

Medica Care Coordinator Training Manual:

Medica DUAL Solution®
Medica Choice CareSM MSC+

For Minnesota Senior Health Options
(MSHO) and Minnesota Senior Care Plus
(MSC+) Members

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Introduction

As a representative of Medica, the Care Coordinator (CC) manages benefits provided by state plan home care services, as well as Elderly Waiver (EW) services and Personal Care Assistance (PCA) for members who qualify. The MSHO program integrates the members Medicare and Medicaid benefits. Although the MSC+ program does not include Medicare benefits, it is the responsibility of the care coordinator to coordinate services with Medicare as applicable.

Care Coordinators have the unique responsibility of assisting the member across all settings of care, transitions, and stages of the aging process. The CC is the member's primary contact for accessing all benefits under MSHO or MSC+.

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Job Duties of a Medica DUAL® Solution/Medica Choice CareSM MSC+ Care Coordinator

1. Care Coordinators work to develop a care plan with the member, and arrange for services and to assure consent to the medical treatment or service in partnership with:
 - The member and/or authorized family members or alternative authorized decision makers
 - The primary care provider, if known, in consultation with any specialists caring for the member

The Care Coordinator collaborates with the member in developing, coordinating and, in some instances, providing supports and services identified in the member's care plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the Member and/or authorized family members or alternative authorized decision makers, as appropriate to implement and monitor the care plan.

2. Upon receiving the enrollment information, within ten (10 days) contact the member to:
 - Introduce yourself to the member
 - Provide contact information
 - Answer any questions about the plan the member has

Medica provides the member a letter containing the general contact information for the entity or partner providing their care coordination along with Medica Customer Service numbers.

3. Care Coordinators conduct a **Health Risk Assessment (HRA)** of each member's health needs within the first thirty (30) calendar days of enrollment and annually (within 365 days) thereafter. The Care Coordinator is to complete a face-to-face assessment with all members annually using the appropriate HRA document for all community members:
 - MSHO
 - MSC+ with EW
 - MSC+ with personal care attendant (PCA)
 - Medica approved HRA for long term care (nursing home) members

MSC+ non-EW members without PCA may have the HRA conducted either face to face or telephonically.

See the Assessment Schedule Policy found on the [Medica Care Coordinator](#) site for information related to timelines.

The assessment addresses medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the member. The member's HRA must identify person-

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centered principles and practices: assurance that members have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected.

LTCC assessments and reassessments are used to determine access to home and community based services and/or home care services performed as part of this assessment process. Upon completion of the assessment, the Care Coordinator is required to enter specified information into MMIS for all community members.

Note: Upon implementation of MnCHOICES with a Medica MSHO or MSC+ member Care Coordinators are required to use the state's MnCHOICES tool.

4. Facilitate annual physician visits for primary and preventive care, and assist in removing any barriers member is facing related to obtaining this care.
5. Care Coordinators assist members in locating and accessing specialists and sub-specialists including those with experience in working with persons with disabilities.
6. Develop an individualized Care Plan with the member and/or authorized family members or alternative authorized decision makers following the completion of the Health Risk Assessment (HRA) process. This care plan includes goals identified during the HRA as well as the monitoring of progress towards those goals. This care plan serves as a "living document" which is updated as the members needs and services change.
7. Arrange and coordinate supports and services identified through the assessment and care planning process.
8. Assist the member and/or authorized family members or alternative authorized decision makers, if any, to maximize informed choice of services and control over services and supports.
9. Monitor and record outcomes in order to evaluate the adequacy of services and interventions.
10. Assist the member with health plan related issues as needed. This could include referring the member, family or provider to the appropriate contact point within Medica. Care Coordinators are not the primary contact for billing issues for providers. For billing issues refer providers to Medica Provider Services.
11. Coordinate with primary care, including assisting a member locate appropriate providers if needed.
12. Educate member about good health practices, including wellness and preventative activities. The CC obtains and distributes self-management materials and education to members regarding disability related conditions common among persons with disabilities.
13. Participate in Performance Improvement Projects (PIPS) or Chronic Condition Improvement Projects (CCIP) for applicable members.
14. Assist members in accessing resources and services beyond the Medical Assistance and Medicare benefit set including formal and informal supports.
15. Care Coordinators may need to complete a referral for some services that require an authorization in our system.
 - The *Referral Request Form* can be found on the [Care Coordination](#) website under *Tools and Forms*.

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- Refer to *Claims Referral Guidelines for MSC+, MSHO, and SNBC* for a list of services that require a service authorization. The guide can be found on the [Care Coordination](#) website under *Tools and Forms*.
16. Ensure smooth transitions and coordination of information between acute, sub-acute, rehabilitation and nursing facilities and home and community based settings. A transition log is required for MSHO members, highly recommended for MSC+ as all transition tasks remain the same.
 17. Stay up to date with changes that relate to Medical Assistance benefits and program changes. Attend trainings offered by DHS, PIP collaborative, Medica and other entities as needed.
 18. Care Coordinators are to have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.
 19. Complete all necessary activities surrounding nursing home placements including but not limited to DHS-3427T *LTC Screening Document - Telephone Screening* per the DHS pre-admission screening process (PAS). The document is found on the DHS eDocs site by clicking [here](#) and searching for 3427T.
 20. Conduct DHS-3426 *OBRA Level I Criteria - Screening for Developmental Disabilities or Mental Illness* and convey any information obtained during the screening to the Local Agency and send copy to nursing facility (NF). The document is found on the DHS eDocs site by clicking [here](#) and searching for 3426. Follow the OBRA Level II process if indicated.
 21. Care Coordinators are to be familiar with the Medica twenty four (24)-hour, seven (7)-day-per-week nurse line members can access. Care Coordinators are to direct members to the nurse line phone numbers on their member ID cards for use by the member when needed and educate members on the importance of this resource. More information is found in the [NurseLine by HealthAdvocate](#) section of this document.

