MEDICAL MUTUAL®

Mutual News

Third Quarter 2021

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
  - Contact Information Sub-section: revised to update Cincinnati Provider Contracting office address and phone numbers for all Provider Contracting offices
- Section 2 – Claims Overview
  - Coding Instructions for Selected Services and Related Billing Policies and Procedure Sub-section: revised information on endoscopic billing procedures
- Section 3 – Clinical Quality and Health Services Overview
  - Availability Goals and Accessibility Standards Sub-section: revised provider accessibility standards
- Section 12 – Medicare Advantage Plans and Guidelines
  - Clinical Quality and Health Services Programs, HEDIS and Stars Sub-section: revised pharmacy programs formulary information and pharmacy programs contact information

Contact Us

The phone number for our Medical Mutual Provider Contracting team is now 1-800-625-2583. This number is being used in all of our provider contracting regions.

If you do not know who your Provider Contracting Representative is, you can find the information on the contact us page of MedMutual.com/Provider.

General Information

Notice of Changes to Prior Authorization Requirements: Clinical Documentation Required at Time of Prior Authorization Submission

Beginning in January 2022, providers will be required to attach clinical documentation with all Medical Mutual prior authorization requests submitted through NaviNet.

When completing the authorization request in Navinet, providers can attach clinical documentation under the attachment section. If clinical documentation is not attached, providers will receive an error message.

More information will follow on Medical Mutual's Plan Central page on NaviNet. To log into NaviNet, please go to www.navinet.net.

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, began making calls to providers in the third quarter of 2021. These calls are meant to assess access and availability of appointments across our provider networks.
- Similar to last year, a random sample of primary care, behavioral health, OB/GYN and oncology providers were chosen for a 5-minute telephonic survey. For 2021, we also included the specialties of neurology, cardiology and orthopedics as well.
- In addition to assessing primary business hours, SPH Analytics will also assess after-hours care for primary care practices only.
- 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.

Medical Mutual Cincinnati Office Moving

The Medical Mutual office in Cincinnati, Ohio, which includes network management, sales and client services staff, is moving to a new location. The move is scheduled to take place sometime in early October 2021. The new office address is:

Centre Pointe Building II
9050 Centre Pointe Drive Suite 225
West Chester, Ohio 45069

Phone numbers for the Cincinnati office will stay the same with the move.
If you have any questions, please contact your Medical Mutual Provider Contracting Representative.
If you don't know who your Provider Contracting Representative is, please visit the Contact Us page at MedMutual.com/Provider.

Reminder to Enroll to Receive Electronic Communications with Availity

Medical Mutual transitioned our provider portal to Availity, a multi-payer platform, to provide you with a more comprehensive experience and easier access to information.

To receive electronic communications, please take the following actions:

- Enroll or login to Availity at Availity.com/medicalmutual.
- Choose e-communications. Locate the Medical Mutual payer space, go to the Applications Tab and input the applicable email address.
- Enjoy the benefits of e-communications vs. paper including:
  - Faster and more timely communication of essential information
  - Easier sharing and referencing of previous communications
  - Convenient access to additional information/resources through links within the e-communication

If you have any questions, please contact your Medical Mutual Provider Contracting Representative. If you don't know who your Provider Contracting Representative is, please visit the Contact Us page at MedMutual.com/Provider.

Updates and New Features in our Provider Portal

There are new features and updates to the provider portal, which you can access at MedMutual.com/Provider. Below are some of the important items we want to highlight.

- Provider Action Request (PAR) Form Updates
  - Change to email addresses – you will no longer be permitted to modify the PAR Form email address.
    - For security reasons, Medical Mutual cannot accept email address changes on PAR forms, over the phone or through email, and cannot email sensitive member information to an email address that has not been validated through the provider portal.
    - All email communication with providers will be sent to the provider's email address that is registered and validated on the provider portal.
    - To change your email address that has been registered in the provider portal, go to My Account Dashboard and select My Contact Info from the drop down.
  - You will have the ability to search for and monitor the status of inquiry and appeal submissions. (Note: Retaining the initial confirmation number is required and will not be provided, so you should record this number for your organization tracking.)
  - You will be able to optionally input both a Patient Account number and Contact phone number to the PAR form.

