Medica Care Coordinator Training Manual:

Medica AcessAbility Solution®

For Special Needs Basic Care (SNBC) Members
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As a representative of Medica, the Care Coordinator (CC) helps members build and maintain an independent and healthy life. Although SNBC does not include waiver benefits, personal care attendant (PCA), or home care nursing benefits (formerly called private duty nursing), the Medica CC still has the responsibility to assist the member in understanding their SNBC benefits, coordinating care across payers including Medicare, assisting across all settings of care, and being involved with member transitions. In addition, the CC will also communicate with any county case managers and others to coordinate efforts and advocate for the member. The CC is the member’s primary contact for accessing all benefits under SNBC.
1. Care Coordinators (CC) will work to develop a care plan, arrange for services, and to assure consent to the medical treatment or services in partnership with:

   - The member and/or authorized family members or alternative authorized decision makers
   - The primary care provider in consultation with any specialists caring for the member

2. Upon receiving the enrollment information, within ten (10 days) contact the member to:

   - Introduce yourself to the member
   - Provide contact information (including phone number and contact person knowledgeable about the SNBC program that the member can call for assistance in transitioning to managed care)
   - 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 will 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. HRA’s will be offered to all members at least annually using the Medica HRA document or Medica approved HRA. See the Assessment Schedule Policy SNBC found on the **Medica Care Coordinator** site for information related to timelines.

   This HRA includes questions designed to identify health risks and chronic conditions, including but not limited to:

   - Activities of daily living
   - Risk of hospitalizations
   - Need for primary and preventive care
   - Mental health/behavioral needs
   - Rehabilitative services

   **Note:** Upon implementation of MnCHOICES with a Medica SNBC member Care Coordinators will be required to use the state’s MnCHOICES tool.

4. Follow Medica Policies/Protocols for facilitating annual physician visits for primary and preventive care, and assist in removing any barriers member is facing related to obtaining this care.

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5. Care Coordinators are to 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 should not be the primary contact for billing issues for providers. For these issues providers should be referred 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 will obtain and distribute self-management materials and education to members regarding disability related conditions common among persons with disabilities.

13. Participate in Performance Improvement Projects (PIPS) or Quality Improvement Project (QIPS) for applicable members.

14. Assist members in accessing resources and services beyond the Medical Assistance and Medicare benefit sets including informal and quasi-formal supports.

15. Assist members by making appropriate referrals for services outside of the SNBC benefit set such as waiver services, PCA services, etc. With these referrals, the Care Coordinator will provide the county with information related to the members assessed need which may include a copy of the member’s last HRA and care plan.

16. 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.

   - 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.

17. Ensure smooth transitions and coordination of information between acute, sub-acute, rehabilitation and nursing facilities and home and community based settings. Document transition activity in member’s chart or transition log.
18. Stay up to date with changes that relate to Medical Assistance benefits and program changes. Attend trainings put on by Medica, DHS, PIP collaborative and other entities as needed.

19. Care coordinators are to have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.

20. 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 can be found on the DHS eDocs site by clicking [here](#) and searching for 3427T.

21. 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 can be found on the DHS eDocs site by clicking [here](#) and searching for 3426. Follow the OBRA Level II process if indicated.

22. 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 can be found in the NurseLine by HealthAdvocate section of this document.

23. **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 SNBC members. Communication will include HIPAA compliant electronic communication vehicles.

   - With any referrals of the member to the county for waiver services, the Care Coordinator is required to submit to the county a summary of the member’s strengths and needs, and services the managed care organization has authorized to meet the members identified needs. The Care Coordinator will provide, at minimum, a copy of the complete health risk assessment and current care plan.

   - The Care Coordinator will coordinate 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, death, or disenrollment. The document can be found on the DHS eDocs site by clicking [here](#) and searching for 5181.

   - The Care Coordinator will communicate with lead agencies (counties/tribes) on the authorization of:
     - Medical Assistance home care services
     - Change in authorization of Medical Assistance home care services
     - Home care service changes authorized by managed care organization (MCO)
     - Addition of home care services authorized by MCO
     - Reduction of home care services

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To request information about services that have been authorized to facilitate collaborative service planning between the county/tribal workers and MCO’s.

This communication should be completed using the DHS-5841 Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services. The document can be 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 to be done using the DHS-6037 Home and Community-Based Services Case Management Transfer Form. The document can be 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 will coordinate and communicate with tribal assessors and case managers. Care Coordinators will 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.

