PROVIDER UPDATE

MediGold

MARCH 2026

To ensure that we are continuing to provide quality content and salient topics, the Provider Update has moved to a quarterly cadence. Thank you for your ongoing dedication to member engagement.

Help Us Maintain Provider Directory Accuracy

Directory accuracy is an industry-wide issue, and CMS itself has been working to identify solutions to improve the accuracy of directory data. We now have approximately 48,000 physicians and 2,000 facilities published in our directory. CMS requires that members be able to call — and make an appointment with — any physician published in a health plan's directory. This means there are some specialties that will always be excluded (such as Anesthesiologists, for example).

Data published in our directory comes to us directly from our contracted provider groups via contracts or monthly "rosters," which our Provider Data Management (PDM) Team then uses to load newly added providers or update existing providers in HealthRules Payer (HRP), our core operating system. **It's important to note that a significant portion of our provider data is delegated to our provider groups themselves.**

This means these delegated groups are **accountable for maintaining and updating addresses, phone numbers and participation status for their providers published in our directory. In addition, identify what has changed in each monthly roster on your change report.**

Please notify us of any changes by navigating to the Provider Information Change Form.

We're Here To Serve You.

Trinity Health Plan of Michigan is a Medicare Advantage plan, fully owned by Trinity Health. It's designed to provide our members with a more seamless health care experience, while also making it easier for health care teams to coordinate and deliver the best possible care. LEARN MORE

Provider Service Center 800-991-9907 (TTY: 711)

1 Trinity Health Plan of Michigan is a Medicare Advantage organization with a Medicare contract. Enrollment in Trinity Health Plan of Michigan depends on contract renewal. Benefits vary by county.

PRJ-11137

Reminder: Novologix and 2026 Part B Drug Prior Authorization and Step Therapy Updates

On January 1, 2026, Trinity Health Plan of Michigan expanded our Part B drug prior authorization (PA) requirements and implemented step therapy for select medications. These changes support high-quality, evidence-based use of drug therapies and help ensure members receive the most clinically appropriate and cost-effective treatment.

What is Changing in 2026?

1. Expanded Part B Drug Prior Authorization Scope

As of 1/1/2026, additional Part B medications require prior authorization. A complete up-to-date list of drugs requiring authorization can be **found here**.

2. New Step Therapy Requirements

We are introducing step therapy for certain Part B medications where therapeutically comparable alternatives exist. A list of drugs requiring step therapy can be **found here**.

We are also pleased to share that on January 1, 2026, we partnered with CVS Caremark, powered by the Novologix online prior authorization system, for our Part B drug prior authorization and step therapy reviews.

The transition will streamline processing, enhance clinical consistency and improve turnaround times.

Submitting Authorization Requests

- You may submit prior authorization requests via phone, fax or mail:
- Call: **1-800-932-7013**
  - o Monday - Friday, 9am - 7pm EST
  - o Weekend coverage: 8am - 4:30pm EST
- Fax: **1-844-306-1163**
- Write: CVS Caremark Medicare Part B Department

  Attn: Part B NLX Team
  P.O. Box 52000 MC 109
  Phoenix, AZ 85072-2000

What You Need to Do:

Please submit all Part B drug prior authorization requests to CVS Caremark powered by Novologix using one of the methods described above.

If you have questions about these changes, please contact CVS Caremark at **1-800-932-7013**.

Our appeals process remains unchanged. Please continue to submit Part B drug appeals directly to Trinity Health Plan of Michigan. Contact information for appeals is located **on our website**.

Effective 4/1/2026, our plan will be adding skin substitutes and biologics for wound care to our prior authorization list. The codes that will require prior authorization are:

- CPT codes 15002-15278
- HCPCS codes Q4101-Q4433 and A2001-A2010

Submit these requests to the Utilization Management department for review via fax, email or through our Essette Provider Portal for Authorizations. If you have any questions, please outreach to Lindsey Glass, Director Utilization Management.

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Best Practices for Coding/Documentation

The Centers for Medicare & Medicaid Services (CMS) requires reporting all applicable diagnosis codes, diagnoses to the highest level of specificity and substantiation in the medical record. This is important because proper coding and documentation impacts the patient's overall quality of care and reimbursement accuracy.

