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PROVIDER NEWS

Your monthly Prevea360 Health Plan Provider News

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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?



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 musculoskeletal (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)

Effective Jan. 1, 2025:

Commercial plans moving to new business platforms

More plans are moving to resources and processes administered under payer ID 41822.

We'll be moving Prevea360 commercial plans to our business platforms administered under payer ID 41822 as groups come up for renewal beginning Jan. 1, 2025. If you have 2024 Prevea360 Individual and Family Business (IFB)/Affordable Care Act (ACA)

patients, you're already using the business resources and processes under payer ID 41822 (e.g., Availity EDI, Availity Essentials provider portal, Customer Care with IVR system, etc.). You will use these same business resources and processes for your commercial plan patients when they renew coverage:

- Payer ID 41822 business processes will be effective for the dates of service *on and after* their renewal date.
- Payer ID 39113 business processes will be effective for dates of services *before* their renewal date.

What this transition means to providers:

- **New member ID cards:** As commercial groups renew, commercial members will receive new member ID cards with payer ID 41822, a newly assigned group/policy number, and a 10-digit member ID number.
- **Dual navigation:** Because commercial plans have varied enrollment and renewal dates, we're transitioning plans to business platforms administered under payer ID 41822 based on these dates in phases throughout 2025 and 2026.
 - This means that you'll use business resources and processes under payer ID 41822 like you do currently for IFB/ACA members (e.g., Availity EDI, Availity Essentials provider portal, Customer Care with IVR system, etc.).
 - You will continue to use current platforms under payer ID 39113 for commercial plans that have not transitioned.
- **New Customer Care number:** Effective for dates of service on or after renewal, providers will need to call Provider Customer Care at **1 (800) 458-5512** for information regarding commercial plans administered under payer ID 41822. (This is the same provider service number for 2024 IFB plan information and support).

See the [Prevea360 Plan Provider Quick Reference by Payer ID](#) that shows which resources to use and processes to follow based on payer ID. The [Prevea360 Provider Manual](#) has also been updated with resources regarding processes for payer ID 41822.

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:

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 <ul style="list-style-type: none">○ 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.

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.

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.

