality Improvement
Mail Route CP405
PO Box 9310
Minneapolis, MN 55440-9310

Report forms are available by:

- **Downloading from Medica.com**, or
- Calling the Medica Provider Literature Request Line, to obtain paper copies

Note: Providers submitting a report for multiple clinics should list all the clinics included in the report.

Providers who have questions about the complaint reporting process may:

- **Refer to Medica’s Provider Administrative Manual**, or
- Call the Medica Provider Service Center at 1-800-458-5512.

Pharmacy News

Effective October 1, 2022:

Upcoming changes to Medica Part D drug formularies

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica posts changes to its Part D drug formularies on Medica.com 60 days prior to the effective date of change. The latest lists will notify Medicare enrollees of drugs that will either be removed from the Medica Part D formulary or be subject to a change in preferred or tiered cost-sharing status effective October 1, 2022. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

As of October 1, 2022, **view the latest Medicare Part D drug formulary changes**.

Medica periodically makes changes to its Medicare Part D formularies: the Medicare Part D Closed Formulary and the Medica DUAL Solution® and Medica AccessAbility Solution® Enhanced List of Covered Drugs. The Medica Medicare Part D drug formularies are available online or on paper:

- **View Medica formularies**.
- **Download formularies for free at epocrates.com**.
- Call the Medica Provider Literature Request Line for printed copies of documents.

Medication request forms
A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information. To request formulary exceptions, providers can submit an exception form or call Express Scripts.

Network News

Effective January 1, 2023:

Medica to update commercial standard radiology fee schedule

(This applies to Medica direct-contracted providers only.)

Effective with January 1, 2023, dates of service, Medica will implement standard radiology fee schedule updates for Medica commercial products.

This fee schedule change will implement updates from the Centers for Medicare and Medicaid Services (CMS), incorporating CMS relative value units (RVUs) and conversion factor, as well as various CMS non-RVU fee maximums. Overall impact by practice will vary based on mix of services provided.

Providers who have questions may contact their Medica contract manager.

Administrative News

SELF-SERVICE RESOURCES

Featured this month: Timely filing e-learning

Medica has a new self-guided training on “Timely Filing and Late Claims Policies” posted on Medica.com. It’s available 24/7 for providers who wish to learn more about this topic, including an overview of timely filing for claim submissions and exceptions to the rule, plus details on claim adjustments, appeals and resubmissions. It also covers information on appeals for late claims. **See this e-learning on Timely Filing and Late Claims Policies**.

Provider administrative training webinar for October

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica offers educational sessions on various administrative topics. The following class is available by webinar for Medica network providers, at no charge.

Training class topic

"Life of a Claim"

Understanding all three components of a clean claim — submission, process and output — is important to ensure proper payment. This training will review all three claim stages in order to show how they work together to facilitate the proper processing of Medica claims. It will focus on claim submission policies and requirements; 837P and 837I electronic transactions; provider remittance advices (PRAs) and explanations of payment (EOPs); common denial reasons; and how to request claim adjustments and appeals.

Class schedule

Topic	Date	Time
Life of a Claim	Oct. 20	11:30 a.m.- 12:30 p.m. CT

For webinar trainings, login information and class materials are e-mailed close to the class date. To ensure that training materials are received prior to a class, providers should sign up as soon as possible. The times reflected above allow for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement.

Registration

The registration deadline is one week prior to each class date. **Register online for the class above**.

Effective December 1, 2022:

Medica to implement new reimbursement policy

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon adopt a new reimbursement policy indicated below, effective with December 1, 2022, dates of service. Such policies define when specific services are reimbursable based on the reported codes.

Genetic and molecular laboratory testing

Medica will implement the “Genetic and Molecular Laboratory Testing” policy to align with industry standards regarding the appropriate billing of genetic and molecular testing. Providers will be required to follow the coding recommendations in **the Concert Genetics portal** for genetic and molecular testing services.

The quality and billing integrity requirements in this new reimbursement policy will be facilitated by Concert Genetics, Medica’s partner and a software and managed services company that promotes health by providing the digital infrastructure and reliable and efficient management of genetic testing and precision medicine. Genetic and molecular laboratory testing claim audits will be conducted via a post-payment review by Concert Genetics. The new Medica policy will be applicable to both facility and physician claims reported on a UB-04, CMS-1500, or their electronic equivalent or successor forms.

Laboratory providers should do the following:

- Register with Concert Genetics via the portal.
- Self-report on quality metrics in a common framework supplied by Concert Genetics.
- Verify accuracy of the test catalog and view coding recommendations and the fee schedule.
- Utilize Concert Genetics’ recommended codes when billing for genetic and molecular tests.

This new policy will apply to all Medica members, except those enrolled in Medicare-only products. The policy will be available online or on hard copy:

- **View reimbursement policies** at Medica.com as of December 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Reminder:

Up-to-date directories help members find providers

(This applies to Medica leased-network providers as well as direct-contracted providers.)

It is important that patients and members have access to accurate, up-to-date information when seeking care in their provider network. To ensure that members have the best experience possible when looking for care, health plans need providers’ help to ensure provider details and clinic locations are up-to-date. Information in Medica’s provider directories can be reviewed and edited through the **secure provider demographic-update online tool (PDOT)**.

