MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, OH 44115-1355

Mutual News

Fourth Quarter, 2017

Inside This Issue

This material is considered part of the ProviderManual for Medical Mutual of Ohio® and its subsidiaries. Mutual News and Mutual News Bulletin are published for network providers serving Medical Mutual. To contact us or for more information, visit Provider.MedMutual.com.

MEDICAL MUTUAL®

Mutual News Fourth Quarter, 2017

Stay Informed with the Provider Manual

The Provider Manual is available at Provider.MedMutual.com under Tools and Resources. The Provider Manual is updated quarterly to include the latest policies, procedures and guidelines providers need to effectively work with Medical Mutual.

During Q4 2017, the following subsections were added to the the Provider Manual:

- Care Management Overview (Section 3): NaviNet
- Care Management Overview (Section 3): eviCore
- Medicare Advantage Plans and Guidelines (Section 12): Advance Beneficiary Notice of Non-coverage (ABN)
- Medicare Advantage Plans and Guidelines (Section 12): First Tier Downstream and Related Entities (FDR)

Provider.MedMutual.com

Contact Us

Visit **Provider.MedMutual.com** to log in to the Provider Portal.

If you have questions, please contact your provider contracting representative:

Central/SE Ohio (Columbus Office)
(800) 235-4026

NE Ohio/Pennsylvania (Cleveland Office)
(800) 625-2583

NW Ohio/NE Indiana (Toledo Office)
(888) 258-3482

SW Ohio/SE Indiana/Kentucky (Cincinnati/Dayton Office)
(800) 589-2583

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised beginning July 1 through September 18, 2017 are outlined in the following charts. CMPs are regularly reviewed, updated, added or withdrawn, and therefore are subject to change. For a complete list of CMPs, please visit Provider.MedMutual.com and select Tools & Resources, Care Management, and Corporate Medical Policies.

Medical

Policy Number		Title
94007	●	Evaluation of Vestibular Disorder
94022	●	Bone Mineral Density Studies
94057	●	Light Therapies for Dermatological Conditions
95029	●	Manipulation Under Anesthesia
99005	●	Allergy Testing
200117	●	Continuous Glucose Monitoring
200135	●	Surgical Treatment of Migraine Headaches
200209	●	Pancreas-Kidney Transplantation
200224	●	Sublingual Immunotherapy
200229	●	Whole Body CT Scan Screening
200301	●	Small Bowel, Small Bowel-Liver and Multivisceral Transplantation
200314	●	Prothrombin Time (PT) or International Normalized Ratio Home Monitoring
2003-C	●	Electrical Stimulation for Treatment of Dysphagia
2005-D	●	Percutaneous Neuromodulation Therapy
2005-E	●	Pulsed Electrical Stimulation—Osteoarthritis of Knee
2006-D	●	Radiofrequency Microtenotomy
2007-C	●	Endobronchial Valve for Tx of a Brochopleural Fistula
2007-E	●	Uterine-Sparing Fibroid Treatments
200801	●	Smooth Pursuit Neck Torsion Testing
200813	●	Artificial Intervertebral Disc Replacement
200903	●	Skin Surveillance Technologies
200905	●	Surgical Repair of Pectus Deformities
2009-C	●	Anal Fistula Plug
201017	●	Autologous Platelet-Rich Plasma
201022	●	Spinal Unloading Device—Low Back Pain—Scoliosis
201105	●	Prolotherapy—Musculoskeletal Conditions
2011-B	●	Bioimpedance Spectroscopy
2011-C	●	Wireless Gastrointestinal Motility Monitoring System
2011-E	●	Suit Therapy
2011-F	●	Ovarian Adnexal Mass Assessment Score Test System
201202	●	FerriScan
2012-B	●	Bronchial Thermoplasty
2013-B	●	Bulking Agents for Fecal Incontinence—Solesta
201426	●	Transcatheter Pulmonary Valve Implementation
2014-A	●	Nonsurgical Treatment of Obstructive Sleep Apnea
201525	●	Thermal Intradiscal Procedures for Chronic Low Back Pain
201526	●	Low Level Laser (Light) Therapy
201528	●	Disc Decompression
201531	●	Salivary Hormone Testing
201532	●	Gait Analysis
201536	●	Quantitative Sensory Testing
201539	●	Radiofrequency Thermal Neurolysis
2015-A	●	Prostatic Urethral Lift
2015-B	●	Sacroiliac Joint Fusion (iFuse System)
2015-C	●	Computer-aided Detection of Breast MRI
201617	●	Non-wearable automatic external defibrillator (AED)
2016-B	●	Myoelectric Mobility Systems—Upper Extremity
201721	▲	iStent Trabecular Micro-Bypass
2017-B	▲	Micra Transcatheter Pacing System (TPS)
98017	■	Ventricular Assist Devices and Total Artificial Heart System
200606	■	Radiofrequency Ablation for Treatment of Trigeminal
201309	■	Implantable Miniature Telescope
201402	■	Bone Growth Stimulation (Invasive & Semi-Invasive)
201515	■	Digital Breast Tomosynthesis
201530	■	Breath Testing for Detection of Heart Transplant Reject