22. **Communication and Coordination with Counties, Tribes and Providers:**

- The Care Coordinator is responsible for communications with county social service agencies, community agencies, nursing homes, residential and home care providers involved in providing care under fee for service to MSHO and MSC+ members. Communication includes HIPAA compliant electronic communication vehicles.
- The Care Coordinator coordinates with local agency/county as necessary, including use of the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* with any new Care Coordinator assignment, change of address, change of living setting, etc. The document is found on the DHS eDocs site by clicking [here](#) and searching for 5181.
- The Care Coordinator communicates with lead agencies (counties/tribes) for members on waivers such as BI, CADI, DD related to the members need for state plan home care services using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services*. The document is found on the DHS eDocs site by clicking [here](#) and searching for 5841.
- Care Coordinators are required to communicate with the receiving health plan if the member has changed health plans or with the lead agency (county/tribe) if the member has dis-enrolled and is receiving services which may need to be paid for Fee-For-Service. This communication is done using

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the DHS-6037 *Home and Community-Based Services Case Management Transfer Form*. The document is found on the DHS eDocs site by clicking [here](#) and searching for 6037. See the instructions for this form related to communications that are required.

- Care Coordinators coordinate and communicate with tribal assessors and case managers. Care Coordinators accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the Medica network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

23. Care Coordinators must be aware of services that include procedures for promoting rehabilitation of members following acute events, and for ensuring smooth transitions and coordination of information between acute, sub-acute, rehabilitation, nursing facilities, and home and community-based services settings.

24. **Range of Choices**

Care Coordinators work with members to ensure access to an adequate range of elderly waiver and nursing facility services and will provide appropriate choices among nursing facilities and/or elderly waiver services to meet the individual needs of members who are found to require a nursing facility level of care.

These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying institutionalized members whose needs could be met as well or better in non-institutional settings and methods for meeting those needs, and assisting the institutionalized member in leaving the nursing facility. For purposes of this section, the word “assisting” includes, but is not limited to, discharge planning and care management responsibilities.

25. **Coordination with the Local Agency (county or tribe).** Referrals and/or coordination with county social service staff are required when the member is in need of the following services (as outlined in the DHS contract):

- Pre-petition Screening
- OBRA Level II Screening for Mental Health and Developmental Disability
- Spousal Impoverishment Assessments
- Adult Foster Care
- Group Residential Housing Room and Board Payments
- Chemical Dependency room and board services covered by the Consolidated Chemical Dependency Treatment Fund
- Adult Protection

26. **Identification of Special Needs & Screening information**

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Care Coordinators implement and coordinate with other care management and risk assessment functions conducted by appropriate professionals when indicated, including Long Term Care Consultation (LTCC) and other screenings to identify special needs such as but not limited to:

- Common geriatric medical conditions
- Functional problems
- Difficulty living independently
- Polypharmacy problems
- Health and long term care risks due to lack of social supports
- Mental and/or chemical dependency problems
- Mental retardation
- High risk health conditions
- Language or comprehension barriers

This information is shared with the new health plan in the event that the member chooses to transfer to that health plan.

27. Medica Care Coordinators make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) for members eligible for VA services.
28. Advance Directive Planning is important and the Medica Care Coordinator shall inform members of resources available for advance directive planning based on individual member needs and cultural considerations. Members receive an advance directive document in their new member packets.

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MHSO Rate Cells/MSC+ Classifications

MSHO rate cells

MSHO members are assigned to a rate cell. This categorization determines the monthly capitation payment paid by the state and CMS to the health plan. The information entered in the Medicaid Management Information System (MMIS) by the CC and MAXIS by the county financial worker determines this assignment. The principle determinants are living arrangement, Nursing Home Certifiability and Elderly Waiver Status. The criteria for nursing home certification are on the *Nursing Facility Level of Care Criteria* document. The document is found on the DHS eDocs site by clicking [here](#) and searching for 7028.

A change in rate cells is an automated process through the state's data system. The new rate cell will be assigned to members if the data is entered by the Care Coordinator by the capitation date for the following month.

Nursing facilities need to submit DHS Form 1503 to counties to change a member's living arrangement to "institutional". If the nursing facility has not done this, the county financial worker may need to be contacted by the CC.

Drug copay is tied to living setting. Institutional members do not have drug copays. Until living setting is changed by the financial worker, the copay is member liability.

MSC+ classifications

MSC+ members do not have rate cell categories as MSHO members do. MSC+ members are placed in the following 3 classifications based on where they live and waiver status:

- MSC+ community (non-EW)
- MSC+ EW
- MSC+ institutional

MSC+ group numbers help identify whether a member is coded as institutional or not. The group number identifies if a MSC+ member has Medicare or does not have Medicare. The [Care Coordination Product Group Numbers for Medica Special Needs Plans \(SNP\) and Minnesota Senior Care Plus \(MSC+\)](#) document on the Medica Care Coordination page shows these differences.

NOTE: If providers working with Medica members are wondering where they can get more information on MSHO or MSC+ there are provider fact sheets that overview the Medica products located on [Medica.com](#)
Providers → Administrative Resources → Product Information.

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Health Risk Assessments (HRA) and Medicaid Management Information System entry (MMIS)

Assessments

Per DHS requirements, Care Coordinators must conduct a health risk assessment of each member's health needs within thirty (30) calendar days of the enrollment date for MSHO and MSC+ EW and within sixty (60) days for MSC+ non-EW. Reassessments will be completed within 365 days of the previous HRA. The assessment addresses medical, social, environmental and mental health factors. See the [Assessment Schedule \(MSHO, MSC+\)](#) and [Care Coordination Accountability \(MSHO, MSC+\)](#) for more information.

Assessment requirements

MSHO Rate cell A and B:

MSHO requires face to face visits annually and as needed. Medica utilizes the LTCC or Health Risk Assessment for MSC+ and MSHO (used for members on other waivers) for assessing all community members. **Care Coordinators must enter the assessment into MMIS on or before the capitation cut-off date.**

MSC+ Telephonic Option:

All MSC+ EW members or MSC+ non EW members with PCA services must be seen face to face annually and as needed. MSC+ non EW members without PCA may be assessed telephonically.

