Medica's Just in Time for Providers

Dec. 28, 2023

This document contains the latest information on preparation and processes as we transition to business platforms under payer ID 41822 for Individual and Family business (IFB) plans, effective for dates of service on and after Jan. 1, 2024. It will be updated as new information becomes available. Processes for all other payer IDs and plan types will remain the same until further notice.

PREPARATION CHECKLIST

Connect with our vendors and health plan resources for essential business for payer ID 41822.

Have you…

☐ **Signed up with Availity to exchange EDI HIPAA transactions with us?**
Why? Availity is our EDI clearinghouse for HIPAA transactions for payer ID 41822 – Medica/Dean Health Plan/Prevea360.
How? Go to our HIPAA transactions page for EDI setup information for payer ID 41822.
Tip: Check with your clearinghouse to see if they have connectivity with Availity to ensure that your organization is ready to exchange transactions with us. *Note*: The Confirmation Reports Portal won't include claim information for payer ID 41822.

☐ **Established an Availity Essentials Portal account?**
Why? Availity Essentials is the secure provider portal for payer ID 41822.
How? Go to our Availity page to create an account.
Tip: Access recorded webinars and register for upcoming trainings from the Availity page, as well as get current information on available functionality from this page and our Provider communications page.

☐ **Registered with InstaMed to receive claim payments?**
Why? InstaMed manages payment services (i.e., remittance advice, Explanations of Payments, electronic funds transfer [EFT], and paper checks) for payer ID 41822.
How? Go to instamed.com/eraeft to register.
Tip: Sign up for electronic EFT as a convenient, paperless, and secure way to receive claim payments.

☐ **Seen our Payer ID Quick Reference?**
Why? The reference identifies resources and processes with the addition of payer ID 41822 for our new business platforms.
How? Go to the Provider communications page and click the "Medica (formerly WellFirst Health) Provider Quick Reference by Payer ID" link.
Tip: Share the link with providers and support teams in your organization. *Note*: Any interim processes will be included in this "Just in Time" document, which will be updated for new information and/or as interim processes are replaced by long-term processes.

☐ **Seen our new 2024 member ID cards for IFB members?**
Why? 2024 IFB member ID cards have a new look and members are assigned new group and IDs numbers that are different than those from their 2023 enrollment.
How? See the Medica (formerly WellFirst Health) Provider Manual for a variety of member ID card images and the Fall 2023 (formerly WellFirst Health) Provider News article about 2024 member ID cards on page 2.
Tip: Obtaining an ID card from members will assist you in identifying which Health Plan resources and systems apply to that member.

PROCESSES

Follow processes and resources applicable to payer ID 41822. In some cases, interim processes are in place so that providers and support teams can conduct business while long-term processes are being activated.

How to…

☐ **Contact Customer Care?**
Call customer care at 1 (800) 458-5512 to speak to a representative or access 24/7 self-service through our Interactive Voice Response (IVR) system. Have your organization's 9-digit tax ID number and the

member's group and ID numbers ready when calling, as well as other information specific to your inquiry.*

Tip: Keep business hours in mind. The option to speak with a representative is only available during business hours.

☐ **Identify a member enrolled in a plan under payer ID 41822?**

- In the HIPAA 271 eligibility response, Element NM103 lists payer "HRCATE."
- In the Availity Essentials Portal Eligibility and Benefits application, benefit information for active members is returned along with the logo for their benefit plan and payer "HRCATE."
    - If a member was, but is no longer, enrolled in a 2024 Medica IFB plan, the response indicates that the enrollment is "inactive" and lists the benefits the member had before enrollment ended.
    - If a member was never enrolled in a 2024 Medica IFB plan, the response indicates that member information is missing or not found.

Tip: If member information is missing, not found, or if an error message is returned*, be sure that you're using the correct 270/271 Eligibility and Benefit Inquiry and Response or provider portal for the payer ID, member's benefit plan, and date of service.

☐ **Submit a prior authorization request?**

Follow the interim steps for your preferred submission option until the authorization submission function in Availity Essentials is activated.

Option 1: Submit an electronic prior authorization form from the Medica provider portal:

1. Sign in to your Medica (formerly WellFirst Health) Provider Portal account, select the Authorization Submission Payer ID 41822 tile from Provider Portal Home Page.
2. Click "Inpatient and Outpatient Services" at the top of the page.
3. Complete all fields on the form and click Submit. A message confirming receipt is sent. *Note:* The form must be completed and submitted within a single session as it cannot be saved and returned to for a future submission.
4. Submit the supporting documentation via one of the following ways:
    - **Fax:** 1 (608) 252-0830; **or**
    - **Email:** ifbhealthmanagement@medica.com. For emailed supporting documentation, an acknowledgement is sent to the submitter's email address.

Option 2: Fax or email prior authorization form from our website:

1. Go to the Medical Management page and select the appropriate form under the "Prior Authorization Forms" section. *Note*: The new "General" form is for Outpatient and Inpatient requests.
2. Complete all fields on the form. *Note*: Forms have been updated with added fields for information that will help facilitate authorization reviews.
3. Submit the form and supporting documentation via:
    - **Fax:** 1 (608) 252-0830; **or**
    - **Email:** ifbhealthmanagement@medica.com. For emailed requests, an acknowledgement is sent to the submitter's email address.

☐ **Obtain authorization status?**

To inquire about an **authorization status,** regardless of how the authorization was requested, call customer care at 1 (800) 458-5512 once the processing timeframe has elapsed.

All authorizations are processed in adherence to state and other regulatory turnaround times which can vary based on the authorization type and/or state in which the service will be provided. Please refer to the Medica Provider Manual for determination and notification timeframes applicable to your authorization request before calling customer care.

☐ **Receive authorization determination?**

Authorization determinations (approved/denied) are communicated via fax, regardless of how the authorization was requested, to the fax number that was entered on the authorization form. Please

monitor the return fax number for the determination. All authorization determinations are mailed to the member.

☐ **Update or cancel authorization requests?**

Make **authorization updates** and **cancellations** via:

- **Fax:** 1 (608) 252-0830; **or**
- **Email:** ifbhealthmanagement@medica.com.

☐ **Check claim status?**

As an interim step until the claim status function in Availity Essentials is activated, to inquire about **claim status**, call customer care at 1 (800) 458-5512.

Tip: At this time, claim status can only be retrieved from a representative (and not through IVR).

* If you receive an error message in the Health Plan's provider portal or Availity Essentials, please review the member's ID number, the date of service, the Provider Quick Reference, and any processes on our Provider Communications page to ensure you are submitting the inquiry to the correct portal and following the appropriate steps. If a call to customer care is necessary, please have information regarding the error message and your attempted inquiry when calling.