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

- Pre-petition screening
- Preadmission screening for Home and Community Based- Waiver Services (HCBS)
- County Case Management for HCBS
- Child protection
- Court ordered treatment
- Case Management and service providers for people with developmental disabilities
- Relocation service coordination
- Adult protection
- Assessment of medical barriers to employment
- State medical review team or social security disability determination
- Working with Local Agency social service staff or county attorney staff for members who are the victims or perpetrators in criminal cases

25. Medica Care Coordinators shall make reasonable efforts to coordinate with services and supports provided by the Veteran’s Administration (VA) for members eligible for VA services.
26. Medica Care Coordinators will be aware of the contract requirement stating that members with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 USC § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

27. Advance Directive Planning is important and 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.

28. Assist members turning 65 years old in understanding their transition to a senior product. SNBC members are not able to remain on the SNBC program after age 65; these members are required to choose a senior program. DHS requires that SNBC members turning 65 years old either default into the MSC+ program, or actively enroll into MSHO if they are eligible. See the policy on the Medica Care Coordinator site for more information.
SNBC members fall into 1 of 3 categories in terms of what assessment(s) are completed with them by the Care Coordinator. Members are either on a waiver program (through the county), not on a waiver program, or residing in a nursing home/institutional setting.

**Assessments**

Per our contract with DHS, Care Coordinators will make a best effort to conduct a health risk assessment (HRA) of each member’s health needs within thirty (30) calendar days of the enrollment date. Reassessments will be completed within 365 days of the previous HRA. At a minimum, face to face assessments must be offered to SNBC members not currently on a waiver program. The SNBC assessment addresses medical, social, environmental and mental health factors. See the [Assessment Schedule SNBC](#) and [Telephonic Assessment (SNBC and MSC+ only)](#) policies for more information.

**Assessment requirements**

- All members are required to have an assessment offered to them annually and at reassessment. For members not on a waiver program, this offer is to be for a face to face assessment. If the face to face assessment is declined, a telephonic assessment should be offered.

- If a member has requested an HRA, the CC is to schedule this

- Upon completion of the assessment, the CC is required to enter specified information into MMIS for all members.
  
  o The SNBC assessment completed with members is **not** the Long Term Care Consultation (LTCC), but is an assessment designed specifically to the needs of the SNBC population.

  o Entry in MMIS is done as “H” type screening documents.

  o The Medica health plan code in MMIS is MED

  o In 2018, we will begin MMIS entry of SNBC members in nursing facilities-watch for updates related to that.

**NOTE:** Upon implementation of the MnCHOICES assessment for SNBC 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 SNBC Members**
• If a member is admitted to a nursing home (NH) an assessment is due within thirty (30) days. It is important to collaborate with the member’s waiver worker (if applicable) as well as the facility staff on discharge planning.

• NH Members who have been determined will remain in long term care should be transferred back to the Medica Care System by day 100 unless the assigned delegate is contracted to provide institutional care coordination. CC’s should notify the member’s county of financial responsibility (COR) of the admission.

• 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 should be done by day 30 of placement. Activity type would be 01 Telephone Screen. Communication of the nursing facility admission should be 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 can be found on the DHS eDocs site by clicking here and searching for 5181.

• See the Partner Nursing Home Checklist (SNBC) for more information found on the Medica Care Coordinator site under *Tools and Forms → SNBC*.

**Medicaid Management Information System (MMIS)**

Per the contract with DHS, MMIS entry is required for all SNBC members, even if the member has refused to participate in an assessment, or is unable to be located. MMIS entry is to 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.

Timeliness of when the assessment data is gathered and when it gets entered into MMIS are very important. Per DHS-5020A *Instructions for Completing and Entering the LTCC Screening Document/Health Risk Assessments into MMIS for the Special Needs Basic Care (SNBC) Program*:

> "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 can be found on the DHS eDocs site by clicking here and searching for 5020A.

**Missing members and refusing members**

If a member has refused an assessment or is unable to be located MMIS entry is required by DHS. See the SNBC Assessment Schedule Policy and Missing Member/Refusing Member Policy on the Medica Care Coordinator site for more information related to the MMIS specifics.