- Provider Invoices App

  The Provider Invoices app can be found on Medical Mutual's Payer Space in Availity. The app allows providers to see invoices for a selected TIN/NPI. It is meant to assist you with researching or providing access to information about your invoices. You must have claims status inquiry and remit viewer access to see this app. Also, you will only be able to select TINs of organizations you have access to. The invoices are available on a rolling 70-day time period.

To see a summary of all of the recent updates to the provider portal, go to MedMutual.com/Provider > In The News.

Medical Mutual Launches Free MedMutual Maternity App for our Members

Medical Mutual has recently launched our new MedMutual Maternity app. This app is free for our members and can help them manage their pregnancy journeys. Some of the features and benefits of the app include:

- Week-by-week pregnancy updates
- Daily tips and affirmations
- A tool to look up symptoms and issues
- Screening for high-risk pregnancy and support from our clinical team
- Due date calculator
- Weight gain calculator
- Baby Boost relaxation tool
- Feeding and diaper tracker
- Developmental milestones from birth to age 2
- Health profiles for the whole family
- Articles about health and wellness

Plus, our members can easily connect with Medical Mutual resources like My Health Plan, Customer Care, Nurseline and Case Management with just one click.

Additionally, if there is a risk detected with one of our members through the MedMutual Maternity app, our care management team will connect with you to provide information and support. Members can also share their tracker information directly with you.

If you have any questions, or for more information, please contact our Population Health support line toll free at 1-800-590-2583 Monday through Friday from 8 a.m. to 4:30 p.m.

Key Components and Documentation Requirements for Telehealth Services

With the recent growth of telehealth (telemedicine) services, there are important coding and documentation guidelines that providers should follow.

Patient consent to telehealth services

- Patients must consent to having a telehealth visit instead of an in-person encounter.
- Verbal consent is acceptable and must be documented and retained permanently in the patient's record.

Patient consent to electronic communications

- The patient's consent to receive communications electronically (for example via email) for the visit should be documented in the patient's record.

Documentation and claim information related to the telehealth visit

Providers should document a telehealth visit as they would an in-person office visit. This includes:

- Patient name, date of birth or other unique patient identifier, and the date of service
- The start and stop times and the consulting site location of the medical service
- For telehealth visits to be considered risk-adjustable for Medicare Advantage members, they must include both an audio and video component. If audio-only is noted, it is not considered a risk-adjustable visit
- History, which includes the primary complaint, history of present illness, review of symptoms and past family social history, should be included
- Exams will be limited if completed via video, but providers are encouraged to consider what is appropriate and medically indicated.
  - If billing an Evaluation and Management (E/M) visit, please code 99202-99205 for new patients and 99211-99215 for established patients when using audio and visual communication.
  - Please indicate if the visit was audio only and an exam was not conducted. Please use code 99441-99443 for audio-only, no face-to-face visits (during the current COVID-19 public health emergency).
- If the clinical assessment and treatment plan is limited by the use of video, and additional workup is needed, this should be noted in the documentation.
- The documentation of the visit must be electronically signed by the provider, along with the provider's credentials.

Documentation related to coding

- Code with the diagnosis code that best describes the patient's current condition/reason for the telehealth (telemedicine) visit.
- List all chronic conditions that may affect patient care as subsequent diagnosis codes 2-12.

We encourage you and your staff to perform your own claims reviews to ensure documentation meets the billing requirements for telehealth. If you have questions or would like more information on documentation and billing for telehealth (telemedicine) services, please contact Katy Davis at Katy.Davis@medmutual.com.

Specific information related to telehealth (telemedicine) services can be found in our COVID-19 Provider FAQ at MedMutual.com/Provider. Medical Mutual's Telemedicine Reimbursement Policy can be found at MedMutual.com/Provider > Policies and Standards > Corporate Reimbursement Policies. Please see the links below for more information about telemedicine services from the Centers for Medicare & Medicaid Services (CMS).

- Telehealth Services - www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes
- Evaluation and Management Services Guide Booklet - www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

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.

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.

Tools and Resources for Falls Prevention in Older Patients

As a healthcare provider, you are already aware that falls are a serious threat to the health and well-being of your older patients. We would like to make you aware of resources that can help you develop a standardized care plan to reduce the risk of falls for our older members.

