MEDICA

January 2021

CARE COORDINATOR NEWSLETTER

All Products

Bridging reminders

Bridging is a service for all Medica members enrolled in our Care Coordinated products that meet criteria. We have recently been informed that there has been a change to the shopping preference options. **Note:** Bridging is very fluid, they continue to change forms and process to meet the needs of their staff and the members they serve. Members who chose to pick up their items from the Bridging warehouse will not have a virtual shopping appointment. All "pick up" appointments will have their shopping completed by Bridging staff.

Please refer to the updated Bridging Benefit Guideline on the CC site: **medica.com/care-coordination/policies-and-guidelines**

A Bridging request is not considered complete until all three of the following checklists are submitted: Bridging Referral Form, Bridging Client Checklist, and the Bridging Shopping Preference Sheet. These forms can be found under the Quarterly Care Coordinator Meetings: All Products Care Coordinator Meeting December 2020 on the Medica Care Coordination website: **medica.com/care-coordination/training-resources/training-materials**

Flu Shots – it's not too late!

As we have transitioned to illness-prone winter months, we strongly advise members to complete needed preventive vaccines – including influenza (flu). Many people have put off care due to COVID-19, but we're stressing that receiving needed preventive care is the best way to avoid developing more serious conditions. Flu vaccines are important every year, but especially this year. Encouraging members to stay current with vaccines is essential to protecting their own health and the health of the community. Flu vaccines are offered by many health care provider clinics, urgent care clinics, pharmacies and health departments. Members can contact their preferred facility in advance to verify vaccine availability, service hours, age restrictions and other conditions.

Model of Care Reminder

Just a reminder that the Annual Model of Care Training was due to be completed by Dec 31st. For those CC's that have not completed this training, please take it via the link below as soon as possible.

2021 Medica Annual Model of Care Training for Care Coordinators

Note: There is no need to submit attendance logs.

New Minnesota COVID-19 hotline for immigrants and refugees answers questions in 13 languages

The state of Minnesota launched a new COVID-19 hotline this week that aims to bring information about the pandemic and related resources to immigrants and refugees.

Run through the state Department of Human Services' Refugee Resettlement Network, the hotline is live each weekday from 9 a.m. to 5 p.m. and can be reached at (651) 318-0989.

Eighteen staffers who speak 13 different languages will run the hotline during the day. People who call the hotline after hours or during the weekend can leave messages in any language. Hotline staff will return the call the next business day.

https://sahanjournal.com/health/minnesota-multilingual-covid-19-hotline-immigrants-refugees/

MSHO/MSC+

Denial Termination and Reduction (DTR) Reminders

Care Coordinators (CC) complete DTR requests following the **DTR Policy** available on the CC website. The CC will complete the **DTR Form** and submit the DTR by faxing it to the number on the DTR form. For proper completion of the DTR Form, please reference the **DTR Form Instruction** document on the CC website.

- It is pertinent the DTRs are submitted timely. As soon as the CC is aware a service or item will be denied, terminated or reduced, the CC must submit the DTR. Minnesota Department of Health has set a 10-day timeline regulation that has potential to result in financial penalties due to lack of compliance. The first day of the timeline is the date the CC determines or is notified of a denial, termination or reduction.
- When completing a DTR to reduce or terminate Personal Care Assistant (PCA) services, please include the details in the rationale section indicting what resulted in the reduction of PCA, such as decreased dependencies in an activity of daily living or the member no longer meets a specific complex health-related need, etc. The current PCA assessment and previous PCA assessment should be included with the DTR request. This information is needed to properly process the DTR request and if not included may delay the timely processing of the DTR.
- Member's service plan is based on a member's individual assessed needs. DTR's should not reference Medica Benefit Guidelines. Rationale should include if member's needs have changed and/or that member's needs will be met with the denial/termination/reduction, termination or by other formal or informal services.
- Do not complete a DTR for members who have passed away.

Medica is developing on a new web based form for submitting DTRs. When this new format is ready to implemented, we will be providing a training to review the form as well as an overview of DTRs. If you have any questions about DTRs that you would like addressed in the training, please send your questions with the subject line of "DTR Training" to **MedicaCCSupport@Medica.com**.

Members with Personal Care Assistance (PCA) on a waiver managed by the county

Care Coordinators (CC) may have a member who is receiving PCA services and is on a waiver managed by the county, such as Community Access for Disability Inclusion (CADI). Upon new member enrollment, waiver status must be verified by reviewing MN-ITS and/or Medicaid Management Information System (MMIS). The Department of Human Services (DHS) requirement for waivers is a reassessment must be completed within 365 days of the last assessment. The CC can expect a member on a waiver managed by the county will be reassessed for services, including PCA, within that time frame.

It is the CC's responsibility to be aware of members services through CADI and communicate with the waiver case manager that any medical assistance home care must be with an in network provider, including PCA. If using an out of network PCA agency upon enrollment, the CC must work with the member and waiver case manager to transition to an in network agency within 120 days from enrollment.