**DHS resources related to SNBC and MMIS entry:**

- DHS-3427 *LTC Screening Document - AC, BI, CAC, CADI, ECS, EW, MHM, MSC+, MSHO, SNBC*

  The document can be found on the DHS eDocs site by clicking here and searching for 3427.
• DHS-3427T LTC Screening Document - Telephone Screening
  The document can be found on the DHS eDocs site by clicking here and searching for 3427T.

• DHS-5020A Instructions for Completing and Entering the LTCC Screening Document/Health Risk Assessments into MMIS for the Special Needs Basic Care (SNBC) Program
  The document can be found on the DHS eDocs site by clicking here and searching for 5020A.

• Pre-Admission Screening Bulletin #17-25-06

OBRA level 1 activity - DHS contractual requirements

Medica Care Coordinators are to complete an OBRA level 1 form for all SNBC members during the initial assessment as well as with annual reassessments. This is a DHS contract requirement. See below for the DHS form and for information on why this is completed as well as the instructions. Given the nature of the SNBC population many members will “trigger” for an OBRA Level II to be done. The OBRA Level II is done by the County so if your member is in need of NH placement and requires a Level II you will contact the county to complete that assessment.

• DHS-3426 OBRA Level 1 Criteria - Screening for Developmental Disabilities or Mental Illness
  The document can be found on the DHS eDocs site by clicking here and searching for 5020A

• Enter the LTCC screening document information into MMIS for SNBC

• Pre-Admission Screening Bulletin #17-25-06

The MMIS health plan code for Medica is MED.

Note: If you need more information related to MMIS DHS offers MMIS entry classes. Each entity is responsible to keep up with any MMIS changes related to SNBC.
Care Planning is an essential and required task completed by the Care Coordinator with the member and/or authorized family members or alternative authorized decision makers. 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 SNBC members who live long term in a nursing home, they do not require a care plan.

- Medica recommends use of the AccessAbility Solution (SNBC) Care Plan found on the Medica Care Coordinator site. Alternate care plan tools must be approved by Medica prior to their use in order to ensure it contains all necessary elements.

- Care Coordinators will develop, monitor, and update the member’s care plan based on the HRA within thirty (30) days of HRA completion.

Care Plans must include the following components:

1. **Interdisciplinary/holistic focus** - The Care Plan should incorporate the primary, acute, long term care, behavioral health and social service needs of each member with coordination and communication across all Providers.
   - For community members: this includes communication with primary care, attending appointments as needed and involving family in care planning process and visits.
   - For nursing facility members: this includes review of the nursing home chart, involvement in care conferences, and staff input.

2. **Preventative focus**
   - For community members: this may include immunizations, vision, hearing, and dental exams, tobacco cessation, alcohol use, fall risk, medications and nutrition.
   - For nursing facility members: this includes immunization status and health risks, skin integrity, nutrition and activities to improve functioning.

3. **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 Medica Care Coordinator site for more information.

4. **Back up for emergency situation** - The Care Coordinator should assist the member and/or authorized family members or alternative authorized decision makers in planning for emergency situations, such as sudden illness, accident, worsening of chronic conditions. This planning should also include back up plans for failed or refused services. This would be documented on an Emergency Plan.

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5. **Advance Directive planning** - Care coordinators should review health care directives annually and with changes in care needs. These reviews should be documented on the care plan. This includes documentation of refusals. All Medica SNBC 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: [www.honoringchoices.org](http://www.honoringchoices.org)

6. **Annual comprehensive primary care visit** - Care planning should document efforts to ensure all members have had an annual comprehensive PCP visit.

7. **Identified goals and member specific interventions** – Care plans must include identified goals and member specific interventions. 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. Completion of a schedule for a follow-up plan and communication.

8. **Follow-up, Monitoring and evaluation of goal outcomes**: Monitoring and evaluation of goal outcomes should be ongoing and must include dates. The date to evaluate outcomes may be the next scheduled reassessment date, but could also be the date of the next planned follow-up contact.
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). Even though SNBC is not a product that includes Medicare, Medica asks that transitions still be managed per the current Transitions Process. Though the transition log is not required to be completed for SNBC members it is a best practice to use it. All transition activities need to be documented in the member’s chart.

When a member goes to the hospital or other care setting due to a change in condition, this is considered a transition. Care Coordinators should remind members to inform them of both planned and unplanned transitions. A planned transition is typically due to a surgical procedure, the member and/or authorized family members or alternative authorized decision makers 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) 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 within one business day of admission (or prior to admission if a planned event) to learn about any changes in health status and/or care needs. Explain the transition process and provide CC contact information for additional support.

