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

Mutual News

Third Quarter, 2019

Inside This Issue

This material is considered part of the Provider Manual 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 MedMutual.com/Provider.

MEDICAL MUTUAL®

Mutual News

Third Quarter, 2019

Stay Informed with the Provider Manual

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

Sub-sections Revised — Current updates to the Provider Manual include:

- Section 2—Claims Overview
  - Time Limit for Submitting Claims
  - UB-04 Claims Involving Medicare
- Section 3—Clinical Quality & Health Services Overview
  - Prior Authorization
    - General Guidelines
  - Member Programs
    - Pharmacy Management Programs
- Section 4—Appeals Overview
  - Prescription Drug Appeals
- Section 5—Other Carrier Liability
  - Coordination of Benefits
    - COB with Medicare
- Section 12—Medicare Advantage Plans and Guidelines
  - Timely Notice of Demographic Changes
    - Provider Verification Outreach
  - Clinical Quality & Health Services Programs, HEDIS, and Stars
    - Quality Improvement
    - HEDIS
    - Star Quality Rating System
    - Access to Care
    - Grievances
    - Pharmacy Programs
  - Dual-eligible Beneficiaries
  - Fraud, Waste, and Abuse
    - FDR Oversight

Contact Us

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

If you have questions, please contact your Medical Mutual Provider Contracting representative:

Central/Southeast Ohio (Columbus Office)
1-800-235-4026

Northeast Ohio (Cleveland Office)
1-800-625-2583

Northwest Ohio (Toledo Office)
1-888-258-3482

Southeast Ohio/Kentucky (Cincinnati/Dayton Office)
1-800-589-2583

Sub-sections Removed

- Section 12—Medicare Advantage Plans and Guidelines
  - Prior Authorizations Required for All Home Health Services for Medicare Advantage Sub-section of General Network Guidelines Sub-section

Sub-sections Moved

- Section 12—Medicare Advantage Plans and Guidelines
  - Provision of Covered Services to Covered Persons Sub-section moved to Access to Care Sub-section of Clinical Quality and Health Services Programs, HEDIS, and Stars Sub-section

General Information

Notice of Changes to Prior Authorization Requirements:
New Prior Authorization Vendor for Medical Drugs

Effective Jan. 1, 2020, Medical Mutual will engage Magellan Rx Management to provide prior authorization services for specialty drugs when they are administered by professional and outpatient institutional providers to Medical Mutual members under the member's medical benefit. Magellan Rx Management is a utilization management company that will improve the efficiency of Medical Mutual's drug utilization review process.

You can review a complete list of medical drugs that require prior authorization by visiting MedMutual.com/Provider and selecting Tools & Resources, Care Management, Medical Policies, Prior Approval & Investigational Services. In addition, you can review corporate medical policies and associated prior approval forms by visiting MedMutual.com/Provider and selecting Tools & Resources, Care Management.

For select specialty drugs administered with a date of service on or after Jan. 1, 2020, prior approval requests must be submitted one of the following ways:

- Online at IH.MagellanRx.com
- By fax at 1-888-656-1948
- By phone at 1-800-424-7698

Requests are accepted electronically, or via facsimile, 7 days a week, 24 hours a day. Requests may be submitted by phone Monday through Friday, from 8:00 a.m. to 7:00 p.m., EST/EDT.

Note: If a provider would like a member to obtain a specialty drug through a retail network or mail/specialty delivery pharmacy under his/her prescription drug benefit, please contact the member's pharmacy benefit manager (PBM) at the number on the member's ID card for prior approval requirements. In some circumstances, a member may have a separate PBM prescription drug card.

Information related to Magellan Rx Management will be updated in the Prior Authorization sub-section of Section 3 – Clinical Quality and Health Services Overview of the Provider Manual as of Jan. 1, 2020.