It is also the responsibility of the Care Coordinator to obtain the PCA Assessment that is completed by the waiver case manager or MnCHOICES assessor, and complete the referral request form for the authorization. It

is also important to align the PCA authorization dates with the waiver span.

The Care Coordinator will review the PCA Assessment and reach out to the waiver case manager and/or assessor if there are any questions about the assessment. Information from the assessment is used for care planning purposes. The CC can utilize the **DHS 5841** to facilitate communication which also provides documentation of communication. The section on the form “special member concerns or other comments” allows for narrative details. It may require a multiple attempts by phone and/or fax to connect with the wavier case manager. If you have made attempts to reach the waiver case manager with no response, please reach out to the waiver worker’s supervisor as it is imperative to obtain this document.

As a reminder, Medica is responsible for the medical assistance benefit determined by the MnCHOICES or PCA Assessment. Any PCA provided to the member in addition to the amount determined by the assessment is not authorized by Medica and is considered extended PCA and authorized through the member’s waiver.

Out of Network PCA Providers Reminder

As a reminder, Medica will authorize an out of network PCA provider only when member is newly enrolled with Medica with a current PCA authorization using an out of network provider. The Care Coordinator can authorize the out of network provider for up to 120 days from the Medica enrollment date. It is important that the Care Coordinator is working with the member to transition the member to an in network PCA provider upon enrollment and coordinate the transfer with the member, and both PCA providers. For members on a waiver managed by the county, such as the Community Access for Disability Inclusion (CADI) waiver, it is important that the Care Coordinator communicate with the county case manager to authorize PCA services with an in network PCA provider.

Out of Network PCA Authorization Process:

- The Medica Care Coordination Products (CCP) Support Specialist will receive referral request form from the CC. It is very important that the CC complete the referral request Form fully including the PCA provider name, address, phone, fax, email address and include provider Tax Identification Number (TIN) or National Provider Identifier (NPI) number. Indicate in the comments section this is a new member with an out of network PCA provider.
- The Medica CCP Support Specialist will complete the authorization and send an authorization letter to the member and the provider. The letter includes the authorization details and that the member needs to work with their care coordinator to transition to an in network provider. Per usual process, the care coordinator will still need to communicate the authorization with the provider and work with the member to transition to an in network provider upon enrollment with Medica.
- The CCP Support Specialist will send an email to the provider and copy the CC. You do not need to not reply to this email, it is for your informational purposes only. If you receive questions from the provider about set up, please refer them to Medica Provider Service Center (1-800-458-5512). The OON PCA provider will need to give information to PSC representative to get set up to bill Medica.
- If you receive questions about claims, refer providers to Medica Provider Service Center (1-800-458-5512) and can also reference the following document on **Medica.com**.

Requests for out of network (OON) PCA that do not meet the 120 day continuity of care, require a prior authorization. Care Coordinators can submit the BEI form completing the required information for OON PCA requests. This will need to include the attempts to transition member to an in network provider. The BEI will be forwarded to Medica Utilization Management for a Prior Authorization review. The member, provider CC (via fax) will be notified if it is approved or denied. If denied, the letter will include the member’s appeal rights.

PCA Assessment documents for the Member, Provider and Physician Reminder

To meet statute requirements, PCA Assessments completed by the Care Coordinator must be sent to the member and the provider within 10 business days from the date of the assessment. It is the Care Coordinator/delegate’s responsibility to send the assessment to the provider and the member when authorizing the services or when a DTR is completed.

The Communication to Physician of PCA Services document (DHS-4690) is completed by the Care Coordinator and shared with the member’s Primary Care Provider when authorizing PCA services.

SNBC/SNBC Enhanced

Housing Stabilization Service (HSS) & SNBC members

Reminder, please refer to the Medica Housing Stabilization Services Benefit Guideline posted on the Medica Care Coordination page related to the role of the care coordinator when a member is on SNBC and wanting to access HSS. The HRA that is completed by the SNBC Care Coordinator is not an eligible assessment that is used by Housing Transition/Sustaining providers in the process to get DHS approval for HSS. SNBC members must work through their waiver CM, MH-TCM, Coordinated Entry or direct to a HSS Housing Consultant provider. One of these professionals will complete the required member assessment that can be submitted along with the member centered plan needed by DHS for HSS consideration/approval.

Reminder: Medica AccessAbility Solution® Enhanced (SNBC SNP) Service Area Expansion

There's a lot of information flying around at the end of the year. So in case you missed it, as of 1/1/2021 Sherburne and Wright Counties are part of the Medica AccessAbility Solution Enhanced (HMO D-SNP) (SNBC SNP) service area. This is in addition to the existing service area that includes, Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties. We are happy that we are able to offer the benefits of this plan that combines Medicare and Medical Assistance coverage to even more adults with disabilities in Minnesota.

We're here to help
Sometimes talking over the phone is easier, or send us a secure email if you prefer.

Call us at
1-888- 906-0971 (TTY:711)

Email us at
MedicaCCSupport@medica.com

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