MEDICAL MUTUAL®

Mutual News

Third Quarter, 2020

Stay Informed with the Provider Manual

The Provider Manual is available at MedMutual.com/Provider > Provider Manual. 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 1 – Overview
  - Provider Office Assistance, Provider Portal
  - Policy on Special Needs
- Section 3 – Clinical Quality and Health Services Overview
  - Prior Authorization, Submitting Prior Authorization Requests
  - Clinical Practice and Continuity of Care Guidelines
  - Medical Record Documentation Standards, Available Documentation and Compliance Sample Forms and Policies
- Section 4 – Appeals Overview
  - Non-clinical Claim Payment Inquiries
- Section 6 – Adjustment and Provider Inquiries Overview
  - Provider Inquiries, Provider Action Request (PAR) Forms
- Section 7 – Forms and Publications
  - Forms
- Section 12 – Medicare Advantage Plans and Guidelines
  - Clinical Quality and Health Services Programs, HEDIS and Stars

Contact Us

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

If you have questions, please contact your 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

General Information

Observation Status Reimbursement Policy

Effective Dec. 1, 2020, Medical Mutual is implementing a new Reimbursement Policy, Observation Status (Policy Number RP-202004). To view this policy, please visit MedMutual.com/Provider and select Policies and Standards > Corporate Reimbursement Policies.

Medical Mutual Transitioned Our Provider Portal to Availity

Medical Mutual transitioned our provider portal to Availity, a multi-payer platform. With this transition, here are some important reminders:

- The old Medical Mutual provider portal was eliminated on Sept. 15, 2020, at which point all features, functionality and resources were on our new portal at MedMutual.com/Provider.
- If you have not registered yet with Availity, you can do so and learn more about Availity by going to www.availity.com/medicalmutual.
- If you were enrolled to receive electronic (paperless) communications with Medical Mutual through our old provider portal, you must re-enroll through Availity to continue to receive communications electronically. The Communications Preference Application can be found in Availity in the Medical Mutual Payer Space under the Applications tab.
- If you are registered on the Availity portal, our new online PAR form can be found in the Medical Mutual Payer Space under the Resources tab.

If you are not registered on the Availity portal, our PAR form can be found at MedMutual.com/Provider > Resources > Forms.

If you have questions about our transition to Availity, please contact your provider contracting representative. If you don't know who your representative is, please visit the Contact Us page at MedMutual.com/Provider.

Two Medical Mutual Initiatives You Should Know About

Provider Survey on Appointment Accessibility

Medical Mutual is conducting our annual provider survey to ensure our networks meet the appropriate standards in providing timely appointments. If you are contacted to participate in the survey, we ask that you consider participating. Details of this initiative follow.

- Our vendor, SPH Analytics, started making calls to providers on Sept. 2, 2020. These calls are meant to assess access and availability of appointments across our provider networks.
- A random sample of primary care, behavioral health, OB/GYN and oncology providers were chosen for a 5-minute telephonic survey.
- In addition to assessing primary business hours, SPH Analytics will also assess after-hours care.
- The results will be used to help Medical Mutual identify any barriers that may affect a member's access to care, which is necessary for us to uphold the NCQA accreditation requirement.
- For our most recent accessibility guidelines, please see our Provider Manual or provider portal at MedMutual.com/Provider.

Promoting Preventive Services to Our Members

Medical Mutual is working hard to ensure your patients, our members, get the preventive care they need to stay healthy and safe, especially as many people have postponed care because of COVID-19. Here are just a few things we are doing, and we ask that you help in any way you can.

- We offer free in-home testing to Medicare Advantage plan members with open care gaps.
  - Hgb A1C Testing
  - Microalbumin Testing
  - Colorectal Screening Fit Kit
  - Diabetic Retinal Eye Exam
  - Bone Mineral Density Testing
- We provide educational materials to members
  - Members Turning 50 educational materials – these materials go to members who have recently turned 50 years old and gives them important information on the health screenings they now should have.
    - Colorectal Cancer Screening
    - Breast Cancer Screening
    - Cervical Cancer Screening

- Diabetes Resource Guide for people newly diagnosed with diabetes
- Testing checklist for people with diabetes
- Healthy Outlooks informational newsletter – this is our bi-annual member newsletter with health and wellness tips.
- Heart Healthy informational booklet for member's diagnosed with hypertension

Caring for your patients, our members, is a team effort. We need your help to make sure your patients know about the preventive resources and services available to them. If you have questions about our in-home testing or educational materials for members, please email the Clinical Quality Department at ClinicalQuality@medmutual.com.