Medical Mutual Implementing New Professional Claims Editing Processes

On Oct. 1, 2019, Medical Mutual is implementing new professional claims editing processes. We are enhancing our existing, internally developed claims editing processes, which we use to administer reimbursement policy and claim edit rules, by passing professional claims through the Optum Claims Edit System® (CES). CES uses the following sources for its edits:

- National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
- Federal Register (the Daily Journal of the US Government that contains agency rules, proposed rules and public notices)
- Medicare publications
- American Medical Association (AMA) Guidelines
- Local and National Coverage Determinations (LCDs/NCDs)
- Medicare Code Editor (MCE)

What do you need to do?

Because many other carriers with whom you work already use Optum's CES, we do not anticipate this implementation will disrupt how you work with Medical Mutual. CES will replace and supplement our legacy edits and automatically review and catch errors, omissions and questionable coding. The result will be streamlined claims, reduced reimbursement errors and improved payment integrity. All edits are transparent, and you will be able to look up specific claims and see both the edits and the sourced citations.

The following are examples of types of professional edits that will be reviewed through CES beginning Oct. 1:

Data validity edits

- Invalid diagnosis codes
- Diagnosis code requires additional digits
- Diagnosis to age or gender conflict
- Procedure to age or gender conflict
- Duplicate claim/line
- Missing required data field
- Place of service validation
- Provider specialty validation

Medical necessity edits

- Diagnosis not typical for procedure
- Not medically necessary for this age or gender

Frequency edits

- Maximum frequency exceeded (day/month/year)

Reduction edits

- Multiple procedure reduction
- Bilateral procedure reduction
- Team/Co-surgeon

Coding issues

- Add-on procedure billed as primary
- Unbundles
- Rebundles (lab codes/panel codes)
- Global follow-up

Anesthesia edits

- Anesthesia crosswalk
- Anesthesia secondary procedure
- Performed by non-anesthesia provider

To model how claims will process through CES, we encourage you to access the Optum Claim Edit Portal on the dashboard of our ePortal. Log in at MedMutual.com/Provider, then click News & Information. This web application allows users to test claims and identify possible edits without submitting a final claim to Medical Mutual. The test portal will be available on or around Sept. 15, 2019, to allow hypothetical claims processing for professional claims. Data entry points include a patient's gender, year of birth, procedure codes, diagnosis codes and modifiers. After Oct. 1, 2019, you will be able to enter your provider ID and a coordinating claim number to see CES edits on a processed claim.

Medical Mutual is updating certain sections of our Provider Manual as part of the implementation of these new professional claims editing processes. The updates are made in Section 3—Clinical Quality and Health Services Overview, Clinical Review Process, Clinical Claim Edits. The updated Provider Manual is available at MedMutual.com/Provider > Tools & Resources > Provider Manual.

State of Ohio Employees in the Columbus and Toledo Regions Now Medical Mutual Members

Effective July 1, 2019, Medical Mutual is the new medical plan administrator for State of Ohio employees in the Columbus and Toledo regions. Approximately 60,000 State of Ohio members in these areas are now covered by Medical Mutual, in addition to Medical Mutual's already existing coverage of State of Ohio members in Northeast Ohio.

As Medical Mutual is working to ensure a smooth transition for our new State of Ohio members, we are relying on providers to accept only up-to-date ID cards, pay close attention to prior authorization guidelines, and submit all claims accordingly.

State of Ohio members received their ID cards in June 2019. An example of a current Medical Mutual ID card can be reviewed below.

To review Medical Mutual's prior authorization guidelines, visit MedMutual.com/Provider and select Tools and Resources, Care Management, Prior Approval and Investigational Services Resources. Prior authorization information is also available in Section 3, Clinical Quality and Health Services, of the Provider Manual located at MedMutual.com/Provider.