**For additional transitions that occur before return to the usual care setting:**

- Start a new note if there are additional transitions that occur before return to the usual care setting and complete all activities above for the new care setting.
• Update the member’s plan of care.

**Upon discharge to the member’s usual or “new” usual care setting:**

• Communicate with the member and/or authorized family members or alternative authorized decision makers about:

  o The care transition process

  o Changes to the member’s health status; does the member have any needs that require a change to their services/supports?

  o Plan of care updates; review care plan to ensure that member’s plan continues to meet their needs.

  o 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

    ▪ Addressing potential barriers

    ▪ Medication self-management

    ▪ Knowledge of warning signs to watch for related to their transition? Does member know what red flags would indicate a call back to their physician?

    ▪ Benefits of maintaining a personal health record

**Transition care resources**

• [Notification of Care Transition Fax](#)

• [Transition Log](#)

• [Transition Log instructions](#)

Though the transition log is not required to be completed for SNBC members it is a best practice to use it. All transition activities need to be documented in the member’s chart. Care Coordinators should work to support and manage members during all transitions regardless of whether the log is required.
Primary Care Provider (PCP) communication

Care Coordinators must communicate with the member’s primary care provider 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 should be documented in the care plan. Best practice includes accompanying your member on their PCP visit if that level of support is needed by that member.

Communication with Waiver program worker/Targeted Case Manager

Communication between a Medica CC and a member’s waiver worker or a member’s targeted case manager is essential and required. Medica Care Coordinators are required to contact the member’s worker within their month of enrollment to collaborate and communicate the member’s plan. Joint visits may be an option if it is in the best interest of the member.

Per the DHS contract CC’s are to communicate with a member’s waiver worker if they want to put any state plan home care or therapy services in place for the member using the DHS-5841 Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services. The document can be found on the DHS eDocs site by clicking here and searching for 5841. This is to ensure that the waiver case manager accounts for these services in the member’s waiver budget and on their service agreement and to ensure duplication of services is not occurring.

A listing of county contacts, as well as county managed care advocate at each county is located on the DHS website.
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 can be 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 exceptions to this is:

- Member is an unable to reach 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.
- The member resides in a nursing facility, the minimum amount of information we require are a copy of the institutional assessment.

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 will confirm the transfer. The transfer documents can be sent via SPPEnrollmentQ@medica.com or fax 952-992-2682. The Member Transfer Responsibilities policy can be found on the Medica Care Coordinator site under Policies and Guidelines → Policies.
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 → Evidenced-Based Medicine.

- Record all disease management intervention and education on the member’s care plan.

Medica has a disease management program for the following conditions:

- Asthma

- Diabetes

- Cardiac

Members with these above diagnosis 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 also refer members to the Disease Management program and the Tobacco Cessation program at Medica by completing the Health Support Referral Form found on the Medica Care Coordinator site under Tools and Forms → SNBC.
Following is a non-exhaustive list of benefits covered under the SNBC product. Care Coordinators use these formal benefits when developing the plan of care for a member in addition to informal and quasi-formal services.

See the SNBC Member Handbook for detailed information regarding benefits.

Reminder: The SNBC product does not include waiver benefits, personal care attendant (PCA), home care nursing (formerly private duty nursing) or Medicare benefits. Care Coordinators are to assist members in contacting their county of residence if determined through the AccessAbility Solution (SNBC) Assessment there is a need for waivered services.

**Medical Services**

- SNBC members are entitled to all services covered under Medical Assistance.

- For SNBC members who do not have Medicare or another primary insurance, providers will bill Medica.

- For SNBC members who have Medicare or another primary insurance, providers will bill Medicare first; Medica will coordinate benefits (referred to coordination of benefits or COB) with Medicare.

- The role of the Care Coordinator is not to make medical decisions. The Care Coordinator often times will receive requests for approval of medical services. Providers are to call Medica Provider Services 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. Medica Care System utilizes the Medica Choice network for specialty care, which includes over 95% of providers in our service area. Refer to the provider search tool.

- Prior Authorizations-Medica does have a list of selected procedures which require a prior authorization. These claims will not pay without a referral in the system. The Health Services department at Medica reviews the request for Medical Prior Authorizations.