▲ = New ● = Revised ■ = Retired

Pharmacy

Policy Number		Title
201316-CC	●	Immune Globulin IV (IVIG) Bivigam Carimune NF Flebogamma DIF Gammagard Gammagard SD Gammaplex Gamunex-C Octagem Privigen
201711	●	Darzalex (Daratumumab)
201415-CC	●	Docetaxel
201404-CC	●	Herceptin (Trastuzumab)
201430-CC	●	Keytruda (Pembrolizumab)
201006	●	Haegarda (c1 esterase inhibitor)
201614	●	Zinbryta (Daclizumab)
201732	▲	Rituxan Hycela (Rituximab and Hyaluronidase)
201720-CC	●	Global PA
201305	●	Tysabri (Natalizumab)
201511-CC	●	Opdivo (Nivolumab)
201731	▲	Tremfya (Guselkumab)
99002	●	Viscos/Hyaluronic Acid Derivatives Euflexxa Gel-One Gelsyn-3 GenVisc 850 Hyalgan Hymovis Monovisc Orthovisc Synvisc Synvisc-One Supartz/Supartz FX
201521	●	Nplate (Romiplostim)
201107	●	Benlysta (Belimumab)
201423-CC	●	Entyvio (Vedolizumab)
201410-CC	●	Oncology Medications
201722-CC	●	Cyclophosphamide IV
201424	●	Colony Stimulating Factors Neupogen Neulasta Zarxio Granix Leukine
200807	▲	Renflexis (Infliximab-abda)
201612	●	Probuphine (Buprenorphine)
201619-CC	●	Tecentriq (Atezolizumab)
201729	▲	Radicava (Edaravone)
200809	●	Orencia (Abatacept)
201410-CC	▲	Vyxeos (Daunorubicin/Cytarabine)
201312	●	Erythropoietin Stimulating Agents (ESA) Aranesp Epogen Procrit
201317	●	Immune Globulin SC (SCIG) Gammagard Gammaked Gamunex-C Hizentra HyQvia Cuvitru
201708	●	Ocrevus (Ocrelizumab)
201510	●	Mircera (Methoxy Peg-Epoetin Beta)
201714	▲	Parsabiv (Etelcalcetide)
201707	▲	Kymriah (Tisagenlecleucel)
201410-CC	▲	Mylotarg (Gemtuzumab Ozogamicin)
201410-CC	▲	Besponsa (Inotuzumab Ozogamicin)
201412-CC	●	Erbitux (Cetuximab)
201428-CC	●	Vectibix (Panitumumab)

▲ = New ● = Revised ■ = Retired

Pharmacy

Update to Hyaluronic Acid Product Coverage for Medical Mutual Plans, except for Medicare Advantage

The preferred hyaluronic acid products for Medical Mutual plans, except for Medicare Advantage Plans, are noted on the left side of the table below. Effective August 10, 2017, all other hyaluronic acid products, including those on the right side of the below table, will be considered non-preferred and will require a trial of a preferred product first. For more information, please visit Provider.Medmutual.com, Tools and Resources, Care Management, Corporate Medical Polices.

