Medica AccessAbility Solution® - Special Needs Basic Care (SNBC)

SNBC care coordination helps members build and maintain an independent and healthy life. Although SNBC does not include Medicare benefits, waiver benefits, personal care attendant (PCA) or home care nursing (formerly called private duty nursing) benefits, the Medica care coordinator (CC) still has the responsibility to assist the member in understanding their SNBC benefits, coordinate care across payers, assist across all settings of care, and be involved with member transitions. The care coordinator will also communicate with any county or other workers in the member’s life to coordinate efforts and advocate for the member. The care coordinator is the member’s primary contact for accessing all benefits under SNBC.

Basic job duties of a Medica Care Coordinator are:

1. Upon receiving the enrollment information, contact the member to introduce yourself and answer any questions about the plan the member is in.

2. Arrange for the initial assessment and periodic reassessments as necessary.

3. Facilitate annual physician visits for primary and preventive care.

4. Care planning based on ongoing assessment.

5. Arrange and coordinate supports and services identified through the assessment and care planning process, including annual physician visits.

6. Assist the Member and their legal representatives, if any, to maximize informed choices of services and control over services and supports.

7. Monitor and record outcomes in order to evaluate the adequacy of services and interventions.

8. Coordinate with local agencies as necessary, including use of the Minnesota Department of Human services (DHS) form #5181 “Case Manager/Financial Worker Communication”. Also communicate with lead agencies using “Managed Care Organization/Lead Agency Communication Form” #5841 when necessary. (These forms can be found on DHS website under the edocs link.)

9. Assist member with health plan related issues as needed. This could include referring 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 Provider Services.

10. Coordinate with primary care, including assisting a member locate appropriate providers if needed.

11. Educate member about good health practices, including wellness and preventative activities.

12. Performance Improvement Projects (PIPS) or Quality Improvement Project (QIPS) for applicable members.

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


15. Stay up to date with changes that relate to Medical Assistance benefits and program changes. Attend trainings put on by DHS, PIP collaborative, Medica and other entities as needed.

16. Complete all necessary activities surrounding nursing home placements including but not limited to [DHS-3427T-ENG LTC Screening Document per the DHS pre-admission screening process (PAS)].

17. Conduct OBRA Level 1 screenings and convey any information obtained during the screening to the Local Agency and send copy to nursing facility (NF).

The following is summarized from language found in the current DHS manual regarding the role of the SNBC care coordinator.

18. Partnership with Member. Care coordinators will work in partnership with the member and/or authorized family members or alternative decision makers, and primary care physicians in consultation with any specialists caring for the member, to develop and provide services and to assure consent to the medical treatment or service.

19. Health Risk Assessment (HRA). 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 thereafter (unless Medica has received notice of approval of a different timeline by DHS). HRA’s will be offered to all members at least annually using the Medica HRA document or Medica approved HRA. This
HRA includes questions designed to identify health risks and chronic conditions, including but not limited to: 1) activities of daily living, 2) risk of hospitalizations, 3) need for primary and preventive care, 4) mental health needs, 5) rehabilitative services, and 6) protocols for follow up to assure that physician visits, additional assessments or interventions are provided when indicated. Member’s HRA must identify **Person-Centered Principles and Practices**: Assurance that people have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected. Health risk 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.

a. Upon completion of the assessment, the care coordinator is required to enter specified information into MMIS for all community members.
b. Upon implementation of the MnCHOICES assessment for SNBC members, Care Coordinators will use the health risk assessment component of the state’s MnCHOICES tool which will meet the requirements of this section and will become mandatory when MnCHOICES is implemented.

20. **Nurse Line.** Medica maintains a 24-hour, seven-day-per-week nurse line members can access. Care coordinators are to be familiar with this service and be able to direct members to the nurse line phone numbers on their member ID cards for use by the member when needed.

21. **Case Management System.** Medica has developed written policies and protocols related to the expectations for assessment completion and member follow up. Please refer to these policies.

1. **ASSESSMENT REQUIRED**
   a. If the member is new to Medica.
   b. If there is a member change of condition
   c. If there is a request made by the member that an assessment be completed
   d. If the member is a transfer and current required information is not available (HRA, care plan, member signature sheet)

2. All non-waivered members are required to have a face to face assessment offered to them annually and at reassessment. If the face to face assessment is declined, a telephonic assessment should be offered. See Telephonic Assessment Policy.
   e. Medica care coordinators are to have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services. See relevant Medica policies regarding the qualifications of a Medica Care Coordinator.
   f. Medica will provide training to all care coordinators in the use and referral process for home care and mental health services.
covered by Medica and relevant linkages to Fee for Service (FFS).
g. Medica has clinical consultation services available to identity
the health care needs of the member and develop a care plan that
appropriately addresses the individual’s health care needs. This
is met through our Medica Clinical Liaisons who are available to
all SNBC Care Coordinators.