If you do complete an assessment telephonically for a MSC+ non-EW member:

- Complete the DHS-3428 H *Minnesota Health Risk Assessment Form*
The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428 H.
- Benefits of telephonic assessments:
 - Less time to complete the assessment
 - Members who refuse a home visit may agree to complete telephonic assessment
- A signature sheet is sent to member along with member letter and care plan
 - Include a self-addressed stamped envelope, and ask for member to return the signed sheet to you
 - Document in your case notes that you sent this to the member and when you receive this back from member
 - Best practice is a minimum of two (2) documented attempts to obtain member's signature

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- If a member requests a LTCC be completed, CC must complete a face to face visit within twenty (20) calendar days

NOTE: Upon implementation of the MnCHOICES assessment for members Care Coordinators are required to use the HRA component of the state's MnCHOICES tool which will then meet the requirements of this section.

Institutional members

If a member assigned to you is admitted to a nursing facility, and during that time is due for their annual assessment, you can complete the Institutional Assessment found on the [Medica Care Coordinator](#) site. If the member is in the process of discharging to the community, complete the LTCC assessment. Be sure to follow the pre-admission screening process, also known as PAS when needed. See the [Partner Nursing Home Checklist](#) for more information.

- MMIS entry of the Preadmission Screening activities (PAS) is needed to follow state and federal requirements that prohibit medical assistance payments for NF services provided prior to completion of required preadmission screening. It confirms the need for nursing facility level of care and screens people for mental illness or developmental disabilities. This MMIS entry is done by day 30 of placement. Activity type would be 01 Telephone Screen. Communication of the nursing facility admission is made to the financial worker using the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* and the OBRA activities completed. The document is found on the DHS eDocs site by clicking [here](#) and searching for 5181.
- Institutional members are to be assessed annually at a minimum and with changes in condition. CC to communicate with PCP, if known, annually at a minimum.

Medicaid Management Information System (MMIS)

Per the contract with DHS, MMIS entry is required for all MSHO and MSC+ members who are not in a nursing home/institution, even if the member has refused to participate in an assessment, or is unable to be located. MMIS entry must be completed timely, completely and accurately. DHS provides Medica some reporting which identifies when entry has been missed or entered late and you will be contacted if you have a member on this list.

Per DHS MMIS entry manual for MSHO/MSC+ (DHS edoc #4669):

“Because this document plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, each agency must ensure timely submission of the LTC screening document information into MMIS. It is strongly recommended that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS”.

The document is found on the DHS eDocs site by clicking [here](#) and searching for 4669.

Missing members and refusing members

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If a member has refused an assessment or can't be located MMIS entry is required by DHS. See the *Assessment Schedule Policy (MSHO, MSC+)* and *Unable to Reach/Refusing Member* policy on the [Medica Care Coordinator](#) site for more information related to the MMIS specifics.

DHS resources related to MMIS entry:

- DHS-3428 *Minnesota Long Term Care Consultation Services Assessment Form*
The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428.
- DHS-3428H *Minnesota Health Risk Assessment Form*
The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428H.
- DHS-4669 *Instructions for Completing and Entering the LTCC Screening Document into the MMIS for the MSHO and MSC+ Programs*
The document is found on the DHS eDocs site by clicking [here](#) and searching for 4669.
- [Pre-Admission Screening Bulletin #19-25-02R](#)

The MMIS health plan code for Medica is **MED**.

MMIS must be kept current with the name of the current CC assigned to each member per DHS contract. See the [Assessment Schedule Policy \(MSHO, MSC+\)](#) for more information on this process.

Community Members on a waiver other than Elderly Waiver:

Members on Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), or Developmental Disability (DD) waivers can be enrolled in MSHO or MSC+. Care Coordinators use the [Minnesota Health Risk Assessment \(DHS form 3428H\)](#) at least annually or as needed. The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428H. This data gets entered into MMIS as "H" screening documents. CC is required to communicate and coordinate with the members waiver case manager including but not limited to sharing of information including the care plan and joint visits with the member.

Key points and best practices for providing care coordination for members on other waivers:

- A Care Coordinator can see in MN-ITs if the MSHO or MSC+ member is on another waiver.
- If the member has a legal guardian they must be contacted and invited to be present at the assessment. The legal guardian can decline to be present; if they do that must be documented. If present, the legal guardian signs any paperwork; if not present paperwork needs to be sent to the legal guardian for review and signature.
- If the member lives in a group home setting, the CC must communicate with and meet with the group home provider to let them know that we are involved and create a relationship for team work on the member's behalf.
- Assessment timelines, care plan timelines and, follow-up contact schedules apply.
- The waiver worker is seen as the member primary case manager (lead agency) as most of the member's Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) needs are being met by the disability waiver services.

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- The CC does not need to complete a LTCC (DHS 3428). The county waiver worker enters a screening document into MMIS.
- The CC completes the Minnesota Health Risk Assessment (3428H) annually and with significant change of condition and keeps it in their records. The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428H.
- Request a copy of the waiver workers care plan and refer to that when completing the MSHO/MS^{C+} care plan.
 - The CC completes a care plan, and indicates on this care plan when items are being managed by the county waiver worker and refer to the waiver care plan if received. Include copy of the county care plan in the member's records. CC completes sections of the care plan not addressed by the waiver worker including by not limited to: advanced directives, preventative areas, PIP related areas, etc.
- The CC communicates with the waiver worker (DHS MCO/County/Tribal Agency Communication form # 5841) throughout the year when necessary, and request that the waiver worker includes them in their annual assessment of the member. The CC also provides the waiver worker with a copy of the completed care plan as a way to create a collaborative, integrated care plan.
- For members on waiver programs other than EW, the county case manager is responsible for completing the PCA assessment through MnChoices. Once completed the CC submits a Referral Request Form to have authorization entered. The form is found on the [Medica Care Coordinator](#) site under *Tools and Forms* CC is responsible to communicate with waiver case manager to be sure annual PCA reassessment (MnChoices or legacy document depending on county) is completed so that there is no gap in the member's service/authorization.

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Care Planning

Care Planning is an essential and required task completed by the Care Coordinator with the member and/or their responsible party. Information obtained during the HRA is incorporated into an Individualized Care Plan (ICP) that is individualized to the member and reflective of their health care needs, goals, wishes and values. The ICP centers on the member goals and priorities as well as input received from the member's interdisciplinary care team (ICT) with the goal to improve or maintain their health and functioning. A comprehensive care plan is written and maintained for each member except for MSHO and MSC+ members who live long term in a nursing home, they do not require a care plan.