Preferred Products*	Non-Preferred Products		
▪ Euflexxa	▪ Gel-One	▪ Hyalgan	▪ Orthovisc
▪ Synvisc	▪ Gel-syn-3	▪ Hymovis	▪ Supartz FX
▪ Synvisc One	▪ GenVisc 850	▪ Monovisc	

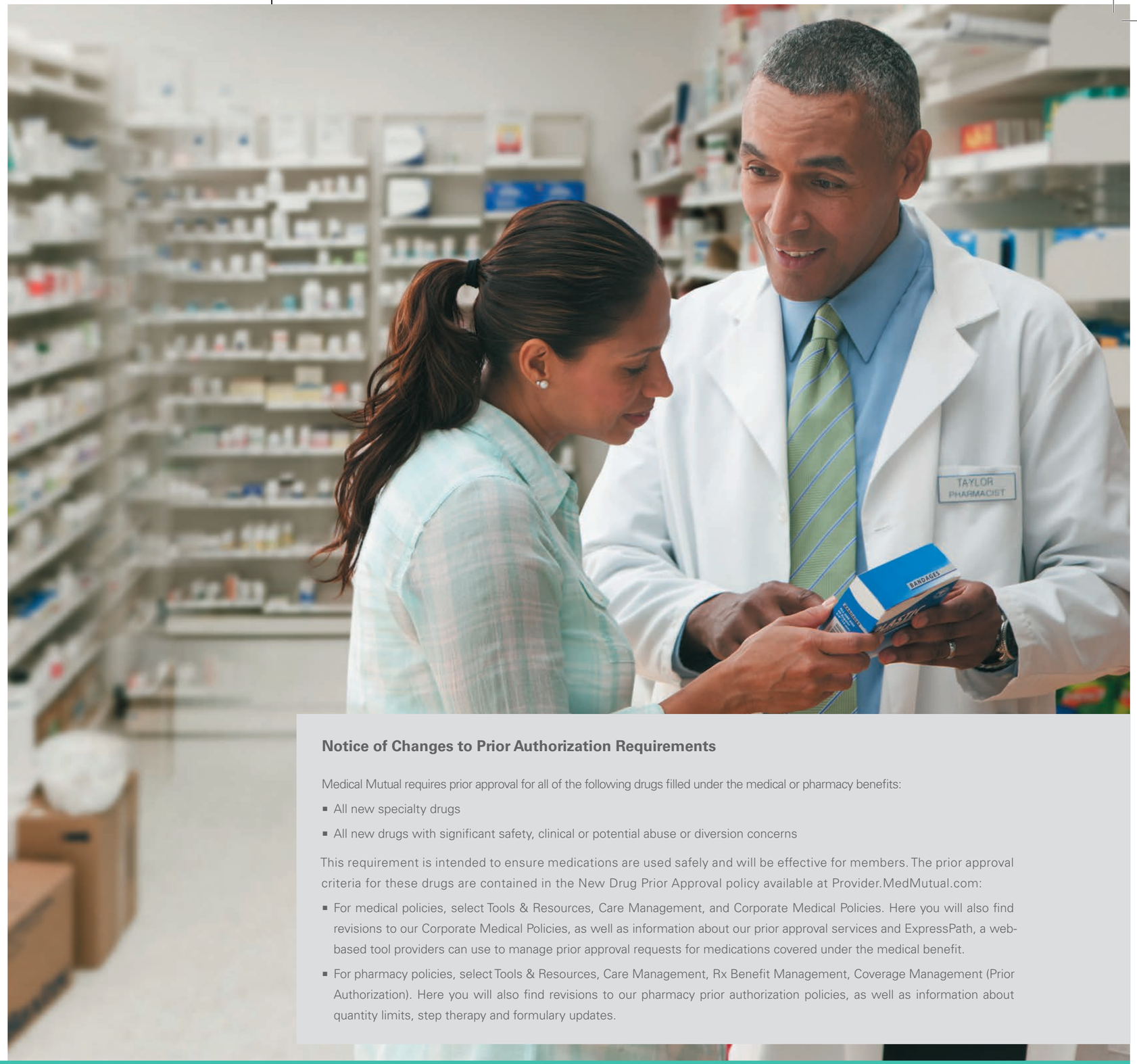
*Preferred products are subject to any benefit limitation set forth in the member's benefit certificate.