22. Notification of Contact Persons. Upon a member’s enrollment, Medica
provides the member with the general contact information for the entity or
partner who will be providing their care coordination along with information
regarding Medica’s Customer Service number. These contacts are
responsible to be knowledgeable about the SNBC program that a member
can call for assistance in transitioning to managed care including assistance
in accessing medications and services that require prior authorization.
a. Within ten (10) days of assignment, the entity assigned to work with
that member must provide the member with the name and telephone
number of their assigned care coordinator.

23. Self-Management Materials and Education. The care coordinator will
obtain and distribute self-management materials and education programs to
members regarding disability related conditions common among persons
with disabilities.

24. Communication and Coordination with Counties and Providers.
a. The care coordinator is responsible to understand written
communication protocols 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. Such protocols will include HIPAA compliant
electronic communication vehicles (ex. securely sent email).
b. Prior to referral 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.
c. The care coordinator will communicate with lead agencies
(counties/tribes) on the authorization of Medical Assistance home care
services using the State form #5841, “Managed Care
Organization/Lead Agency Communication Form- Recommendation
for State Plan Home Care Services.”
d. 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. This
communication is to be done using the Lead Agency Health and
Community Based Services (HCBS) Case Management Transfer Form,
DHS-6037 as provided by the State or other approved transfer
document if the state form is not available.
e. When a CC refers a member to the county for evaluation for HCBS the
care coordinator will provide, at minimum, a copy of the complete health risk assessment.

25. **Coordination with the Local Agency (county/tribe).** Referrals and/or coordination with county social service staff will be required when the member is in need of the following services:
   - Pre-petition screening,
   - Preadmission screening for 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.

26. **Coordination with Veterans Administration.** Medica and 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.

27. **Assistance with other Support Programs.** 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.

28. **Advance Directive Planning.** The 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.

**References:** SNBC contract

**Member Classifications**

**SNBC**

SNBC members are either on the waiver (through the county) or not on a waiver. SNBC members have to be certified disabled through Social Security or the State Medical Review Team (SMRT).
Assessment-

Per contract, care coordinators will make a best effort to conduct a health risk assessment of each member’s health needs within 30 calendar days of the enrollment date. The assessment addresses medical, social, environmental and mental health factors. In the past, Medica had 2 different assessments that could be used with members depending on a member’s waiver status. Due to feedback we received from care coordinators in 2016, Medica made some edits to the assessment and there is now 1 SNBC HRA to use with all members. See the SNBC Assessment Schedule Policy (SNBC) and the Telephonic Assessment Policy (SNBC, MSC+) for more information.

The assessments for SNBC members who are NOT on a waiver are entered into MMIS. Reminder: The SNBC assessment is not the Long Term Care Consultation (LTCC).

Institutional SNBC members: If a member is admitted to a nursing home (NH), an assessment is due within 30 days. It is important to collaborate with the member’s waiver worker (if applicable) in regards to discharge planning. For NH members where it has been determined they 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. See Partner Nursing Home Checklist (SNBC) for more information.

Medicaid Management Information System (MMIS)

Per the contract with DHS, MMIS entry is required for all SNBC members not on the waiver and not in the nursing home. MMIS entry is to be completed timely and completely. 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.

The 3 scenarios when entry is required per our contract with DHS:

- Member has refused an assessment, or is unable to contact. MMIS entry is required to note the refusal/unable to contact. Program type: #28, Assessment result #39, and activity type #07. See the Missing Member/Refusing Member Policy for more information.
- Member has agreed to an assessment. MMIS entry of the screening document information is required. Program type: #28, Assessment result #35, Activity type #1 or #2.
- Member has entered the NH and placement is expected to be long term. MMIS entry of required fields is needed because state and federal requirements 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 (best practice is day 30 of placement, DHS requires this done no later than day 40 of placement). Activity type would be 01 Telephone Screen. Communication of the
nursing facility admission should be made to the financial worker using the Case Manager/Financial Worker Communication Form (DHS 5181).

Note: Timeliness of when the assessment data is gathered and when it gets entered into MMIS is important. Per DHS MMIS entry manual for SNBC:

“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”.