1. A comprehensive care plan is written and maintained for each member on MSHO and MSC+ that is not identified as unable to contact or a refuser; for MSHO members the *Unable to Contact Refusal Care Plan* must be completed. Members who reside in long term care do not require a care plan to be written.
2. Care Coordinators develop, monitor, and update the member's care plan based on the HRA, including person-centered principles and practices within thirty (30) days of HRA completion.
3. Care Plans must include the following components:
 - a. **Interdisciplinary/Holistic Focus**- The care plan should incorporate the primary, acute, long term care, mental health and social service needs and wishes of each member with coordination and communication across all providers.
 - For community members, communication with primary care (see PCP letter template), attending appointments as needed and involving family in care planning process and visits.
 - b. **Preventative Focus**
 - For community members: this may include immunizations, vision, hearing, and dental exams, tobacco cessation, alcohol use, fall risk, medications and nutrition.
 - c. **Disease Management**- Adoption of protocols and best practices are encouraged. Care Coordinators are to provide education to members as needed. See the Health Improvement Programs section under tools and forms on the CC webpage for more information.
 - d. **Back up for emergency situation**- Assist the member/responsible party in planning for emergency situations, such as sudden illness, accident, worsening of chronic conditions. This planning should also include back up plans for essential services.
 - e. **Safety Plan**- This is completed when there is a safety concern or risk identified with the member. If there are identified health and safety risks, document how these will be addressed with services or the members plan for managing risk in the applicable portion of the care plan. If the member doesn't have a plan because member doesn't have the risks identified or doesn't believe they have any risks, note this on the applicable section of the care plan. If the Care Coordinator offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted.
 - f. **Advance Directive Planning**- Care coordinators review health care directives annually and with changes in care needs. These reviews are documented on the care plan. This includes documentation of

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refusals. All Medica MSHO and MSC+ members receive an Honoring Choices health directives packet in their enrollment materials. These materials are also available in several other languages from the Honoring Choices website.

- g. **Annual Comprehensive Primary Care Visit-** Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.
- h. Care plans must be written in SMART format and include:
 - Identified goals and member specific interventions; including who is responsible for each intervention (for example: “Jane Doe will...”; “care coordinator will...”)
 - Monitoring and evaluation of goal outcomes must include dates; the date to evaluate outcomes will be the date of the next follow-up contact or at a minimum be the next scheduled reassessment date.
 - Identify possible barriers, such as lack of transportation, language, cognition, and design interventions that address these barriers so goals can be achieved
 - Underlying barriers/issues can be discussed under CC recommendations
 - A schedule for a follow-up plan and communication

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Member Transitions

Monitoring and managing transitions, whether they are planned (ex. scheduled knee surgery) or unplanned (emergency admission due to an acute episode) are an important function of the CC. Not only does CC involvement make the transitions more seamless, it also is a requirement from the Centers for Medicare and Medicaid Services (CMS).

When a member goes to the hospital or other care setting due to a change in condition, this is considered a Transition. Care Coordinators encourage members to inform them of both planned and unplanned transitions. A planned transition is typically due to a surgical procedure, the member/responsible party is involved in the planning and timing of the admission. An unplanned admission is usually due to illness or accident.

Transition requirements

Within one business day of notification of admission:

- Communicate with the receiving facility to share key elements of the care plan. This may include but is not limited to:
 - Current services
 - Informal supports
 - Advance directives
 - Medication regimen
 - CC contact information
- Communicate admission with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member/responsible party to learn about any changes in health status and/or care needs. Explain the transition process and provide CC contact information for additional support.

As needed after notification of admission:

- Start a new note if there are additional transitions that occur before return to the usual care setting.
- Update the member's plan of care.

Upon discharge to the member's usual or "new" usual care setting:

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- Communicate discharge with primary care provider (PCP), if known, within one business day of notification unless PCP was the admitting physician
- Communicate with the member and/or authorized family members or alternative authorized decision makers about:
 - The care transition process
 - Changes to the member's health status
 - Plan of care updates
 - Educating member/responsible party about transitions and how to prevent unplanned transitions/readmissions. Education should include but is not limited to:
 - The importance of keeping appointments
 - Understand discharge instructions
 - Medication self-management
 - Knowledge of warning signs and response needed
 - Addressing potential barriers (adequate food, housing transportation, home safety, vulnerability concerns etc.)

Transition care resources

- [Notification of Care Transition Fax](#)
- [Transition Log](#)

The Transition Log is only required for MSHO members and does not need to be completed for MSC+ members. However, care coordinators should work to support and manage members during all transitions regardless of whether the log is required. If log is not used for MSC+, it is expected that the Care Coordinator will document transition management activities.

- **Note: Relocation Service Coordination Targeted Case Management (RSC-TCM)** – A form of TCM that provides coordination of activities to help a person who resides in an eligible institution gain access to medical, social, educational, financial, housing and other services and supports that are necessary to move to the community.
 - The *expectation* of DHS and Medica is that Relocation Service Coordination (RSC) is provided by the care coordinator and well within the scope of the CC's role.
 - RSC from an outside provider is permissible when a member comes to Medica already receiving the service and chooses to continue utilizing that RSC-TCM provider.
 - There may be extenuating circumstances where an outside provider may be used. If this is the case, the CC should consult with the Clinical Liaison before accessing these services.

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Communication

Primary Care Provider (PCP) communication

Care Coordinators must communicate with the member's primary care provider, if known, at least annually, as well as with changes of a member's condition and member transitions. Medica encourages the use of the PCP letter template. The annual communication is documented in the member's case notes.

Communication with Waiver program worker

For MSHO/MS^{C+} members on waivers other than EW such as BI, CADI, and DD, the care coordinator has the responsibility of communicating and collaborating with that waiver worker to be sure the members needs are being met, that the waiver worker is part of the interdisciplinary care team, and that there are no duplication of services occurring. The DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services* form could serve as the communication tool as well as other methods such as phone calls. The document is found on the DHS eDocs site by clicking [here](#) and searching for 5841. All communication is documented in the member's case notes.

