PREVEA360 health plan℠

Provider News

December 1, 2023

Your monthly Prevea360 Health Plan Provider News!

The new year is right around the corner as we get ready to move Individual and Family (IFB) plans to our new, long-term business platforms, effective for dates of service on and after Jan. 1, 2024. Go to our Provider News and Provider Communications pages to refer back to the articles and communications we have released throughout the year to help providers prepare for these changes.

In this edition:

Join a live webinar featuring the new provider portal

Join us for a live preview of Availity Essentials, our new provider portal for Individual and Family Business (IFB) plans for dates of service on and after Jan. 1, 2024.

We're offering live webinars in early December on Eligibility and Benefits, Claims, and Authorizations portal functions for our health plans within the Medica family which includes Dean Health Plan, Prevea360 Health Plan, and Medica (formerly WellFirst Health). Each session is hosted by Availity and health plan experts who can guide you through the tools you need to successfully navigate the new provider portal.

Overview webinar dates and times:

- For Dean Health Plan: Dec. 11, 2 to 3 p.m. CT
- For Prevea360 Health Plan: Dec. 4, 11 a.m. to 12 p.m. CT
- For Medica (formerly WellFirst Health): Dec. 6, 1 to 2 p.m. CT

Sessions will be recorded and available online. Additional training will be offered later in December and January.

For more information about the portal, creating an account, and training opportunities, go to availity.com/medica-health-plans.

Remember, Availity Essentials will only be for IFB business initially, identified by payer ID 41822. You must retain your Dean Health Plan, Prevea360 Health Plan, or Medica (formerly WellFirst Health) Provider Portal account for all other lines of business under payer ID 39113.

Missed our Availity announcements? See our Fall 2023 and November 2023 Provider News editions.

New electronic data interchange Gateway

As our new electronic data interchange (EDI) clearinghouse, Availity will facilitate the transfer of electronic HIPAA transactions exchanged between us and providers under new payer ID 41822 for Individual and Family Business (IFB) plans for dates of service on and after Jan. 1, 2024. See our HIPAA transactions web page for EDI setup information for payer ID 41822.

Remember, the current EDI transactions under our existing payer ID 39113 will continue to be used for all non-IFB plans.

Do you work with a clearinghouse for your current transactions? Check with your clearinghouse to see if you have connectivity with Availity.

Be ready to receive 2024 IFB payments

Your organization should have received a letter from our vendor InstaMed with instructions on how to register for free electronic funds transfer (EFT). We've contracted with InstaMed to manage payment services under our new payer ID 41822 which will be effective for Individual and Family Business (IFB) plans for dates of service on and after Jan. 1, 2024. InstaMed services will include provider remittance advices, paper and electronic Explanations of Payments (EOPs), electronic funds transfer (EFT), and paper checks.

Remember, current payment services for our existing payer ID 39113 will remain for all other business.

If you have questions about the letter or registration, please contact InstaMed at connect@instamed.com.

Diagnosis and follow-up care for substance use disorders

After a patient is diagnosed with a substance use disorder (SUD) in the primary care setting, it's crucial to ensure that the patient receives treatment with a behavioral health provider. Treatment, including medication assisted-treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce substance-associated morbidity and mortality.

Here's some additional considerations to keep in mind:

- When a primary care provider makes a new diagnosis of SUD, they should schedule a follow-up visit with that patient within two weeks. Two additional visits within a month of the first follow-up visit are also recommended, preferably with a behavioral health provider. Telehealth visits are encouraged.
- If a patient does not want a referral to a behavioral health provider, ongoing follow-up visits with the primary care provider are recommended.
- Claims for follow-up visits with a primary care provider or behavioral health provider should document the same diagnosis as the initial diagnosis.
- Ensure an SUD diagnosis code submitted on the claim accurately reflects the use and severity documented in the medical record (e.g., for a patient who reports binge drinking occasionally but whose overall use pattern is not concerning, use code F10.90 [alcohol use, uncomplicated] instead of code F10.10 [alcohol abuse, uncomplicated]).
- Please be aware that an SUD diagnosis code, such as F11.20 (opioid dependence), should not be reported on claims for patients who are “dependent” on pain medications, but not considered to have an SUD. Instead, these claims should include code Z79.891 (long-term current use of opiate analgesic), which indicates that the patient is using long-term medication for pain but does not denote the presence of an SUD.
- If a patient has a history of abuse or dependence that is not currently active, please remember to use a '1' at the end of the diagnosis code to denote that the condition is in remission (example: F10.21, alcohol dependence, in remission).

Race and ethnicity during provider recredentialing

As part of our National Committee on Quality Assurance (NCQA) accreditation, Prevea360 Health Plan 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.

Explore biosimilars

A biosimilar is a biological product that is highly similar to, and has no clinically meaningful differences from, a biologic product already approved by the U.S. Food and Drug Administration (FDA). Biosimilars increase treatment options for patients, create further competition in the marketplace, and contribute to significant cost reductions for both health systems and members. Biosimilars are safe and effective treatment options for illnesses such as psoriasis, ulcerative colitis, or rheumatoid arthritis.

Numerous biosimilars have come to market recently for the reference product Humira. These biosimilar products differ in concentration, citrate content, needle size, and interchangeability status. Biosimilars have no clinically meaningful difference in safety, purity, or potency compared to the reference product.

Our Commercial and Individual and Family Business (IFB) formularies cover the following biosimilars, alongside Humira:

- adalimumab-bwwd (Hadlima)
- adalimumab-adaz (low WAC Hyrimoz)
- adalimumab-fkjp (low WAC Hulio)

Consider investigating the use of these biosimilars for your patients. These products, in addition to Humira, offer copay assistance programs (for $0 member cost share, depending on a member's benefit coverage) and/or a transition program that offers a health care debit card to help defray member costs.

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, Dec. 1, 2023

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.

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