Directory information to regularly review and keep current includes:

- Office locations where members can be seen for appointments
- Provider names and credentials
- Specialties
- Location names
- Addresses, including suite numbers
- Phone numbers
- Clinic hours
- Practitioner status for accepting new patients
- Clinic services available
- Cultural competency training*
- Compliance with ADA*
- Website URL (optional)
- Termination of individual practitioner, closing of a site or termination of a provider entity

  * (Look for an annual update request specific to cultural competency training and compliance with the Americans with Disabilities Act, or ADA, coming soon. Medica will mail this out to providers by early October.)

It's required that provider directories be accurate and updated regularly, based on federal and state laws such as Centers for Medicare and Medicaid Services (CMS) rules and Qualified Health Plan (QHP) and Federally Facilitated Exchange (FFE) standards, and in accordance with applicable state laws, including Minnesota network adequacy statutes. As a result, providers need to update their practitioner and site-level demographic data — such as the items listed above — in Medica's directories as soon as they know of a change to that data, and to regularly review demographic information for accuracy. **See more about this**.

Note: Providers who are part of a leased network that contracts with Medica, such as a preferred provider organization (PPO), should work with their network's administrative office to update demographics with Medica, rather than make updates individually using Medica's PDOT tool. Doing so could override corrected data.

Reminder:

Providers who see certain MHCP patients need to enroll with Minnesota DHS

(This applies to Medica leased-network providers as well as direct-contracted providers.)

For both of Medica's 2022 Minnesota Health Care Programs (MHCP) Families and Children products, Medica Choice Care℠ PMAP (for Prepaid Medical Assistance Program) and Medica MinnesotaCare, providers are required to be enrolled with the Minnesota Department of Human Services (DHS) to serve these members. If providers do not take this step, *related member claims will be denied as provider liability*. **See more on the enrollment requirement from DHS**.

The Medica payer ID that applies for Medica's two MHCP Families and Children products is MEDM1. For more claim submission details, **see Medica's Claim Submission and Product Guidelines**.

Providers need to keep national Medicare demographics data current

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica wants to remind providers of the importance to review, update and certify existing provider information in the National Plan & Provider Enumeration System (NPPES). *Providers who see Medicare patients are legally required to keep their NPPES data current*. When reviewing provider data in NPPES, providers should update any inaccurate information in modifiable fields — including provider name, specialty, mailing address, telephone and fax numbers. **Refer to NPPES online**.

Coming soon:

Claim-validation updates coming to Availity for improved claim submission

(This applies to Medica leased-network providers as well as direct-contracted providers.)

In updates coming soon, expected in October 2022, Availity will be making changes for electronic claim submission that affect providers who send claims through the Availity gateway: The front-end gateway level of validation for claim submission will be elevated to Strategic National Implementation Process (SNIP) level 7. Currently, claims are validated using SNIP level 3. Availity is Medica's preferred vendor for electronic data interchange (EDI) transactions. As a result of this SNIP upgrade at Medica's prompting, Availity will validate inter-segment dependencies, external code sets — such as International Classification of Diseases (ICD) and Current Procedural Terminology (CPT®) codes, for example — and type-of-service data. Claims will also be validated against X12 standards and Health Insurance Portability and Accountability Act (HIPAA) implementation guide requirements, in addition to custom

member-eligibility requirements.

These upcoming changes will apply to electronic claims submitted using Medica payer IDs 12422, 71890 and MEDM1, but not 94265.

Note: With these EDI changes, providers may initially see an increase in claims rejections from the clearinghouse and that they will see the reason for these rejections on their clearinghouse acknowledgement report. The changes will enhance the provider experience by giving providers notification of claim data issues sooner, and will also give providers increased clarity on what specifically to change on a claim to get it through claims processing channels cleanly for a more accurate, efficient result and quicker payment. But the bottom line: Incomplete claims won't be denied so much as rejected before processing.

If providers have questions about rejection messages received on a claim acknowledgement report, Availity Client Services is available at 1 (800) 282-4548.

Updates to Medica Provider Administrative Manual

To ensure that providers receive information in a timely manner, changes are often announced in *Medica Connections* that are not yet reflected in the Medica Provider Administrative Manual. Every effort is made to keep the manual as current as possible. The table below highlights updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

Information updated	Location in manual	When posted
Updated Post-Payment Medical Record Review requirements to extend review timeframe from 12 months to 36 months for purposes of fraud, waste and abuse; removed third-level appeal opportunity for providers to appeal medical record review findings	“Billing and Reimbursement” section, in “Payment Integrity Program” subsection (**found here**)	September 2022

For the current version, providers may **view the Medica Provider Administrative Manual online**.

Do you receive Connections?
Sign up for regular updates, if you haven't already.

Subscribe

Looking for past issues?
You can access the archive on our website.

View archive

Leadership in Provider Support Areas

Lori Nelson, Senior Vice President of Provider Strategy and Network Management
Rob Geyer, Chief Operations Officer and Senior Vice President
David Webster, MD, MBA, Chief Clinical and Provider Strategy Officer
Amit Khurana, PharmD, Vice President of Pharmacy
John Piatkowski, MD, MBA, Vice President of Physician Services
Charlotte Hovet, MD, Senior Medical Director
Kristen Kopski, MD, Senior Medical Director

'Medica Connections' editor

Hugh Curtler III, Communications

Email: **Hugh.Curtler@Medica.com**

Distributed: 9/21/22

Contact Us | Privacy | Terms of Use | Unsubscribe | Manage Preferences

© 2022 Medica.

This email was sent to: hugh.curtler@medica.com
This email was sent by: **Medica**
401 Carlson Pkwy Minnetonka, MN, 55305, USA

The address above is not for mailing records or claims.

Medica Connections® is a registered trademark of Medica Health Plans. All other marks are the property of their respective owners.