The following are four key best practices for coding/documenting the medical record:

1. **Problem list:** Should be kept up-to-date and show the status of each condition (e.g., active, chronic or resolved and whether the condition is "current" or no longer has the condition, rather "history of"). Do not use only default, unspecified codes – they do not accurately show severity.
2. **Include all problems in the assessment:** Don't limit the diagnosis codes to only those that brought the patient into the office. All problems assessed during the visit should be noted in the assessment and coded accordingly.
3. **All diagnoses should be documented:** Any diagnoses that were part of the provider's medical decision-making process should be documented. For instance, a patient being treated with medication that might affect the treatment of the current presenting issue should be documented and coded.
4. **Annually document all chronic conditions:** All chronic conditions should be assessed during a face-to-face encounter, at least once annually, and documented in the medical record. This includes status codes such as amputations, transplant status, ostomies, etc., as well as pertinent past conditions and other underlying medical problems.

Importance of Documentation

- Ensures that all the patient's medical conditions are addressed during the visit
- Supports accurate claim payment, reducing denials
- Allows for appropriate Risk Adjusted payment due to accurate coding of conditions
- Enables proper coding (if a condition is not documented, it cannot be coded)

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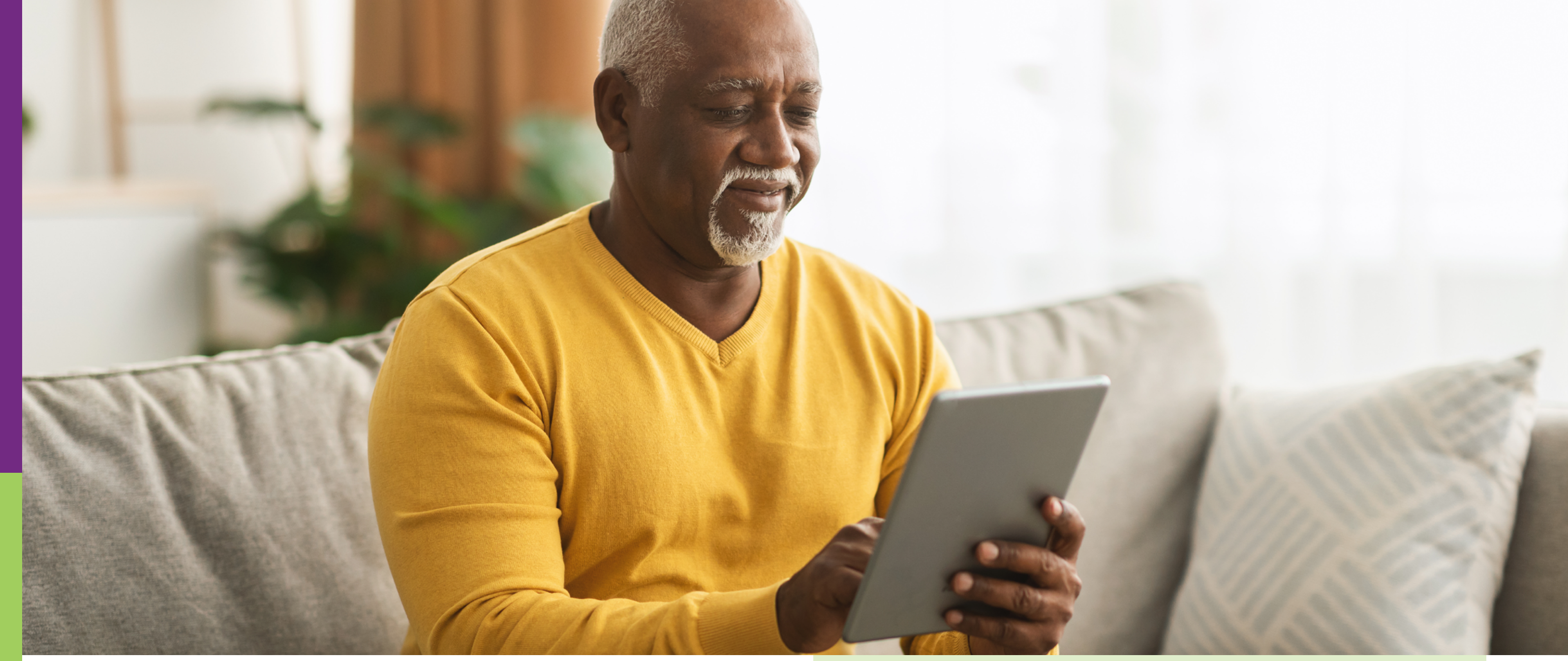


Upcoming CAHPS Survey Reminder

The Medicare Experience Survey or CAPHS will start to be distributed to Medicare members early March. Please let your patients know that they may receive a survey and encourage them to complete the survey online or send the survey back in the mail.