A listing of county contacts, as well as county managed care advocate at each county is located on the DHS website.

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Member Transfers

When members transfer between Care Coordinators (change of care system, member relocated, etc.), the exchange of the transfer paperwork is not only a requirement, but is important to the receiving Care Coordinator. It allows them to continue the work done by the previous Care Coordinator without always requiring the member to go through the assessment and care planning process again.

With all transfer requests transfer paperwork is required to accompany the request. At a minimum this includes:

- The DHS-6037 *Home and Community-Based Services Case Management Transfer Form*. The document is found on the DHS eDocs site by clicking [here](#) and searching for 6037.
- A copy of the current assessment
- A copy of the current care plan.
- A copy of the member signature page

Note: The only exception to this is if the member is a missing member or has refused an assessment, the minimum amount of information we require are notes related to your attempts to reach or engage the member.

If there are additional documents you are still completing and plan to send at a later date, indicate that with the transfer request so the receiving Care Coordinator knows when to expect it. Medica enrollment confirms the transfer. The transfer documents are sent via Sharefile.

The *Transfer Responsibilities* policy is found on the [Medica Care Coordinator](#) site under *Policies and Guidelines* → *Policies*.

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Disease Management/Condition Management

Medica offers a Disease Management Program for members per our contract with DHS. Care Coordinators help support members in the following ways:

- Refer to leading organizations materials when providing education to members such as American Cancer Society, National Alliance of Mental Illness (NAMI), etc.
- Refer to websites such as Medline Plus, Center for Disease Control (CDC), etc.
- Refer to materials on the [Medica Care Coordinator](#) site under *Tools and Forms* → *Gaps in Care*
- Record all disease management intervention and education in the member's case notes.

Medica has a disease management program for the following conditions:

- Asthma
- Diabetes
- Cardiac

Members with these above diagnoses are identified for the program via a predictive modeling identification process and are contacted by Medica to be part of the disease management program. Members in the program can receive resources for their condition; an online “digital coaching” program or telephonic disease management with a nurse based on their risk factors and severity of their illness.

- Care Coordinators can refer members to the Disease Management program and the Tobacco Cessation program at Medica by completing the *Complex Case Management/Health Support Referral Form* found on the [Medica Care Coordinator](#) site under *Tools and Forms*.

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Provision of Services

Following is an incomplete list of benefits. Care Coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services. MSHO members have access to supplemental benefits through Medica that may change each calendar year. To learn more about these supplemental benefits see the *MSHO Supplemental Benefits* document found on the [Medica Care Coordinator site Policies and Guidelines → Benefits Guidelines](#).

See the Member Handbooks on each product page for detailed information regarding benefits.

Reminder: For MSHO and MSC+, the waiver is the payer of last resort, and the Care Coordinator is responsible for seeking out formal and informal services prior to accessing waived services.

Medical services

- MSHO members are entitled to all services covered under Medicare, Medical Assistance and elderly waiver (if eligible for and open to EW).
- For MSC+ members who do not have Medicare, providers will bill Medica.
- For MSC+ members who have Medicare, providers will bill Medicare first; Medica will coordinate benefits (referred to coordination of benefits or COB) with Medicare.
- The role of the CC is not to make medical decisions. The CC often times will receive requests for approval of medical services. Providers are to call Medica Provider Service for verification of benefits and to inquire whether prior authorizations through care management are required. Care systems may choose to direct members to in-network care. Refer to the *Quick Links* on the [CC website](#) and choose which product you are coordinating for and from that product page choose *find care*.
- Prior Authorizations (PA): Medica has a list of selected procedures which require a prior authorization. These claims will not pay without a referral in the system. Medical procedures on the PA list are determined by Medica Health Management. The Health Services department at Medica reviews the requests for Medical Prior Authorizations.

Elderly Waiver (EW) Services

- MSHO and MSC+ use the same list of EW services and criteria for eligibility provided by traditional EW. See [DHS MHCP Manual](#) for list of EW services.
- See the complete listing of what requires a referral on Medica.com got to [Tools and Forms](#) *Claims Referral Guidelines for MSC+, MSHO and SNBC*.

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Home care services - state plan services

- MSHO and MSC+ include all state plan homecare services. **Services must be obtained through a Medica contracted provider.** All services are coordinated with the agency.
- Home health aide, extended home health aide, home care nursing (HCN – formerly private duty nursing or PDN) and homemaker services require a referral in our system.

Hospice

Hospice care is end of life care provided by health professionals and volunteers. They give medical, physiological and spiritual support. The goal of hospice care is the help people who are dying have peace, comfort and dignity. Caregivers and care providers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. Hospice programs also provide services to support a person's family.

Hospice Election

If the recipient eligible for both Medicare and Medicaid and elects hospice, they must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are eligible for both.

For a member who has elected hospice Care Coordinators continue to stay involved, complete all care coordination processes including annual reassessments and corresponding paperwork, and communicate and collaborate with the hospice provider.

Initiating the Benefit

Hospice Election paperwork is presented to the member/family by the hospice agency. There is both a Medicare and MA Election for dual eligible members. The hospice agency describes the coverage benefits to the member at time of signing.

- Medicare Election: Sent by agency to CMS
- MA Election: Sent by agency to DHS

NOTE: A member may choose to dis-enroll from hospice at any time after their election. "Regular" Medicare benefits are resumed at that time. The member may re-enroll at any time beginning with the next hospice benefit period.

Providers are responsible to notify Medica when a member elects Hospice. A "hold" is put on claims in Medica's system which prevents hospice related claims from paying in error. For hospice services and services covered by Medicare Part A or B that relate to the terminal prognosis, the hospice provider will bill Medicare for these services. Medicare will pay for hospice services related to the terminal prognosis.

Hospice Certification

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The hospice program must have physician certification that the member has a terminal condition with a prognosis of six (6) months or less (assuming that the clinical disease process follows its normal course). Patients can be “recertified” if necessary. Hospice is suitable for individuals with end stage chronic conditions as well as cancer diagnoses.

Hospice and Waiver Services

When a member enrolls in hospice it is essential for the care coordinator to be in communication with the members interdisciplinary care team which includes the hospice provider and revise the service plan as needed to prevent duplication of services.