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Ohio Med PPO

Print Date: XX/XX/XX

SuperMed XXXXXXXXXXXXXXXXXXXX PPO

NETWORK PRODUCT

John Q. Member XXXXXXXXXXX

Member Name

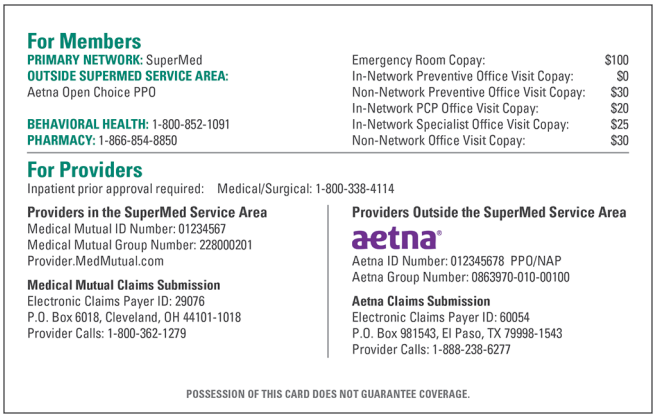
01234567 Medical Mutual ID Number

228000201 Group Number

1-800-822-1152 Customer Care

711 TTY

StateofOhio.MedMutual.com


For Members

PRIMARY NETWORK: SuperMed
OUTSIDE SUPERMED SERVICE AREA:
Aetna Open Choice PPO

BEHAVIORAL HEALTH: 1-800-852-1091
PHARMACY: 1-866-854-8850

Emergency Room Copay:	$100
In-Network Preventive Office Visit Copay:	$0
Non-Network Preventive Office Visit Copay:	$30
In-Network PCP Office Visit Copay:	$20
In-Network Specialist Office Visit Copay:	$25
Non-Network Office Visit Copay:	$30

For Providers

Inpatient prior approval required: Medical/Surgical: 1-800-338-4114

Providers in the SuperMed Service Area
Medical Mutual ID Number: 01234567
Medical Mutual Group Number: 228000201
Provider.MedMutual.com

Medical Mutual Claims Submission
Electronic Claims Payer ID: 29076
P.O. Box 6018, Cleveland, OH 44101-1018
Provider Calls: 1-800-362-1279

Providers Outside the SuperMed Service Area
aetna
Aetna ID Number: 012345678 PPO/NAP
Aetna Group Number: 0863970-010-00100

Aetna Claims Submission
Electronic Claims Payer ID: 60054
P.O. Box 981543, El Paso, TX 79998-1543
Provider Calls: 1-888-238-6277

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE.

Talk to Your Patients about Urinary Incontinence

Urinary incontinence, which is defined as involuntary leakage of urine, is especially common among older adults, ages 65 and over. While this condition can be improved or treated, many patients are hesitant to discuss it with their healthcare providers. The patient may feel embarrassed or lack the knowledge of available management and treatment options. The result is urinary incontinence often being underreported and left untreated, which can significantly reduce a patient's quality of life.

Talk to your patients about the options available for improving urinary health. Lifestyle changes and low-intensity behavioral therapies, including bladder training or pelvic muscle exercises, are safe, inexpensive treatment options ideal for first-time interventions. In addition to behavioral therapies, incontinence treatments include medications, medical devices, surgical procedures and other solutions.

Talking to Patients Increases Preventive Care Screening Rates

According to a study published by the American Society of Clinical Oncology, women with a designated primary care physician (PCP) had a higher likelihood of early breast cancer detection as a result of regular mammogram screenings[1]. Adherence to recommended women's cancer screenings, such as mammograms, drastically increases early-stage diagnosis and higher survival rates for cervical, breast and colorectal cancer.[2]

Despite the proven success of preventive services, many patients do not receive regular screenings. There are many barriers that contribute to this including patient refusal, scheduling issues and forgetfulness.[3]

PCPs have the ability to change negative cancer screening behaviors by talking with patients about their risk factors and the importance of consistent screenings. Regular discussions and shared decision making between providers and patients leads to individualized care, patient participation and increased health literacy when it comes to preventive screening adherence.

To ensure patients are getting quality information about preventive screenings, consider implementing programs and standards that proactively address communication needs.