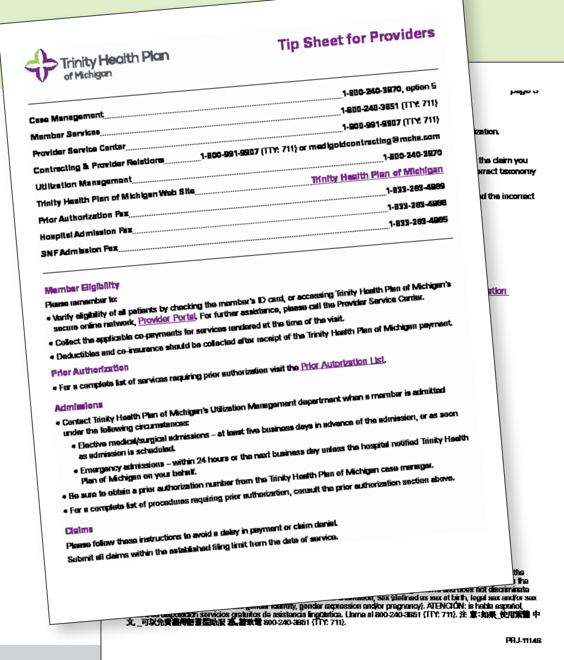
This survey will ask members to rate their experience with providers in areas such as:

- Provider patient communication
- Provider advice on health promotion topics
- Provider listening to patient
- Coordination of care
- Ease of scheduling appointments

This survey is important because it helps to ensure the best care for our members through a better understanding of their experiences. Thank you for your support in this survey process and for continuing to provide high quality care to our members!

Tip Sheet for Providers

For important contacts, information on member eligibility, claims and more, as well as other resource links, go to **Trinity Health Plan of Michigan Provider Resources**. You can also print out the tip sheet for providers here.



Trinity Health Plan of Michigan

Tip Sheet for Providers

Case Management .... 1-800-240-3870, option 5
Member Services .... 1-800-240-3851 (TTY: 711)
Provider Service Center .... 1-800-991-9907 (TTY: 711)
Contracting & Provider Relations .... 1-800-991-9907 (TTY: 711) or medigoldcontracting@mchs.com
Utilization Management 1-800-240-3870
Trinity Health Plan of Michigan Web Site .... Trinity Health Plan of Michigan
Prior Authorization Fax 1-833-263-4869
Hospital Admission Fax 1-833-263-4868
SNF Admission Fax 1-833-263-4865

Member Eligibility

Please remember to:

- Verify eligibility of all patients by checking the member's ID card, or accessing Trinity Health Plan of Michigan's secure online network, Provider Portal. For further assistance, please call the Provider Service Center.
- Collect the applicable co-payments for services rendered at the time of the visit.
- Deductibles and co-insurance should be collected after receipt of the Trinity Health Plan of Michigan payment.

Prior Authorization

- For a complete list of services requiring prior authorization visit the Prior Autorization List.

Admissions

- Contact Trinity Health Plan of Michigan's Utilization Management department when a member is admitted under the following circumstances:
  - Elective medical/surgical admissions – at least five business days in advance of the admission, or as soon as admission is scheduled.
  - Emergency admissions – within 24 hours or the next business day unless the hospital notified Trinity Health Plan of Michigan on your behalf.
- Be sure to obtain a prior authorization number from the Trinity Health Plan of Michigan case manager.
- For a complete list of procedures requiring prior authorization, consult the prior authorization section above.

Claims

Please follow these instructions to avoid a delay in payment or claim denial.
Submit all claims within the established filing limit from the date of service.

Do You Have Access to our Provider Portal?

Through the Provider Portal, you can:

- Verify eligibility of members
- Verify member claims history
- View member payment status, and more!

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