Location for Care

May be whatever residence the member considers to be his/her home which can include nursing care facility.

Medicare Hospice Benefit

- All hospitalizations, home care and respite services for the care of the person’s terminal condition.
 - Any hospitalizations, services or home care related to management of conditions unrelated to the terminal disease process are covered under the “regular” Medicare benefit. These services are billed directly to Medicare.
- Medical supplies (including oxygen) and Durable Medical Equipment (DME) coverage for equipment related to management of the terminal condition: Dressings, incontinence products, nutritional supplements, hospital bed, pressure mattress, commodes, etc.
 - At the time of a member’s hospice election it is important to coordinate with the hospice program about what DME and supplies they will cover. Then, the CC must communicate with their Referral Associate to update related authorizations in the Medica system with an end date (the member’s date of hospice election) for those services that will be covered by hospice and not Medica, and coordinate with the hospice to determine who will communicate with providers.
- Medications for management of the terminal condition.
 - Coordination with the hospice program concerning which, if any, medications they will not cover and for which Medica will continue to have responsibility is necessary.
- Usual core services of hospice include: Nursing, medical social work, counseling/spiritual care. Other services include volunteers, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and home health aide. Members may also still be receiving personal care assistant services. Coordination with the hospice program to maximize that benefit first will be necessary.

Care Coordinator Role in Hospice Care

- Continue to facilitate communication with the interdisciplinary care team involved in members care. Hospice will have regular care coordination conferences. Consider asking to join for case discussion.

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- Continue to communicate with the member's interdisciplinary care team.
- For further information refer to the *Hospice Benefit Guideline* on the CC website under [Policies and Guidelines](#).

Note: Hospice agencies can be found through the online provider directory.

Interpreter services

- MSHO and MSC+ members are eligible for sign and spoken language interpreter services that assist the member in obtaining covered medical services. The health plan is not required to provide an interpreter for activities of daily living (ADL's) in residential facilities, or that are related to waived or non-medical services.
- Medica has contracted providers for interpreter services and the use of non-par vendors is not permitted.
- Telephonic translation services are available for CC's to use when contacting members who speak a different language. TransPerfect is the vendor resource used for telephonic translation services. **CC's can reach out to ProviderOversight@medica.com for further information.**

Medication Therapy Management (MTM)

MTM is a service designed to help the member get the most benefit from their medications and avoid problems, get education on prescribed medications, and often results in reduced costs for medications. The analytical, consultative, educational, and monitoring services provided by pharmacists under this benefit facilitate the achievement of positive therapeutic and economic results from medication therapy.

- How and when to take their prescriptions and over-the-counter medicines.
- How their medicines work and what they can expect them to do.
- What they should do if they think a medicine isn't helping them, or if they are having problems with side effects.
- Help them to identify medications that are interacting in negative ways, and improve how all medications work together.
- Review any non-prescription medications or supplements to make sure they are appropriate for the member's conditions and other medication therapy.
- Identifies goals that the member has for their medications, to engage the member in their own treatments.

For MSHO members

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Medica will determine if MSHO members meet the criteria for MTM. Medica will then provide information to eligible members via mail or over the phone.

MSC+ members *with* Medicare

MTM is provided through their Medicare part D. Members must receive MTM services through providers who accept the members Medicare Part D coverage such as the pharmacy from which they receive their prescriptions.

MSC+ members *without* Medicare

MTM is provided by a DHS MHCP credentialed provider. DHS credentialed MTM pharmacists found on the [DHS website](#).

How it works for members without Medicare:

1. The member calls a participating pharmacy to make an appointment to meet with a pharmacist.
2. The member brings their Medica ID card along with all of their prescription medications, over-the-counter (OTC) medications, and herbals/supplements.
3. The pharmacist reviews the medications with the member to identify any areas of concern, duplication, and cost savings for the member.

Mental/behavioral health and substance use disorder treatment

Medica uses the Medica Behavioral Health (MBH) network. Mental Health Providers contact MBH directly for authorizations.

- MBH assigns a “care advocate” to all inpatient mental health stays. Please contact MBH to coordinate care planning efforts.
- The CC coordinates with county mental health providers for those services provided through the county.
- MBH is available for case consultation by completing a consultation request form which can be found on the CC website under tools and forms-other forms.

NurseLine™ by HealthAdvocate™

Our member’s health care needs do not always follow regular business hours so NurseLine by HealthAdvocate is an easy-to-use phone service staffed by registered nurses twenty-four (24) hours per day, seven (7) days per week. NurseLine by HealthAdvocate offers valuable health information resources that can help our members get the medical care they need quickly. With one call, the nurses can instruct the members on the care of minor illnesses and injuries at home, as well as help them find a doctor near their home.

Medica 24 hour nurse line: 1-866-715-0915, TTY (711).

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Nursing facility Services for MSHO and MSC+

- **MSHO:** Medica is responsible for paying a total of 180 days of nursing home room and board. If the member requires continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for the care. Upon enrollment, if DHS is currently paying for the member's care in the nursing home, DHS, not the health plan, will continue to pay for the care. No prior hospital stay is required. Facilities are responsible to contact Medica related to admissions.
- **MSC+:** Medica is responsible for paying a total of 180 days of nursing home room and board. If the member needs continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for the care. Upon enrollment, if DHS is currently paying for the member's care in the nursing home, DHS, not the health plan, will continue to pay for the care. Facilities are responsible to contact Medica related to admissions.
- **For nursing home inquiries contact NFCcommunications@medica.com**

Palliative Care

Palliative care treats pain and other physical symptoms, as well as emotional and spiritual concerns. It helps patients and their families understand their illness and treatment choices, as well as address financial and community resource options.

Personal Care Assistance for MSHO and MSC+

The care coordinator is responsible to complete the PCA assessment using the DHS 3428D *Supplemental Waiver PCA Assessment and Service Plan*. The document is found on the DHS eDocs site by clicking [here](#) and searching for 3428D. The PCA assessment is a supplement to the HRA, and must be completed along with the LTCC assessment.

Medica requires that all CC's view the DHS Legacy PCA training video series on the DHS website. CC's are also required to review Medica's PCA Training under [Training Materials](#) on the CC website.