Pain Management Program 2018

Effective January 1, 2018, Medical Mutual will be implementing an expanded opioid management program in order to reinforce compliance with state regulations and guidelines. Additional information about these changes are posted at Provider.MedMutual.com, Tools & Resources, In the News, and search by the article titled *Opioid Management Program 2018*.

Express Scripts Discontinues Duplicate Prior Authorization Approval Notifications

Please note physician offices will no longer receive a prior authorization approval letter from Express Scripts in the mail when the approval has already been provided electronically. This change will help eliminate redundancy.



Notice of Changes to Prior Authorization Requirements

Medical Mutual requires prior approval for all of the following drugs filled under the medical or pharmacy benefits:

- All new specialty drugs
- All new drugs with significant safety, clinical or potential abuse or diversion concerns

This requirement is intended to ensure medications are used safely and will be effective for members. The prior approval criteria for these drugs are contained in the New Drug Prior Approval policy available at Provider.MedMutual.com:

- For medical policies, select Tools & Resources, Care Management, and Corporate Medical Policies. Here you will also find revisions to our Corporate Medical Policies, as well as information about our prior approval services and ExpressPath, a web-based tool providers can use to manage prior approval requests for medications covered under the medical benefit.
- For pharmacy policies, select Tools & Resources, Care Management, Rx Benefit Management, Coverage Management (Prior Authorization). Here you will also find revisions to our pharmacy prior authorization policies, as well as information about quantity limits, step therapy and formulary updates.

Care Management & Clinical Practice Guidelines

Prior Authorization Process Updates

eviCore

Medical Mutual recently engaged eviCore healthcare (eviCore) to manage the prior authorization process for outpatient radiology services for Medical Mutual's fully insured and self-funded group members, including those in commercial, individual and Medicare Advantage plans. The updated radiology prior authorization requirements begin for dates of service on or after January 1, 2018. eviCore will begin accepting reviews on December 18, 2017. Prior to these dates, there are no changes in requirements and providers should continue to submit requests to Medical Mutual directly as they do today for imaging services.

NaviNet

Medical Mutual has also engaged NaviNet beginning January 1, 2018 to provide a new electronic tool for submitting prior authorization requests for members, including those in group, individual and Medicare Advantage plans. Using this online tool will create efficiencies in the prior authorization request process for providers. Providers will be able to receive confirmation that the request was sent and received, receive real-time status updates, upload supportive documentation, and submit appeals online if appropriate.

Closing the Gaps on Needed Care

Strong relationships between a member and his/her primary care practitioner, along with connections to specialists for needed care, are key elements to a person's well-being. As 2017 draws to a close, Medical Mutual asks that providers take action to remind and schedule important preventive and screening activities for Medical Mutual members.

Whether members are seeing providers for the first time this year for their annual visit, for follow up on chronic care conditions such as diabetes, or for getting medical clearance for surgery, Medical Mutual encourages providers to check the following list of preventive and screening activities to close any gaps before the end of 2017.