- Research current preventive screening recommendations and talk to patients about any changes.
- Develop systems that incorporate preventive screening interventions into a daily routine. For example, automate a system to post preventive screening reminders on patient charts and online portals.
- Reduce barriers for patients by making it easy to schedule appointments, sending out preventive screening reminders and providing easy-to-access educational resources.
- Set organizational goals to evaluate performance in providing regular screening services.

Current Preventive Screening Guidelines

The U.S. Preventive Services Taskforce (USPSTF) recommends these preventive screenings for women at average risk for cervical, breast and colorectal cancer.

Type	Age	USPSTF Recommended Screening
Cervical Cancer	21–29	Cervical cytology (pap smear) every three years
	30–65	Cervical cytology and high-risk human papillomavirus (HPV) testing every five years
Breast Cancer	50–74	Screening mammography every two years
Colorectal Cancer	50–75	Stool-based tests (FIT, gFOBT) every year; direct visualization tests (flexible sigmoidoscopy, colonoscopy) every five or ten years

Source: U.S. Preventive Services Taskforce. Recommendations for Primary Care Practice. Available at: https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

1. Keshinro, A., Hatzaras, I., Dhage, S., Rifkind, K., & Joseph, K.A. P. (2017). Impact of primary care providers on patient screening mammography and initial presentation in an underserved clinical setting. Journal of Clinical Oncology. doi:10.1200/jco.2015.33.28_suppl.8.
2. Peterson, E. B., Ostroff, J. S., DuHamel, K. N., D'Agostino, T. A., Hernandez, M., Canzona, M. R., & Bylund, C. L. (2016). Impact of provider-patient communication on cancer screening adherence: A systematic review. Preventive medicine, 93, 96–105. doi:10.1016/j.ypmed.2016.09.034
3. Health Net Federal Services and TRICARE West. Improving Prevention Screenings. Available at: https://www.tricare-west.com/content/hnfs/home/tw/provclin_quality_initiatives/improve_screenings.html

Accurate Blood Pressure Reading Improves Hypertension Treatment

High blood pressure can easily be detected during a regular physician office visit. However, it takes more than one blood pressure reading to diagnose a patient with hypertension and develop an effective treatment plan.

Ensure your clinical staff are aware of the importance of taking and recording blood pressure readings correctly. Getting an accurate reading from the start and, if a patient has an elevated blood pressure, re-checking it before the patient leaves the office, as well as scheduling a follow-up appointment, are essential for providing proper care.

Office staff and coders should use the proper CPT II codes when submitting claims based on blood pressure readings. Below are important codes for reporting blood pressure results.

Code	Result
3074F	Systolic pressure less than 130
3075F	Systolic pressure 130-139
3077F	Systolic pressure great than or equal to 140
3078F	Diastolic pressure less than 80
3079F	Diastolic pressure 80-89
3080F	Diastolic pressure greater than or equal to 90

To help reduce elevated blood pressure, be sure to talk to your patients about the importance of maintaining a healthy diet, increasing physical activity and decreasing their level of stress. In addition, please review their medication list with them to ensure they are appropriately taking their medications as prescribed. Scheduling follow-up appointments with patients to monitor and administer repeated readings can also improve and sustain their health over time.

Additional resources for Medical Mutual members diagnosed with hypertension are available on the Medical Mutual Member Portal, including educational videos, assessment tools for high blood pressure and brochures containing tips for maintaining optimal heart health.

Changes to Medical Mutual Banking Vendors

Effective July 1, 2019, Fifth Third Bank replaced PNC Bank as our vendor for the disbursement of claims payments, accounts payable, broker fees and other disbursements. Providers do not need to complete any paperwork due to this change. Updates to provider disbursements were processed automatically.

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised, or retired between April 1, 2019, and June 30, 2019, 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 MedMutual.com/Provider and select Tools & Resources, Care Management, Corporate Medical Policies.