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 healthcare providers. Recommended treatment or services may not be covered Eligibility and coverage depend on the member's specific benefit plan

Correctly Coding Primary, Secondary, and Historical Cancers Ensures the Best Care Decisions for Your Patients

The Centers for Medicare & Medicaid Services (CMS) pays close attention to the coding of cancer diagnoses in patients because of the frequent incidence of error. Errors in cancer diagnosis coding can make important care decisions more difficult because they are being made using information that may not be accurate about the health of your patients.

Basic Rules for Documenting Malignant Neoplasm

The ICD-10-CM official guidelines for coding and reporting neoplasms are complex, but some of the basic rules include:

- If the reason for encounter is the treatment of the primary malignancy, the primary site is sequenced first, followed by any metastatic sites.
- If the reason for encounter is the treatment of a secondary malignancy, the metastatic site is sequenced first, followed by the primary site.
- When treatment is given only for anemia associated with neoplasm, the malignant neoplasm is sequenced first, followed by D63.0 – anemia in neoplastic disease.
- For treatment of other complications from a neoplasm, except anemia, such as dehydration or complication from a surgical procedure for treatment of a neoplasm, the complication is sequenced first, followed by the malignant neoplasm.
- When the reason for encounter is solely for administration of chemotherapy, immunotherapy, or radiotherapy, the therapy is sequenced first, followed by the malignant neoplasm.
- For treatment of a secondary site when the primary site has been previously excised or eradicated and there is no further treatment directed at the primary site, the secondary site is sequenced first and a code from Z85, personal history of malignant neoplasm, should be used to indicate the former site of the primary malignancy.

Additional Guidelines for Documentation

- Document as specifically as possible the primary cancer, specific anatomic site, date of onset, metastatic sites, current treatment, associated conditions and if the malignancy has become historical in nature.
- Be mindful that using "metastatic" and "metastasis" can be misleading when describing primary and secondary sites. Use the words "to" and "from" within documentation to help clarify.
- Document the staging of the malignancy, if known, and avoid using words such as mass, lump, tumor, lesion or growth if more specific language is available.
- For cancer to be coded as an active condition, there must be evidence of current treatment including chemotherapy, radiation, hormonal/adjuvant treatments, watchful waiting, patient refusal for treatment, or newly diagnosed in which treatment has not yet started.

Scenarios Demonstrating the Correct Coding of Malignant Neoplasm

- A 59-year-old patient was diagnosed with prostate cancer and underwent a prostatectomy followed by radiation treatment that has been completed. An annual CT scan reveals a secondary malignant neoplasm of bone. The patient is admitted for chemotherapy treatment of the bone metastases.
  - Z51.11 : Encounter for antineoplastic chemotherapy
  - C79.51 : Secondary malignant neoplasm of bone
  - Z85.46 : Personal history of malignant neoplasm of prostate
- A 62-year-old female patient is being seen today for a well check. She currently does not have any complaints. She has a history of breast cancer and is currently taking tamoxifen. She will follow-up with her oncologist.
  - Z00.00 : Encounter for adult health check-up NOS
  - C50.919 : Malignant neoplasm of unspecified site of unspecified female breast

These scenarios demonstrate accurate and comprehensive cancer diagnosis coding, ensuring better continuity of care and more enlightened medical decision-making.

Sources:

Bernard, Sheri Poe. (2018). Risk Adjustment Documentation & Coding.
AHA Coding Clinic Articles – Lymphomas
Medical Mutual Cancer Coding Guidelines for Risk Adjustment
ICD – 10 – CM Official Coding Guidelines Chapter Two: Neoplasms
Article HCC 12 – Cancer Correctly Coded
Himagine Neoplasms Webinar, Feb. 18, 2020

None of the information included in this article is intended to be legal advice. 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. 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 healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.

Notice of Changes to Prior Authorization Requirements: Process for Members with Outpatient Therapy and Chiropractic Coverage

EviCore healthcare, a vendor of Medical Mutual, has announced an enhancement to the prior authorization process for your Medical Mutual members with outpatient therapy and chiropractic coverage.

Effective Jan. 1, 2021, for Medical Mutual members with plans that require prior authorization, prior authorization of outpatient therapy services and chiropractic services will be required from eviCore healthcare. Services performed without prior authorization may be denied for payment, and you may not seek reimbursement from members.

Under this enhanced prior authorization process, you will have three options for submitting prior authorization requests to eviCore.

Prior Authorization Requests		
	Prior to 1/1/2021	Starting 1/1/2021
Web	Log into Landmark Connect at www.lmhealthcare.com	Log onto eviCore web portal at www.evicore.com/pages/ProviderLogin
Telephone	Not available	Call 877-531-9139
Fax	Chiropractic Treatment Plan form to 888-565-4225	eviCore healthcare request form to 855-774-1319

Starting Jan. 1, 2021, you will no longer be able to submit prior authorization requests via Landmark Connect.