DHS resources related to SNBC and MMIS entry:
- DHS-3427 - LTC Screening Document
- DHS-3427T - LTC Screening Document: Telephone Screening
- Link to DHS SNBC MMIS Entry manual (page 66 of this shows what the required and non-required fields are related to SNBC)

OBRA level 1 activity-DHS contractual requirement:
Medica Care coordinators will need to complete an OBRA level I form for all SNBC members during the initial assessment as well as with annual reassessments. This is a DHS contract requirement. See the DHS form (and below) for information on why this is completed as well as the instructions. The difference with SNBC is that given the nature of this product, many members will “trigger” for a Level II to be done. The Level II is to be done by the County, so if your member is in need of NH placement, and requires a Level II, you will contact the county re: the need for the Level II.
- Obra Level 1
- Preadmission screening bulletin which explains the process as well as the exemptions.
- Instructions for completing and entering the LTCC screening document information into MMIS for SNBC

The MMIS health plan code for Medica is MED.

DHS offers MMIS entry classes, and each entity is responsible to keep up with any MMIS changes as they relate to SNBC.

Care Planning-
- A comprehensive care plan will be written and maintained for each member.

  Medica does not require the use of a designated care plan. Partners may use the AccessAbility Solution (SNBC) Care Plan or the document of their choice. A popular option is the Collaborative care plan. **If one of these 2 mentioned care plans is NOT your entity’s form of choice, a different care plan must be approved by Medica in order to ensure it contains all necessary elements.
Care Plans must include the following components

1. **Interdisciplinary/Holistic Focus**- The Care Plan should incorporate the primary, acute, long term care, mental health and social service needs of each enrollee with coordination and communication across all Providers. For **community members**, communication with primary care, attending appointments as needed and involving family in care planning process and visits. For **nursing home 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 home 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. See the Health Improvement Programs section under tools and forms on the CC webpage for more information.

4. **Back up for emergency situation**- The care coordinator should 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 failed or refused services. This would be documented on an Emergency Plan.

5. **Advance Directive Planning**- All Medica SNBC members receive a health directives packet in their enrollment materials. These materials are also available in Hmong, Somali, Spanish and Russian from Medica (contact your Medica Operations Associate for copies). Care coordinators should review health care directives annually and document on the care plan. This includes documentation of refusals.

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

7. **Care plans** must include identified goals and member specific interventions. Monitoring and evaluation of goal outcomes must include dates. The date to evaluate outcomes will often be the next scheduled reassessment date, but could be the date of the next follow-up contact. 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.

**Note:** Care plans must be maintained in a secure location for a minimum of 3 years per DHS contract.
Primary Care Provider (PCP) Communication-

Care Coordinators must communicate with the member’s primary care provider annually, with changes of condition as well as with member transitions. Medica encourages the use of the PCP letter template. The annual communication should be documented in the care plan. Best practice would include 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 care coordinator 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. When possible and appropriate, joint visits may be an option if it is in the best interest of the member.

Per DHS contract, care coordinators are to communicate with a member’s waiver worker if they want to put any state plan services in place for the member. The communication form that DHS created for this purpose can be found on the DHS edoc site, form DHS-5841.

Disease Management-

SNBC care coordinators are required by the Health Plan and the DHS contract to make available a Disease Management Program for members.

- Refer to the Institute for Clinical Systems Improvement (ICSI) guidelines and other Disease Mgmt materials. (Link to ICSI guideline found on Medica.com care coordinator site under Policies and Guidelines).
- All disease management interventions should be recorded on the member care plan.

Medica also has a disease management program for the following specific conditions:

- Asthma
- Diabetes
- Cardiac

Members are identified for the program via predictive modeling identification process. Members can receive resources regarding 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 at Medica by completing the referral form that can be found on the CC webpage on medica.com.

HOSPICE Benefit-

If the SNBC member has Medicare benefits, Hospice is covered through that Medicare provider. The care Coordinator continues to stay involved and
communicate with the Hospice provider.

If the member does not have Medicare, Hospice will be provided under the member MA benefit and DHS gets notified by the provider.

**Initiating the Benefit**

Hospice Election: Signed by the member or party acting on behalf of the member. There is both a Medicare and MA Election for dual eligible members. The 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.

**Hospice Certification:** The hospice program must have physician certification that the member has a terminal condition with a prognosis of 6 months or less (assuming that the clinical disease process follows its normal course). Patients can be “recertified” if necessary.

NOTE: Hospice is suitable for individuals with end stage chronic conditions as well as cancer diagnoses. So 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:** Per DHS, the primary diagnosis for waiver services should be different than the hospice diagnosis. When a member does enroll in hospice it is essential to revise the service plan to prevent duplication of services.