While needed services vary among patients based upon gender, age and health condition, the ones below have shown to be beneficial:

- Annual visit
- Body Mass Index (BMI): Take height and weight and calculate BMI
  - Refer to: NHLBI.NIH.gov/Health/Educational/Lose_Wt/BMI/BMI_tbl.htm
- Blood Pressure (BP): If BP > 140/90 then retake after 10 minutes
- Breast cancer screening by mammogram starting at age 50 or sooner if history warrants
- Cervical cancer screening starting at age 21
- Colorectal screening by colonoscopy starting at age 50 or sooner if history warrants
- Comprehensive Diabetes Care:
  - Hba1c testing twice per year
  - Diabetic Retinal Eye Exam annually
  - Urine test to monitor for Diabetic Nephropathy annually
- Flu shot annually and Pneumonia vaccine visit CDC.gov/Vaccines
- Discussion on bladder control if there are symptoms of incontinence
- Falls risk assessment including bone density testing for signs of Osteoporosis in older adults
- Medication reconciliation at each visit

Providers are the key to helping Medical Mutual members maintain their health and in engaging them to complete these annual goals. To learn more about Medical Mutual's close the Care Gaps program, please visit MedMutual.com/CareGaps.

These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their health care providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.

Managing Patients' Lower Back Pain

According to Choosing Wisely, an initiative of the ABIM Foundation, many professional medical organizations recommend not performing imaging (plain radiographs, MRI or CT scans) of the spine in patients with non-specific acute low back pain and without red flags. Some red flags include:

- Significant trauma related to age (e.g., injury related to a fall from a height, motor vehicle crash in a young patient, heavy lifting in a patient with known or suspected osteoporosis)
- Major or progressive motor or sensory deficit, new onset bowel or bladder incontinence or urinary retention
- Saddle anesthesia
- History of cancer with metastatic bone disease
- Suspected spinal infection

Patient education, medications (non-steroidal anti-inflammatory drugs, acetaminophen or muscle relaxants) and referral to physical therapy for a home exercise program are beneficial.

Sources:

2012, Diagnosis and Treatment of Acute Low Back Pain, American Family Physician, February Issue.

2014, Don't obtain imaging (plain radiographs, magnetic resonance imaging, computed tomography(CT), or other advanced imaging) of the spine in patients with non-specific acute low back pain and without red flags, American Association of Neurological Surgeons and Congress of Neurological Surgeons, June Issue.

Medicare Advantage

Update to Hyaluronic Acid Product Coverage for Medicare Advantage Plans

The preferred hyaluronic acid product for Medical Mutual Medicare Advantage plans is noted on the left side of the table below. Effective August 10, 2017, all other hyaluronic acid products, including those on the right side of the table below, will be considered non-preferred and will require a trial of the preferred product first. For more information, please visit Provider.Medmutual.com, Tools and Resources, Care Management, Corporate Medical Polices.

Preferred Products*	Non-Preferred Products		
▪ Euflexxa	▪ Gel-One	▪ Hymovis	▪ Synvisc
	▪ Gel-syn-3	▪ Monovisc	▪ Synvisc One
	▪ GenVisc 850	▪ Orthovisc	
	▪ Hyalgan	▪ Supartz FX	

*Preferred products are subject to any benefit limitations set forth in the members benefit certificate.

Reminder about Part D Prescriber Enrollment Requirements

As a reminder, the Centers for Medicare & Medicaid Services (CMS) delayed enforcement of the Part D Prescriber Enrollment Requirements until January 1, 2019. At that time, Medicare may not cover drugs prescribed for Medicare Advantage Part D patients by providers who are not enrolled in or validly opted out of Medicare.

According to CMS, the goal of this requirement is to ensure basic quality protection for Medicare Part D beneficiaries. It is important providers take action to minimize disruption in their patients' access to needed Part D medications. CMS encourages prescribers to submit their enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) as soon as possible.

To enroll, follow one of these processes:

- Use the PECOS system at Go.CMS.gov/PECOS. Step-by-step instructions are available at Go.CMS.gov/PECOSSteps. A video tutorial can be found at Go.CMS.gov/PECOSVideo.
- Complete the paper application for limited enrollment at Go.CMS.gov/CMS855O and submit it to the MAC in your geographic area. A list of MACs by state is available at Go.CMS.gov/PartDMACList.