**Chiropractic care**

**Covered services:**

- One evaluation or exam per year

- Manual manipulation (adjustment) of the spine to treat subluxation of the spine

- Acupuncture for chronic pain management within the scope of practice by chiropractors with acupuncture training or credentialing

- X-rays when needed to support a diagnosis of subluxation of the spine
Not Covered Services:

- Other adjustments, vitamins, medical supplies, therapies and equipment from a chiropractor

Providers **must** be in the network. Providers should be referred directly to Provider Services for all coverage and claims issues.

**Dental services**

- Medica SNBC follows the Medical Assistance benefit.
- Medica uses the Delta Dental Civic Smiles network.
- If a member is requesting a dental procedure or item outside of the dental benefit set, CC’s are to refer members to Delta Dental Customer Service for this request.
- If the CC is unable to locate a participating dental provider Delta Dental will assist in the process. Delta has created a phone number specifically for Care Coordinators to use to find dental care for their members. *The following number is for Care Coordinator use only and should not be distributed to members 651-994-5198 or 866-303-8138.*

**Home care services - state plan services**

- SNBC covers state plan homecare services including skilled nurse visits (SNV) and home health aide (HHA). **Services must be obtained through a Medica contracted provider.** All services should be coordinated with the agency.
- If a SNBC member on a waiver is receiving any state plan home care services, the Care Coordinator is **required** to communicate this to the county waivered worker using the DHS-5841 *Managed Care Organization, County and Tribal Agency Communication Form - Recommendation for State Plan Home Care Services.* The waiver worker must account for these services in their service agreement. The document can be found on the DHS eDocs site by clicking [here](#) and searching for 5841.
- Home Health Aide 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.

**Covered Services from the [SNBC Member Handbook](#)**
Hospice benefits include coverage for the following services when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

**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.

Members age 21 and under can still receive treatment for their terminal condition in addition to hospice services.

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 Hospice Benefit**

Hospice Election paperwork is presented to the member and/or authorized family members or alternative authorized decision makers by the hospice agency. There is both a Medicare and Medicaid Election. The hospice agency describes the coverage benefits to the member and/or authorized family members or alternative authorized decision makers at time of signing.

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

**NOTE:** A member may choose to dis-enroll from hospice at any time after their election. 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 the Medica claim system which prevents hospice related claims from paying in error.

**Hospice Certification**

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. Therefore persons with end stage chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), renal disease, dementia, failure-to-thrive, etc., are also eligible.

**Hospice and Waiver Services**

When a member does enroll in hospice it is essential for the Care Coordinator to be in communication with the waiver case manager and the hospice provider to revise the service plan as needed to prevent duplication of services.

**Location for Hospice 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 and with the waiver case manager (if member on a waiver program) related to what DME is being covered under the waiver program. 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. SNBC members may also still be receiving personal care assistant services paid for by Fee-for-Service. 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.

- Continue to communicate with the member’s waiver worker if applicable.

**Note:** Hospice agencies can be found through the online provider directory on Medica.com on the Physicians and Facilities page. See the SNBC Member Handbook for more information related to hospice.

### Interpreter services

- SNBC 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 waivered 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 obtain the access codes via the Clinical Liaison.** See the Other Resources for Care Coordinators section of this document for contact information.

### Medication Therapy Management (MTM)

MTM is a service is 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 SNBC members with Medicare:**

The MTM benefit is provided through their Medicare part D benefit. Members must receive MTM services through providers who accept the member’s Medicare coverage such as their pharmacy.

**For SNBC members without Medicare:**

This benefit is provided by DHS Minnesota Health Care Programs (MHCP) credentialed providers. DHS credentialed MTM pharmacists can be found on the DHS site [https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/resources/medication-therapy-faqs.jsp](https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/resources/medication-therapy-faqs.jsp).

How it works for SNBC 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 Health/Behavioral Health and Chemical Dependency Services**

Medica uses the Medica Behavioral Health (MBH) network. Mental Health Providers should 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 should coordinate with county mental health providers for those services provided through the county.

• MBH is also a care coordination partner with Medica for SNBC members.

• MBH is available for case consultation by contacting MBH customer service and speaking with a care advocate at 1-800-848-8327
NurseLine™ by HealthAdvocate™

Our member’s health care needs do not always follow regular business hours. 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 is 1-866-715-0915. Hearing impaired members, call the National Relay Service at 1-800-855-2880 and request Medica 24 hour nurse line at 1-866-715-0915. These numbers are available twenty-four (24) hours per day, seven (7) days per week.