Medical

Policy Number		Title
95004	●	Surgical Management of Obstructive Sleep Apnea
200506	●	Retinal Imaging
200704	●	Intensity Modulated Radiation Therapy
200803	●	Scleral Shell Contact Lens
201721	●	Surgical Management of Obstructive Sleep Apnea
201914	▲	Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea
201302	■	Intensity Modulated Radiation Therapy

Pharmacy

Policy Number		Title
201418-CC	●	Abraxane
201101	●	Actemra IV
201405	●	Avastin
201107	●	Benlysta
98006	●	Botulinum Toxins Botox Dysport Myobloc Xeomin
200913	●	Cimzia
201518-CC	●	Cyramza
201704	●	Dupixent
200805	●	Enbrel
201423	●	Entyvio
201918	▲	Evenity
201717-CC	●	Faslodex
201410-CC	●	General Oncology
201307	●	Glatiramer Acetate (Copaxone®, Glatopa™)
201720	●	Global PA
201010	●	H.P. Acthar
201404-CC	●	Herceptin
201917-CC	▲	Herceptin Hylecta
200806	●	Humira
201306	●	Interferon Beta—Multiple Sclerosis Avonex Betaseron Extavia Plegridy Rebif
201513	●	Ocular VEGF Inhibitors Eylea Lucentis Macugen
201410-CC	▲	Oncaspar
201410-CC	▲	Polivy
201528	●	Praluent
200807-CC	●	Infliximab Remicade Renflexis Inflectra
201920	▲	Sinuvia
201919	▲	Skyrizi
201911	●	Spravato
201813	●	Yervoy
201901	▲	Zolgensma
201916	▲	Zulresso

▲ = New ● = Revised ■ = Retired

For a list of services requiring prior approval or considered investigational, please visit MedMutual.com/Provider and select Tools and Resources, Care Management, Prior Approval & Investigational Services.

Pharmacy

Pharmacy Prior Approval Requirements

Medical Mutual requires prior approval for the following drugs regardless of whether they are covered under 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 detailed in the Global PA/New Drug Prior Approval policy available at MedMutual.com/Provider.

For drugs covered under the medical benefit:
Select Tools & Resources > Care Management > Corporate Medical Policies. This page also includes all current Corporate Medical Policies and information about our prior approval services and ExpressPAth, a web-based tool providers can use to manage prior approval requests for medications.

For drugs covered under the pharmacy benefit:
Select Tools & Resources > Care Management > Rx Management, then click Coverage Management (Prior Authorization). This page also includes information about our other coverage management programs (e.g., step therapy, quantity limits) and formularies, as well as a link to the ExpressPAth tool.

Update to Infliximab Product Coverage for Medical Mutual Commercial and Affordable Care Act (ACA) Plans

Effective June 1, 2019, certain infliximab products are considered non-preferred medications. For members new to the therapy, Medical Mutual will require a trial of two preferred infliximab products before a non-preferred product can be prescribed.

Infliximab is a tumor necrosis factor inhibitor (TNFi) agent used to treat many types of inflammatory conditions, such as rheumatoid arthritis, Crohn's disease, plaque psoriasis, psoriatic arthritis and ulcerative colitis.

The preferred infliximab products for Medical Mutual commercial and Affordable Care Act (ACA) plans are noted on the left side of the chart below. The non-preferred products are shown on the right.

Preferred Products*	Non-Preferred Products
Remicade (infliximab)	Inflectra (infliximab-dyyb)
Renflexis (infliximab-abda)	Ixifi (infliximab-qbtx)

For more information, please visit MedMutual.com/Provider, Tools and Resources, Care Management, Corporate Medical Policies.

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

Risk Adjustment

Improve Coding and Diagnosis Documentation Accuracy

Comprehensive medical record documentation and accurate diagnosis coding play a critical role in ensuring accurate risk-adjusted payments. This ultimately impacts the services and benefits that Medical Mutual can provide to our members.