To opt out of Medicare, visit Go.CMS.gov/OptOutInfo. Please direct any questions to CMS at ProviderEnrollment@CMS.HHS.gov.

Please note, Medical Mutual may remove from our Medicare Advantage networks any provider who fails to fully enroll in Medicare, or who fails to partially enroll as a prescriber. In addition, any provider who opts out of Medicare cannot be part of Medical Mutual's Medicare Advantage networks.

First Tier, Downstream, and Related Entities (FDR) Oversight

As a designated Medicare Advantage Organization (MAO), Medical Mutual must comply with and meet certain Centers for Medicare & Medicaid Services (CMS) requirements. Medical Mutual is obligated to oversee compliance for its First Tier, Downstream and Related Entities (FDRs), and establish and implement an effective system for routinely auditing and monitoring compliance. Medical Mutual requires providers to submit an FDR attestation form annually.

Provider Directory Reminder

The Medicare Advantage provider directory is the most commonly used tool available to members and their caregivers to access information about providers. This means maintaining a current and accurate provider directory is vital for connecting members and their caregivers with providers and access to care.

To help ensure accurate information in our provider directories, we ask you to take the following steps:

1. Review your information in the provider directory on a monthly basis.
2. Update your address, locations and phone number when there are changes to your practice via the Provider Information Form located at Provider.MedMutual.com, Tools & Resources and Forms.
3. Work directly with the entity responsible for the accuracy of your directory information if your credentialing is delegated to a third party.

As a Medicare Advantage Organization, Medical Mutual follows the Centers for Medicare & Medicaid Services (CMS) guidelines for what can and cannot be included in a Medicare Advantage provider directory.

Maintaining a current and accurate provider directory is vital for connecting members with access to care.

These are the general areas where CMS provides guidance regarding provider directories:

- The provider must regularly practice at the specific location listed
- Providers who are on-call, substituting or rotating cannot be listed
- Satellite locations cannot be listed unless the provider practices at the location on a regular basis and members can call the location to schedule an appointment
- Hospital locations for which a member cannot call the phone number listed and make an appointment at the hospital location cannot be listed in the directory
- The correct office address, including suite number, must be included in the listing.
- The group name printed in the directory must match the group name given when the member calls to make an appointment.
- The listing must include an accurate status of whether the provider is accepting new patients
- Providers must notify Medical Mutual if the services provided at a location are limited to a certain subset of patients.

For questions about providing demographic information for claims payment purposes, contact your Medical Mutual Provider Contracting Representative. To find your Provider Contracting Representative, visit Provider.MedMutual.com, Tools & Resources, Contact Us.

Accessibility Standards

In an effort to ensure Medicare Advantage members have timely access to care, Medicare Advantage providers are required to follow the access guidelines at Provider.MedMutual.com, Tools & Resources, Provider Manual.

Providers must also ensure wait times in the provider office do not exceed the following standards:

- Scheduled Appointments: Wait times must not exceed 60 minutes. After 30 minutes, covered persons must be provided with an update on waiting time with an option of continuing to wait or rescheduling the appointment.
- Walk-in Appointments: Wait times must not exceed 90 minutes. After 45 minutes, covered persons must be provided with an update on waiting time with an option of continuing to wait or rescheduling the appointment.

Providers must ensure response times for returning calls after hours do not exceed the following standards:

- Urgent calls: Must not exceed 20 minutes
- Non-urgent calls: Must not exceed one hour

Waiver of Liability (WOL)

A provider who is NOT contracted with Medical Mutual as a Medicare Advantage Network provider is permitted to file a standard appeal for a denied claim only if the non-contracted provider completes a waiver of liability statement (WOL). By signing and submitting the WOL, the non-contracted provider waives any right to bill the Medicare Advantage member regardless of the outcome of the appeal. The form can be found at Provider.MedMutual.com, Tools & Resources, Forms, Waiver of Liability.