**Medicare Hospice Benefit Periods:** Two 90-day and unlimited 60-day benefit periods. The physician must certify at each Benefit Period that the individual continues to meet criteria for hospice and has a terminal prognosis.

**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.

NOTE: 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.

   NOTE: 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.
   NOTE: 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. NOTE: There may be a place for personal care attendant (PCA) hours to support care of a member. Coordination with the hospice program to maximize that benefit first will be necessary.

Medical Assistance Benefit

• Hospice should bill DHS directly for expenses not covered under the Medicare hospice benefit. This may include any co-pays the hospice may charge to the member.
• If the member’s residence is a nursing care facility the hospice bills DHS directly to cover room and board.

Care Coordinator Role

• Access elderly waiver (EW) or medical assistance (MA) supports as needed to supplement Medicare and MA covered hospice.
• Continue to facilitate communication between all parties 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 under Clinic/Other Medical Facility.

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.
Social Service Needs-

According to the DHS contract the responsibility of the SNBC care coordinator is to coordinate with Local Agency (county) social service staff for any of the applicable following services:

- Pre-petition screening
- OBRA level II screenings
- Spousal impoverish assessments
- Group Residential Housing
- Targeted Mental Health Case Management
- Adult Protection

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

Provision of Services-

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 Evidence of Coverage for detailed information regarding benefits.

Reminder: The SNBC product does not include waiver benefits, personal care attendant (PCA) 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 enrollees are entitled to all services covered under Medical Assistance.
- For SNBC members who do not have Medicare, providers will bill Medica.
- For SNBC members who have Medicare, providers will bill Medicare first; Medica will complete the coordination of benefits (referred to as 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. Health Management at Medica reviews the request for Medical Prior Authorizations.

**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). Documentation to support the need should be submitted with the BEI form. BEI forms are reviewed, and the care coordinator will be informed of the decision.

- All requests for care outside of the network should be submitted to Health Management by the primary care physician (PCP) or other referring physician. Documentation from a PCP or other medical professional regarding the medical necessity to access care outside of the network is required.

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

- Whenever possible, 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.

**NOTE:**

To begin the BEI process, the CC submits the BEI form as soon as possible after the member has made the inquiry.

- **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 care coordinator. 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 who 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 care coordinator would complete the DTR form immediately, and send into Medica using the DTR fax cover sheet.
on the DTR form would be the date the care coordinator communicated the inquiry decision to the member.

Also, 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 ending of the current authorization.

Ex. If supplements are approved through the BEI for 1/1/17-6/30/17, we ask that the CC submit a new BEI with updates to justify the continued use. This may mean submitting additional supporting information such as notes from the members PCP, a dietician, OT/PT evaluation, etc.

**Denial/Termination/Reductions (also known as DTR’s):**

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 for State Plan Services**, and submit to Medica with 10 days of the decision. 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 are a contract requirement by DHS.

**24-hour nursing hotline**

Because our members’ health care needs do not always follow regular business hours, the 24 hour nurse line is an easy-to-use phone service staffed by registered nurses 24 hours per day, seven days per week. It is a valuable health information resource 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 your home. An extensive health and wellness audiotape library is also part of this service.

Medica 24 hour nurse line – 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 24 hours per day, seven days per week.

**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:

- SNBC follows the Medical Assistance benefit set. Medica utilizes the Delta Dental 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 care coordinator is unable to locate a participating dental provider Delta will assist in the process. Delta has created a phone number specifically for care coordinators to use to find dental care for their members. (For care coordinator use only. Do not distribute 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. The waiver worker must account for these services in their service agreement.

- Home health aide requires a referral in our system.

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 care coordinators to use when contacting members who speak a different language. Transperfect Language Line is the vendor resource used for telephonic translation services. CC’s can
obtain the access codes via the Clinical Liaisons.

**Medication Therapy Management (MTM)**

Coverage Note:
- For SNBC members WITH Medicare, this benefit is provided through their Medicare provider.
- For SNBC members WITHOUT Medicare, this benefit is provided through DHS.

Medication Therapy Management (MTM) is usually provided by a pharmacist. This service is designed to help the member get the most benefit from their medications and avoid problems, and can often result in reduced costs for medications as well. 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.

How it works:
- Member calls a participating pharmacy to make an appointment to meet with a pharmacist.
- The member brings their Medica ID card along with all of their medications, including over-the-counter (OTC’s) and herbals
- The pharmacist sits down with the member to review the medications to identify any areas of concern, duplication and cost savings for the member.

Members who are MA only can access pharmacists found on the DHS site.