Nursing Facility Services

Medica is responsible for paying a total of 100 days of nursing home room and board. If the member needs continued nursing home care beyond 100 days, the Minnesota Department of Human Services (DHS) will pay directly for their care. Upon enrollment into the plan, if DHS is currently paying for the member’s care in the nursing home, DHS, not Medica, will continue to pay for the care. Facilities are responsible to contact Medica related to admissions.

Process if a SNBC member has entered the nursing home:

Refer to the Partner Nursing Home Checklist for SNBC which can be found on the Medica Care Coordinator site under Tools and Forms → SNBC. Medica will track the days, and will place authorizations in the system when needed.

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.

Pharmacy Services

Please refer to the SNBC Member Handbook for detailed pharmacy information. For SNBC members on Medicare refer to their Medicare part D provider for questions regarding coverage. SNBC includes medications covered under Medical Assistance including over-the-counter medications.

- Formularies are available on Medica.com, under each specific product page.
- If a member does not have Medicare, Medica pays for all medications and 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.

• Members can download the CVS app to help manage their medications (see Medica.com for more information).

**Tobacco Cessation**

SNBC members can self-refer to the Medica Tobacco Cessation program by calling Medica, or a referral can be made by the Care Coordinator using the *Health Support Referral Form* which can be found on the [Medica Care Coordinator](#) site under *Tools and Forms → SNBC*.

**Transportation**

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

If a member has access to a vehicle and is interested in exploring whether mileage reimbursement for use of that vehicle for medical appointments is possible, Care Coordinators are to refer members to their county of residence.

**Vision Care Services**

• Medica follows the Medical Assistance restrictions for selection of eyeglasses.

• A member can choose their eyeglass frames from the catalogs provided on Medica.com under the SNBC product page.

• Members must be seen at a contracted provider.

• Refer to the [SNBC Member Handbook](#) for more detailed information.
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.

- The Care Coordinator may be asked by a member to authorize benefits outside the standard benefit set. Care Coordinators can make these requests using the Benefit Exception Inquiry (BEI) form found on the Medica Care Coordinator site under Tools and Forms → SNBC.
  
  o Supportive documentation of the need should be submitted with the form.
  
  o BEI forms are reviewed, and the Care Coordinator will be informed of the decision.
  
  o Depending on the determination, the referral request may be entered, or the request will proceed to a Denial, Termination, and Reduction (DTR).

- When sending in multiple BEI’s be sure to send them separately. This will allow the operations staff to easily identify them and process them accordingly.

- Please 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 provider information. “Provider” would be the provider of the item or service you are requesting, and you will then 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 has been reviewed and if it has been approved, a Medica staff person will enter a referral into Medica’s system and alert the CC. The member, member’s PCP as well as the provider will receive a letter showing the approval.

  Note: it is very important that the Care Coordinator document on the form whom the provider of the item/service will be so an accurate referral can be entered.

- Denials: If the inquiry is denied, the care coordinator will be informed of the decision and directed to talk with the member about the inquiry denial. If the member is satisfied with the actions that have been taken, then the CC would document that contact in the member’s chart. If the member is not satisfied with the denial, then the CC would complete the DTR form immediately and send it Medica. The date on the DTR form would be 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.

  E.g. If nutritional supplements are approved through the BEI for 1/1/18-6/30/18, we ask that the CC submit a new BEI with updates to justify the continued use past 6/30/18. This may mean submitting
additional supporting information such as notes from the members PCP, a dietician, OT/PT evaluation, etc.

All requests for care outside of the network should be submitted to Medica Health Services 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.
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 → SNBC and submit to Medica.

Medica will review, and assign a date which the denial, termination or reduction will be effective. The Care Coordinator will be 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.
Benefit guidelines:

Medica has created benefit guidelines to help guide Care Coordinators in service planning. These can be 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 can be found on the Medica Care Coordinator site under Tools and Forms → SNBC.

Child and teen checkup:

SNBC members under age 21 are eligible for Child and Teen Check-ups provided by their primary care provider or pediatrician. Care Coordinators are asked to educated members/responsible parties of the importance of annual PCP visits.