To recieve more information on these changes, you can attend an online orientation. The orientation schedule and program training resources are available at: https://www.evicore.com/resources/healthplan/medical-mutual-of-ohio.

eviCore healthcare's Clinical Guidelines and request forms are available at: www.evicore.com. For questions about prior authorization requests with eviCore starting Jan. 1, 2021, please contact the eviCore Client and Provider Operations department at **800-646-0418, Option 4**.

Four Focus Areas for Addressing the Physical and Behavioral Health of Medical Mutual Members During COVID-19.

With increased incidents of mental health concerns due to COVID-19, the mental, as well as physical, health of our members, your patients, is more important than ever. Serious mental illnesses and chronic health conditions often go hand in hand, so it's important to address both when coordinating care.

Here are four areas to focus on to improve care coordination and reduce hospital readmissions for members with behavioral health concerns.

1. Ensure all behavioral health patients admitted to a hospital are seen by a medical provider.
   Your patients who are hospitalized for an acute behavioral health event can benefit from a medical consult. This allows you to work with other providers to provide comprehensive care to your patients and improve outcomes such as readmission rates and patient satisfaction.

2. Medication reconciliation should be done within 30 days of discharge.
   You are already familiar with the fact that medication reconciliation after a hospital discharge can play an important role when dealing with behavioral health concerns by reducing readmission rates, improving patient compliance and potentially avoiding other medical/behavioral complications.

   There are several medication reconciliation codes that you can use when submitting claims to ensure capturing care gap closure, including 1111F CPT-CAT-II - discharge medications reconciled with the current medication list in the outpatient medical record.

3. Coordinate care through increased communication.
   Communicating with your colleagues is beneficial to improving continuity of care, ensuring medication compliance and reducing readmissions. Continuity of care guidelines and a form can be found at MedMutual.com/Provider > Resources > Clinical Supply Materials to help with care coordination for your patients.

4. Follow up with your patients after hospital discharge.
   Patients experiencing mental health issues are often less likely to follow up with their primary care providers, and therefore may have more admissions/readmissions. Be sure to call or reach out to your patients after they have been discharged to schedule a follow-up appointment.

   Thank you for working with us to help keep our members healthy.

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With the Latest Guidelines on Treating High Cholesterol, is Statin Therapy Right for Your Patients?

Medical Mutual values the care you provide for our members, your patients. We are always looking for ways to work with providers to improve the health of our members, including those with diabetes or cardiovascular disease. With the most recent guidelines from the American College of Cardiology (ACC) and the American Heart Association (AHA) for treatment of cholesterol, statin therapy can be an important tool to help members lower their cholesterol and improve heart health.

Who can benefit from statin therapy?

The ACC and AHA guidelines[1] recommend statin therapy for the following groups:

- Primary prevention in patients with diabetes age 40-75 regardless of cholesterol levels
- Secondary prevention in patients with atherosclerotic cardiovascular disease (ASCVD)

How does statin therapy affect value-based contracting?

Statin Use in Persons with Diabetes (SUPD) and Statin Therapy for Patients with Cardiovascular Disease (SPC) are important quality measures[2] and may be included in value-based contracts. The measures state:

- Members with diabetes must fill at least one statin prescription with their Medical Mutual plan during the measurement year—any statin at any dose.
- Members with ASCVD (including those who also have diabetes) must fill at least one moderate- or high-intensity statin prescription with their Medical Mutual plan during the measurement year.

Members can receive statin therapy at little to no cost to them through their Medical Mutual prescription benefit.

Statin Options	
Moderate-Intensity	High-Intensity
atorvastatin 10-20 mg rosuvastatin 5-10 mg simvastatin 20-40 mg lovastatin 40 mg	atorvastatin 40-80 mg rosuvastatin 20-40 mg

Are there any exclusions from the statin prescription requirements for the quality measures?

Some patients are excluded, including those with end-stage renal disease or receiving hospice care. Patients with documented myalgia, myositis, myopathy or rhabdomyolysis are excluded from the SPC measure, but not excluded from the SUPD measure.

If someone uses a discount card, pharmacy savings program, or pays out of pocket for their prescription, that claim is not captured and cannot be used to meet the SPC or SUPD measures. Adherence measures are also negatively affected in these cases.

What if your patient is resistant to starting a statin therapy?

Alternate day dosing[3], or intermittent dosing, of atorvastatin or rosuvastatin is a safe and effective option that patients may prefer over daily dosing. Make sure to include specific dosing instructions on these prescriptions—and send an updated prescription if dosing changes—so your patients always have accurate instructions on their bottle.

What can you do to help your patients adhere to their statin therapy?