PCA requires an authorization in Medica's system. Authorizations may not exceed 365 days in length. PCA assessments are completed at least annually.

If an MSHO or MSC+ members is new to Medica and is already receiving PCA services, Medica will honor the current authorization and no new PCA assessment is required. The CC may need to complete more than one HRA in the first year in order to align the LTCC/HRA with the PCA assessment. See [Assessment Schedule Policy MSHO/MS+](#) for more information on this topic.

PCA reassessments are to be completed annually and with change of condition/supports.

If a member new to Medica already receiving PCA services from a provider that is *not* in the Medica network, Medica will authorize PCA services with that out-of-network provider for up to 120 days. In that time the CC must work with the member to find an in-network PCA provider. The CC will

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complete the Referral Request Form, indicating on the form that services are being received temporarily from an out of network provider. The Referral Request Form can be found on the [Medica Care Coordinator](#) site under *Tools and Forms*

Following a PCA reassessment, if there is a denial, termination, or reduction (DTR) related to a service change the CC must follow DTR process. The *DTR Form and Instructions* are found on the [Medica Care Coordinator](#) site under *Tools and Forms*

Pharmacy Services

- MSHO includes Medicare Part D pharmacy coverage. MSHO also covers medications under Medical Assistance, such as over-the-counter medications with a prescription.
- MSC+ includes medications covered under Medical Assistance including over-the-counter medications.
 - If an MSC+ member does not have Medicare, Medica pays for all covered medications
- Helpful information about the pharmacy benefit, list of covered drugs (formularies), and covered pharmacies are available on Medica.com, under each specific [product page](#).
- Medications must be obtained at a Medica contracted pharmacy.
- Medica customer service can be very helpful in terms of pharmacy questions for members and/or care coordinators.
- Co-pays for prescriptions:
 - Members who have Medicare and reside in the community (MSHO and MSC+) have co-pays for their Part D medications.
 - MSHO members do not have co-pays for over the counter (OTC) medications.
 - MSC+ members may be charged a low co-pay for OTC's.
 - When the member has been changed to an institutional living setting in the county system the co-pays will stop.
 - Members in nursing facilities for short stays will continue to have Part D co-pays.

Medication Overrides and Prior Authorizations

Occasionally a member requires a medication that is not on the formulary or a dosage that requires prior authorization.

Medication overrides

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- The best option is to have the pharmacist contact Medica to request an override on the member's behalf. The pharmacist will work directly with the prescribing healthcare provider to gather needed information.
- The member may call Medica Customer Service to request an override.

Prior Authorizations

- The best option is to have the member's healthcare provider submit a prior authorization request using the provider resources on medica.com.
- Members may contact Medica Customer Service to have a Health Plan Specialist complete a prior authorization on the member's behalf.

Residential Services

Residential services are a service covered under MSHO and MSC+ for members on the Elderly Waiver. DHS has created a Residential Services (RS) rate tool which is used to determine a monthly rate based on the member's needs for members in Customized Living settings and in Adult Foster Care.

All RS rate tools are completed within the MnCHOICES application.

Care Coordinators are strongly encouraged to stay current to all residential services related issues by attending DHS videoconferences as able.

Transportation

If a member does not have access to their own transportation, Medica Provide-A-RideSM helps schedule transportation to and from covered health care visits. More information regarding transportation is found on the [Medica Care Coordinator](#) site under *Tools and Forms* → *Provide-A-Ride*.

If a member has access to a working vehicle and use that vehicle for medical appointments; refer members to their county of residence to seek mileage reimbursement.

Care Coordinators can also arrange transportation through the Qryde portal. If you are interested in learning more please contact ProviderOversight@medica.com to get started. Qryde allows for CC's to set-up rides for members on their behalf in the Qryde portal.

Benefit Exception Inquiry (BEI) process

The Benefit Exception Inquiry process is a way for Care Coordinators to ask Medica if a member can receive something outside of the benefit set.

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- The Care Coordinator may be asked by a member to authorize benefits outside the standard benefit set. Care Coordinators make these requests using the *Benefit Exception Inquiry (BEI) form* found on the [Medica Care Coordinator](#) site under *Tools and Forms*.
 - Supportive documentation of the need must be submitted with the form.
 - BEI forms are reviewed, and the Care Coordinator is informed of the decision.
 - Depending on the determination, the referral request is entered, or the request proceeds to a Denial, Termination, or Reduction (DTR).
- When sending in multiple BEI's be sure to send them separately. This allows the operations staff to easily identify them and process them accordingly.
- Include the cost of the item that you are requesting.
- On the BEI form, there is a section for the member's PCP information, as well as service provider information. "Service Provider" is the provider of the item or service you are requesting; note whether they are in network or out of network providers with Medica.

To begin the BEI process, the CC submits the BEI form as soon as possible after the member has made the inquiry. BEI's have a fourteen (14) day turn-around time once received.

- **Approvals:** After the inquiry is reviewed and if it has been approved, a Medica staff person enters a referral and alerts the CC. The member, member's PCP as well as the provider receive a letter showing the approval.

Note: it is very important that the Care Coordinator documents on the form the provider of the item/service so an accurate referral is entered.

- **Denials:** If the inquiry is denied, the Care Coordinator is informed of the decision and directed to talk with the member about the inquiry denial. If the member is satisfied with the action taken, the CC documents that contact in the member's chart. If the member is not satisfied with the denial, the CC completes the DTR form **immediately** and submits it to Medica. The date on the DTR form is the date the CC communicated the inquiry decision to the member.

If an item has been approved through BEI, and the member continues to have the need past the approval timeline it is the Care Coordinator's responsibility to submit the new/updated BEI request prior to the end of the current authorization.

All requests for care outside of the network are submitted to Medica Utilization Management by the primary care provider (PCP) or other referring provider, not through the BEI process. Documentation from a PCP or other medical professional regarding the medical necessity to access care outside of the network is required.

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Denial, Termination, or Reduction (DTR)

If a service is being denied (based on lack of need), terminated (based on member's request or other reason) or reduced (based on member's request or other reason) a Care Coordinator must complete a *DTR form* found on the [Medica Care Coordinator](#) site under *Tools and Forms* and submit it to Medica.