Impact Report/Enhanced Care Coordination (ECC):

This report stratifies membership into four care levels: 1, 2, 3, or 4. The care levels are based off a variety of factors such as utilization, overall claims costs, number of chronic conditions, and overall risk. The purpose of this report is for care coordinators to gain a clearer clinical picture of your members and their utilization and risk factors.

The report also includes a grid with recommended care coordination activities for members in each care level. This does not change what you are required to do, but rather points to resources and recommendations for best practices of managing at risk members in order to decrease unnecessary hospitalizations and improve quality of care.

Medica AccessAbility Solution Member Page

The member webpage is a helpful resource to see what your members can see about the benefits and services available to them under their coverage and offers easy access to many member facing materials. www.medica.com/accessability

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 can be found here which provide CC’s with updates on policies, process and forms etc.

Performance Improvement, Transition Care & Evidenced-Based Medicine - 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 your day-to-day work including assessments, care plans, contact information, health improvement, program flyers, and much more.

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.

Medica Clinical Liaison:

Medica has a Clinical Liaison devoted to assisting our care coordinators by developing trainings, communicating updates, and offering support. You can reach out with questions via email, medicaccsupport@medica.com or by phone at 1-888-906-0971

- The Medica Clinical Liaison will facilitate 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 SNBC Care Coordinators
• The Medica Clinical Liaison will reach out to assigned care coordinators related to member inquiries, service plans, etc.

• Special training requests or training topic requests can be sent to the Clinical Liaison

**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. SNBC 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 will be reevaluated to determine if they are eligible to be released from the program.

Each member is 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 should redirect 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 would like to locate a member’s RRP nurse call 1-888-906-0970.

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

**Resources:**

<table>
<thead>
<tr>
<th>Medica Care Coordinated Products Customer Service</th>
<th>888-347-3630 (toll-free); TTY: 711, 8 a.m. – 6 p.m. Monday – Thursday; 9 a.m. – 6 p.m., Friday</th>
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<tr>
<td>Provide-A-Ride/Interpreter Services</td>
<td>888-347-3630 (toll-free); TTY: 711, 8 a.m. – 5 p.m. Monday – Thursday; 9 a.m. – 5 p.m., Friday</td>
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<tr>
<td>Medica Behavioral Health</td>
<td>800-848-8327 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday</td>
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<td>Behavioral health crisis services 24 hours a day, seven days a week</td>
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<tr>
<td>Delta Dental</td>
<td>Member services</td>
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<td></td>
<td>800-459-8574 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday</td>
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<td></td>
<td>Care Coordinators only</td>
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<tr>
<td></td>
<td>866-303-8138 (toll free); TTY: 711 8 a.m. – 5 p.m., Monday – Friday</td>
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<tr>
<td>Member Pages</td>
<td>DUAL Solution: <a href="https://www.medica.com/members/medicaid/medica-dual-solution">https://www.medica.com/members/medicaid/medica-dual-solution</a></td>
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<td>Service</td>
<td>Contact Details</td>
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<td>NurseLine by Health Advocate</td>
<td>866-715-0915 (toll-free); TTY: 711, 24 hours a day, seven days a week</td>
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<tr>
<td>Care Coordination Support (Clinical Liaison)</td>
<td>888-906-0971 (toll free); TTY: 711 Email: <a href="mailto:MedicaCCsupport@medica.com">MedicaCCsupport@medica.com</a></td>
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<tr>
<td>Medline Plus</td>
<td><a href="https://medlineplus.gov/">https://medlineplus.gov/</a></td>
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<tr>
<td>Tobacco Cessation Program</td>
<td>866-905-7430 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday</td>
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<tr>
<td>Transplant Program</td>
<td>888-906-0958 (toll free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday Email: <a href="mailto:caresupport@medica.com">caresupport@medica.com</a></td>
</tr>
<tr>
<td>Restricted Recipient Program</td>
<td>888-906-0970 (toll-free); TTY: 711, 8 a.m. – 5 p.m., Monday – Friday</td>
</tr>
<tr>
<td>Disability Hub MN</td>
<td>866-333-2466 (toll free); TTY: 711, 8:30 a.m. to 5 p.m. Monday – Friday Email: <a href="mailto:info@disabilityhubmn.org">info@disabilityhubmn.org</a> Web: <a href="https://disabilityhubmn.org/">https://disabilityhubmn.org/</a></td>
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