Medical Mutual cannot process an appeal from a non-contracted provider until a WOL is received. The case will be dismissed if the WOL is not received within 60 days of receipt of the appeal.

Note: There is a possibility a provider is contracted with Medical Mutual as a network provider in commercial networks, but not for the Medicare Advantage Network, so Medical Mutual asks that providers be aware of their network status with Medical Mutual's Medicare Advantage plan and submit the WOL as applicable.

Advance Beneficiary Notice of Non-Coverage (ABN)

The Advance Beneficiary Notice of Non-Coverage (ABN) is not permitted to be used for Medicare Advantage members. While this notice may be used with original Medicare beneficiaries, it is not acceptable for use with members of Medical Mutual's Medicare Advantage plans.

If a provider believes an item or service may not be covered, or could be covered only under specific conditions, the appropriate process for the provider or the Medicare Advantage member to follow is:

- Contact Medical Mutual at the number listed on the member's identification card to confirm benefits and eligibility
- Request a prior written advance determination of coverage (also known as a prior authorization request) from Medical Mutual. This should be completed in advance of providing the service to the member and may be requested using Medical Mutual's Prior Approval Form available on our website at: Provider.MedMutual.com, Tools & Resources, Forms, Prior Approval Form

DO NOT HAVE THE MEDICARE ADVANTAGE MEMBER SIGN A WAIVER OR ANY OTHER ADVANCE NOTICE.

If the service requested by the provider is determined to be not covered, the provider and the Medicare Advantage member will receive a Notice of Denial of Medicare Coverage (NDMC). This notice will inform the Medicare Advantage member of his/her liability, which will provide documentation that the Medicare Advantage member was notified prior to the receipt of the service and that he/she is liable for the full cost of the service.

Medical Mutual expects all Medicare Advantage Network providers to follow this process.

Mail Order Prescriptions

Medical Mutual encourages providers to discuss mail order/extended day supply options when writing prescriptions for Medical Mutual Medicare Advantage members. There is often a cost savings if members use the greater day supply option, and it could help in promoting medication adherence.

If the member elects to receive a 90-day supply via mail, please use the Express Scripts form located at Express-Path.com or e-prescribe. Any questions about the mail order form or e-prescribing can be directed to Express Scripts at (888) 327-9791.

For those members who choose not to use the mail order option, please write a 90 day prescription, as many of our retail pharmacies will dispense the extended day supply.

Social Security Number Replacement Initiative (SSNRI)

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 mandates the removal of the Social Security number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards to address the current risk of beneficiary medical identity theft. Per the legislative requirement, Centers for Medicare & Medicaid Services (CMS) will begin mailing Medicare cards with the new Medicare Beneficiary Identifier (MBI) no earlier than April 2018. The new MBI will replace the HICN. There will be a transition period where CMS will accept either the HICN or the MBI. The transition period will begin no earlier than April 1, 2018, and run through December 31, 2019.

Medical Mutual will provide additional details as to how this may impact provider transactions with Medical Mutual in the 2018 Q1 Newsletter.

Attention: Providers of Skilled Nursing & Skilled Therapy Services

Important information regarding the Jimmo v. Sebelius Settlement Agreement

Providers of skilled nursing and skilled therapy services should ensure all appropriate facility and/or practice staff review and understand the clarifications provided by the Centers for Medicare & Medicaid Services (CMS) regarding the Jimmo v. Sebelius Settlement Agreement. A short summary of the issue is outlined below, along with links to important websites for further education and training.

CMS reminds the Medicare community of the Jimmo v. Sebelius Settlement Agreement (January 2013). This settlement clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health and outpatient therapy benefits, when a beneficiary needs skilled care in order to maintain function, or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo v. Sebelius Settlement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

- Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so as long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a qualified therapist (skilled care) are necessary for the performance of a safe and effective maintenance program. The maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The Jimmo Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Jimmo Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide*.

For links to further information on this settlement, please view our *In the News* article.

*(Jimmo Settlement,"Important Message about the Jimmo Settlement", CMS.gov, August 2017)