Medica reviews, and assigns a date which the denial, termination or reduction is effective. The Care Coordinator is alerted to the final decision. This process takes the CC out of the position to make the final decision, and leaves the final decision with Medica, helping the CC to maintain the positive relationship with the member. DTR's and the timelines around them are a contract requirement by DHS.

Other resources for Care Coordinators

Benefit Guidelines:

Medica has created benefit guidelines to help guide Care Coordinators in service planning. These are found on the [Medica Care Coordinator](#) site under *Policies and Guidelines → Benefit Guidelines*.

Care Coordinator Leave-behind document:

This is required to be given to the member annually. This *Medica Care Coordinator Leave-Behind Document* is found on the [Medica Care Coordinator](#) site under *Tools and Forms*.

Medica Care Coordinator website:

The [Medica Care Coordinator](#) website (medica.com/care-coordination) is the main hub where most all care coordination resources can be found.

- Letter Templates - Prepared letters to correspond with Medica members and primary care providers. These are the letters that are to be used for member correspondence as they have gone through the appropriate approval process.
- News - Care Coordination Monthly Communications are found here which provide CC's with updates on policies, process and forms etc.
- Performance Improvement, Transition Care and Gaps in Care - Care Coordinator toolkits, fliers, and other information related to current performance improvement projects as well as transitions process details.
- Policies and Guidelines - This section has current policies, procedures and guidelines that guide care coordination activities and operations.
- Tools and Forms - Commonly used tools and forms for use in day-to-day work including assessments, care plans, contact information, health improvement, program flyers, and much more.

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- Training Materials - The Medica Care Coordinator Training Manuals are provided to assist you with your job duties. The training manuals describe the Care Coordinator role and responsibilities, member classifications, provision of services, and benefit guidelines. All recorded trainings can also be found under this section.

Medica Clinical Liaison:

Medica has a Clinical Liaison devoted to assisting our Care Coordinators by developing trainings, communicating updates, and offering support.

- The Medica Clinical Liaison facilitates trainings to Care Coordinators in a variety of areas including but not limited to:
 - New processes
 - DHS policy changes
 - Form updates
 - Use of reports
 - Working collaboratively with county/tribes
 - Use and referral process for home care and mental health services covered by Medica
 - Relevant linkages to Fee for Service (FFS)
- Medica has clinical consultation services available to identify the health care needs of the member and develop a care plan that appropriately addresses the individual's health care needs. This is met and/or coordinated through our Medica Clinical Liaisons who are available to all Care Coordinators
- The Medica Clinical Liaison reaches out to the assigned Care Coordinators related to member inquiries, service plans, etc.
- Care Coordinators can reach out to the Medica Clinical Liaison via phone or via email
- Special training requests or training topic requests can be sent to the Clinical Liaison

Reporting

Delegates receive several reports from Medica. Some reports require action on the part of the Care Coordinator. Delegates are asked to review the reports training/overview on the CC website which can be found under [Training Materials](#) – *other trainings*.

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Restricted Recipient Program:

The Restricted Recipient Program (RRP) is for members who have been determined by Medica, or a previous health plan to have received or is still receiving prescription drugs in a quantity or manner that might be harmful to their health. Members who only have Medical Assistance and not a primary insurance such as Medicare, are eligible for RRP. Members in the RRP program are restricted to using only one in-network physician to prescribe all of their medications at one in-network pharmacy. The members remain on this program for 24 months, where they are reevaluated to determine if they are eligible to be released from the program.

Each member in the RRP is assigned a nurse from the Medica Special Investigative Unit (SIU). The member is given the nurse's first name and contact information. The Care Coordinator redirects members with questions about the RRP to their assigned SIU nurse at Medica. A Care Coordinator can see the member's assigned PCP and pharmacy by looking up the member in MN-ITS. If a Care Coordinator wants to locate a member's RRP nurse call 1-888-906-0970.

Additional information on the RRP and referrals is found on Medica.com and the Provider Administrative Manual.

Resources:

Medica Care Coordinated Products Customer Service 888-347-3630 (toll-free); TTY: 711, 8 a.m. – 6 p.m. Monday – Thursday; 9 a.m. – 6 p.m., Friday
Provide-A-Ride/Interpreter Services 888-347-3630 (toll-free); TTY: 711, 8 a.m. – 5 p.m. Monday – Thursday; 9 a.m. – 5 p.m., Friday
Medica Behavioral Health 800-848-8327 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday Behavioral health crisis services 24 hours a day, seven days a week
Delta Dental <i>Member services</i> 800-459-8574 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday <i>Care Coordinators only</i> 866-303-8138 (toll free); TTY: 711 8 a.m. – 5 p.m., Monday – Friday
Member Pages DUAL Solution: https://partner.medica.com/members/medicaid/medica-dual-solution MSC+: https://partner.medica.com/members/medicaid/medica-choice-care-msc
NurseLine by Health Advocate 866-715-0915 (toll-free); TTY: 711, 24 hours a day, seven days a week
Care Coordination Support (Clinical Liaison) 888-906-0971 (toll free); TTY: 711 Email: MedicaCCsupport@medica.com

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Care Coordination website

<https://partner.medica.com/care-coordination>

Medline Plus

<https://medlineplus.gov/>

Tobacco Cessation Program

866-905-7430 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

Transplant Program

888-906-0958 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

Email: caresupport@medica.com

Restricted Recipient Program

888-906-0970 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday

Minnesota Department of Human Services (DHS)

<http://mn.gov/dhs/>

eDocs

<https://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp>

Disability Hub MN

866-333-2466 (toll free); TTY; 711, 8:30 a.m. to 5 p.m. Monday – Friday

Email: info@disabilityhubmn.org

Web: <https://disabilityhubmn.org/>

Senior LinkAge Line

<http://www.mnaging.org/advisor/SLL.htm>

800-333-2433 (Toll Free); TTY: 711

Minnesota Board on Aging

<http://www.mnaging.net/>

Older Minnesotans – Know Your Rights

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4134-ENG>

Honoring Choices Health Care Directive

Honoring Choices website

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