**Mental Health and Chemical Dependency Services**

- Medica utilizes the Medica Behavioral Health (MBH) network. See general section for contact information. 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 Care Coordinator should coordinate with county mental health providers for those services provided through the county.
- MBH is also a partner with Medica and provides care coordination for SNBC
members.

- MBH is available for case consultation by contacting MBH customer service and speaking with a care advocate @1-800-848-8327

Nursing Facility Services-

- SNBC: Nursing Facility Daily Rate – 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 the 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.

  - Process if a SNBC member has entered the nursing home:
    - Care coordinator to contact Medica to inform them of the admission using the Nursing Home Admission Form (MSC+, SNBC)
    - Refer to the Partner Nursing Home Checklist (MSHO, MSC+)
    - Medica will track the days, and will place authorizations in the system when needed.

Pharmacy-

Please refer to the SNBC product specific evidence of coverage for detailed pharmacy information. For those members on Medicare, refer to their Medica part D provider for questions regarding coverage. SNBC includes medications covered under Medical Assistance including over-the-counter medications.

- If a member does not have Medicare, Medica pays for all Medications

- Formularies are available on Medica.com, under each specific product page.

- For SNBC MA only members—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.

Transportation-

If a member does not have access to a vehicle, Medica Provide-A-Ride will help schedule transportation to and from health care visits. More information regarding transportation can be located under Tools and Forms—Provide-A-RideSM

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 Evidence of Coverage for more detailed information.

Other

Benefit Guidelines: Medica has created benefit guidelines to help guide care coordinators in service planning. These can be found here.

Impact Report:
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 is not a change to what you are required to do, but rather some resources and recommendations for best practices for managing at risk members in order to decrease unnecessary hospitalizations and improve their quality of care.

Leave-Behind Care Coordinator Document: This is required to be given to the member annually. Medica Care Coordinator Leave-Behind Document

Medica Care Coordination Website: https://www.medica.com/care-coordination
The website 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.

• 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 and procedures that guide care coordination activities and operations, as well as ICSI guidelines.

• 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.
**Member Transfers:** It is very important that we provide the receiving care coordinator/care system with all of the information that will benefit them in providing care coordination for the members. Once a CC is aware of a member transfer they are to submit the DHS-6037 to Enrollment. Enrollment will confirm the transfer and then the CC can provide the additional supporting documentation to Enrollment for Enrollment to forward onto the receiving care coordination entity. The transfer documents can be sent via SPPEnrollmentQ@medica.com or via fax 952-992-2682. See the Member Transfer Responsibilities policy for more details on this process.

**Medicaid Management Information System (MMIS):** MMIS must be kept current to the CC’s name per DHS contract for members not on a waiver program. See the Assessment Schedule Policy (SNBC) for more information on this process.

**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 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 fit to be released from the program.

Each member is assigned a nurse in Medica’s Special Investigative Unit (SIU). The member is given the nurse’s 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, they can call 1-888-906-0970. Additional information on the RRP and referrals can be found on Medica.com and the Provider Administrative Manual.

**Transitions:** Monitoring and managing transitions, whether they are planned (ex. scheduled knee surgery) or unplanned (emergency admission due to an acute episode) is an important function of the care coordinator. Not only does this care coordinator involvement make the transitions more seamless, it also is a requirement of us by 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. Please note the transition log does not need to be completed for SNBC members however, transition activities do 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/responsible party is involved in the planning and timing of the admission. An unplanned admission is
usually due to illness or accident.

Requirements:
- Upon notification of admission:
  - Communicate within one business day of notification of admission with the receiving facility to share key elements of the care plan. This may include: current services, informal supports, advance directives, medication regimen, CC contact information, etc.
  - Communicate admission with primary care provider (PCP) within one business day of notification unless PCP was the admitting physician.
  - Communicate with the member/responsible party 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.
- Start a new note if there are additional transitions that occur before return to the usual care setting.
- Upon discharge to their usual or “new” usual care setting:
  - Communicate with member/responsible party about the care transition process; about changes to the member’s health status; plan of care updates; educated member/responsible party about transitions and how to prevent unplanned transitions/readmissions. Education should include: information about importance of keeping appointments and addressing potential barriers, medication self-management, knowledge of warning signs, and benefits of maintaining a personal health record, etc.

Update the member’s plan of care as needed

Transition Care
- Notification of Care Transition Fax
- Transition Log
- Transition Log Instructions

Note: The Transition Log is not required for SNBC. However, care coordinators should work to support and manage members during all transitions regardless of whether the log is required.

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