The Centers for Medicare and Medicaid Services (CMS) require that all applicable diagnosis codes be recorded and that all diagnoses be reported to the highest level of specificity. This must be substantiated by the medical record. As such, Medical Mutual conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding. These reviews are performed to ensure all required ICD-10 codes are duly reported to CMS.

Additionally, CMS requires that the medical record fully supports the diagnosis code(s) that have been reported previously by the healthcare provider.

To assist with accurate diagnosis coding and billing compliance, below are guidelines for various conditions, which are based on the ICD-10-CM Official Guidelines for Coding and Reporting provided by CMS. Relying solely on coding software, electronic health record (EHR) systems, and cheat sheets can lead to coding errors.

Guidelines for Diagnosis Documentation

Condition	Documentation Recommendation
Diabetes mellitus (DM)	▪ Type of diabetes, type 1 or type 2 ▪ If secondary DM, document the cause or primary condition along with secondary diabetes ▪ Associated conditions (e.g., neuropathy, skin ulcer, CKD) ▪ Use of insulin or other medications
Chronic obstructive pulmonary disease (COPD)	▪ Specificity of COPD since it includes multiple respiratory conditions, such as asthma, bronchitis and emphysema ▪ Current complication or exacerbation, if applicable ▪ Tobacco use, dependence, history, if appropriate
Cerebrovascular accident (CVA) Note: A CVA is an acute event rarely treated in the office setting. Most cases are treated in the ER or inpatient setting.	▪ Follow-up treatment in an office location as "history of CVA" ▪ Any late effects of the CVA (e.g., hemiparesis, dominant side due to CVA in 2006, stable.)
Coronary Artery Disease (CAD)	▪ Whether it is a native or graft vessel
Deep vein thrombosis (DVT) Note: A DVT is an acute condition not typically diagnosed during an office visit since ultrasound testing is normally how a DVT is confirmed.	▪ If medication for DVT is for active treatment or for prophylactic reasons ▪ Location and if it is chronic
Mental disorders	▪ "Major Depressive Disorder" if that is the patient's diagnosis ▪ Status (e.g., mild, moderate, severe, in partial remission, in remission, recurrent)
Neoplasms	▪ Current malignancy if actively receiving treatment ▪ "History of" if it has been treated by surgery, radiation or chemotherapy and there is no current indication of the disease ▪ Metastatic disease with location along with the primary site and treatment (e.g., Stage IV lung cancer with metastasis to brain, currently on chemotherapy)
Chronic kidney disease (CKD)	▪ Stage of CKD and treatment plan ▪ Dialysis status for end-stage renal disease (ESRD) ▪ Relationship if due to another condition such as hypertension or diabetes
Obesity and body mass index (BMI) Note: As stated in Section I.B.14 of the ICD-10-CM Official Guidelines for Coding and Reporting, the provider must be the one to document a clinical condition (i.e., overweight, obesity, morbid obesity) to justify reporting a code for the BMI.	▪ Height, weight, BMI calculation ▪ Any education or instruction provided for weight loss

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.

Medicare Advantage

Step Therapy Requirements for Part B Drugs for Medicare Advantage Plans

Effective Jan. 1, 2020, Medical Mutual will require review of some medical benefit drugs (primarily injectables and biologics) under step therapy requirements. These new step therapy requirements will be in addition to already-existing, non-step therapy related policies and review requirements for Medicare Advantage members. Corporate medical drug policies will be updated to reflect the new step therapy requirements and will be available at MedMutual.com/Provider, select Tools and Resources, Care Management, Medical Drug Management.

Please note that step therapy requirements do not apply to members who are already receiving active treatment with a non-preferred drug. Step therapy implementation will be administered in accordance with all guidance from the Centers for Medicare & Medicaid Services (CMS).

Furthermore, Medicare Advantage members subject to step therapy requirements have the right to ask for an exception or to appeal a request that was denied due to step therapy requirements.

For questions, please contact your Provider Contracting representative. If you are unsure who your Provider Contracting representative is, please visit MedMutual.com/Provider, select Tools and Resources, Contact Us.