Prescribing 90-day supplies with sufficient refills is the best way to boost statin adherence since it makes it easier for your patients to have medication on hand. Encourage your patients to sign up for refill reminders and automated refill programs. Medical Mutual offers Express Scripts to our members to provide an easy and convenient option for medication home delivery.

Providing quality care for our members, your patients, is a team effort. Thank you for working with us to help keep our members' hearts healthy.

1. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines https://doi.org/10.1161/CIR.0000000000000678
2. Medicare 2020 Part C & D Star Ratings Technical Notes https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf
3. Alternate-day Dosing with Statins by Frank I. Marcus et al. Am J Med 2013;126:99-104. https://doi.org/10.1016/j.amjmed.2012.08.007

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Eligibility and coverage depend on the member's specific benefit plan.

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between April 1, 2020, and June 30, 2020, are outlined in the following charts. CMPs are regularly reviewed, updated, added or withdrawn, and are subject to change. For a complete list of CMPs, please visit MedMutual.com/Provider and select Policies and Standards > Corporate Medical Policies.

CMP Name	Revised, New or Retired
Abraxane	Revised
Acthar HP	Revised
Adcetris	Revised
Alimta	Revised
Aranesp	Revised
Arzerra	Revised
Avastin	Revised
Bendamustine	Revised
Blincyto	Revised
Bortezomib	New
Bortezomib	Revised
Crysvita	Revised
Cyramza	Revised
Darzalex	Revised
Dupixent	Revised
Elzonris	Revised
Empliciti	Revised
Enhertu	Revised
Erbitux	Revised
Evenity	Revised
Faslodex	Revised
Gazyva	Revised
General Oncology	Revised
Global PA	Revised
Halaven	Revised
Hemlibra	Revised
Herceptin	Revised
Imfinzi	Revised
Imlygic	Revised
Infliximab	Revised

Ixempra	Revised
Jelmyto	New
Kadcyla	Revised
Keytruda	Revised
Kineret	Revised
Kyprolis	Revised
Leukine	Revised
Libtayo	Revised
Mircera	Revised
Neulasta, Fulphila, Udenyca, Ziextenzo	Revised
Neupogen, Nivestym, Zarxio, Granix	Revised
Ocrevus	Revised
Opdivo	Revised
Perjeta	Revised
Polivy	New
Portrazza	Revised
Procrit, Epogen, Retacrit	Revised
Reblozyl	Revised
Rituximab_IV	Revised
Rituximab_SQ	Revised
Sarclisa	Revised
Taltz	Revised
Tecentriq	Revised
Vectibix	Revised
Velcade	Revised
Vyepti	New
Yervoy	Revised
Yondelis	Revised
Zaltrap	Revised
Zilretta	Revised
Zolgensma	Revised

For a list of services requiring prior approval or considered investigational, please visit MedMutual.com/Provider and select Policies and Standards > Prior Approval & Investigational Services.

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Pharmacy

Pharmacy Prior Approval Requirements

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

For drugs covered under the medical benefit -

Select Policies and Standards > Corporate Medical Policies. This page includes all current Corporate Medical Policies and information about our prior approval services and Magellan Rx's secure provider portal at https://ih.magellanrx.com. The Magellan Rx portal is a web-based tool providers can use to manage prior approval requests for medications.

For drugs covered under the pharmacy benefit -

Select Policies and Standards > Medical Drug Management, then click Coverage Management (Prior Authorization). This page 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.

Medicare Advantage

Medical Mutual Waiving Primary Care Provider Visit Copays for Medicare Advantage Members

With healthcare systems returning to more normal operations, we are encouraging our members to see primary care providers (PCPs) to get needed preventive screenings and services.

With this goal in mind, Medical Mutual is waiving PCP visit copays for our Medicare Advantage (MA) members through Dec. 31, 2020.

- We are waiving PCP visit copays for in-office and telehealth visits (excluding audio-only visits) for our Medicare Advantage Classic HMO, Preferred PPO and Select PPO plans that currently have copays. Members in our other Medicare Advantage plans already have a $0 copay for PCP visits.
- This copay waiver applies to in-network providers only.
- We are not waiving cost sharing for other services performed during a member's PCP visit.

We began waiving PCP visit copays on July 1, 2020. There are no retroactive adjustments prior to the effective date, and the end date may change based on how the COVID-19 crisis progresses.

New members who enrolled in our Classic HMO, Preferred PPO or Select PPO plans on or after July 1, 2020, received a member ID card reflecting the new $0 PCP visit copay amount. Our existing MA members will not automatically receive an updated member ID card reflecting the $0 PCP visit copay, but can request one.

If you have questions, please contact your provider contracting representative. If you do not know who your provider contracting representative is, please visit the Contact Us page of MedMutual.com/Provider.

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