The Centers for Disease Control and Prevention (CDC) has developed the STEADI Initiative, which offers a comprehensive approach for fall prevention and consists of three parts:

- **Screen** patients for fall risk
- **Assess** modifiable risk factors
- **Intervene** to reduce risk by using effective clinical and community strategies

According to the CDC, when implemented, these elements can have a substantial impact on reducing falls, improving health outcomes and reducing healthcare costs.

The STEADI Initiative also includes tools and resources for providers, patients and their caregivers.

- Clinical Resources (inpatient, outpatient & pharmacy care) www.cdc.gov/steadi/materials.html
  - STEADI Basics
    - Preventing Falls in Older Patients: Provider Pocket Guide www.cdc.gov/steadi/pdf/STEADI-PocketGuide-508.pdf
    - Coordinated Care Plan to Prevent Older Adult Falls www.cdc.gov/steadi/pdf/Steadi-Coordinated-Care-Plan.pdf
  - Clinical Tools
  - Functional Assessments
  - Medication Review
- Patient & Caregiver Resources www.cdc.gov/steadi/patient.html
- Training & Continuing Education www.cdc.gov/steadi/training.html
  - **Provider Training - STEADI: Empowering Healthcare Providers to Reduce Fall Risk**
    With this training, you can make fall prevention a part of your clinical practice. Continuing education is available for this free accredited course.
  - **Pharmacist Training - STEADI: The Pharmacist's Role in Older Adult Fall Prevention**
    As some of the most accessible members of the healthcare team, and as medication experts, pharmacists play a critical role in older adult fall prevention. Take the free online application-based training and earn accredited CPE.

Fall prevention requires a team-based coordinated care approach for success. Consider a referral to our care navigation team to assist older members who are at risk for falls. Call toll free 1-877-480-3105 option 2.

1. https://www.cdc.gov/steadi/about.html

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.

Inpatient Admission and Continued Stay Request Submissions Moving to the MedCommunity Platform

The implementation of MedCompass, Medical Mutual's new Clinical Quality and Health Services (CQHS) medical management platform, is well under way. Once fully implemented, MedCompass will allow our clinical care management programs, including utilization management, case management and disease management, to be managed within a member centric system providing a 360-degree view of our members.

Towards the end of the 4th quarter of 2021, and continuing into the 1st quarter of 2022, Medical Mutual will transition our contracting providers from Reviewlink to the MedCompass MedCommunity portal for the submission of inpatient admissions and continued stay requests. Once we go live with the new system, we will no longer accept these authorization requests from providers through Reviewlink, fax or phone.

The transition to MedCommunity provides you with the following benefits:

- Instant confirmation that your request was submitted
- Real-time status updates, including determinations
- High-Priority Task notification when additional information is required
- The ability to add CPT® procedure codes without cross walking to ICD-10 procedure codes
- The ability to upload supporting documentation

Prior authorization requests for radiology, outpatient services, and medical pharmacy will not be affected by this change, and should continue to be submitted per the instructions in our prior authorization lists available at MedMutual.com/Provider > Policies and Standards > Prior Approval and Investigational Services.

As we gear up for the transition to MedCommunity, we will continue to communicate and work closely with providers to ensure a smooth transition.

There is nothing for contracting providers to do currently. We will continue to provide updates as we have more concrete details and dates to communicate.

In-office Assessment Program Expanded

Medical Mutual currently participates in Optum's in-office assessment (IOA) program for Medicare Advantage. Effective in September 2021, the program will be expanded to also include Medical Mutual's Affordable Care Act (ACA) plans offered through the health insurance Marketplace.

The IOA program assessment form is designed for use at the point of care and helps ensure your patients receive a complete and comprehensive assessment.

In addition to receiving an annual assessment, the IOA program supports a variety of Centers for Medicare and Medicaid Services (CMS) programs, including the Healthcare Effectiveness Data and Information Set (HEDIS) and the Five-Star Quality Rating System.

Optum administers the IOA program on behalf of Medical Mutual. There is a monetary incentive for you to return the IOA forms. The administrative reimbursement rate is determined by how quickly you submit the form back to Optum.

- Forms received within 120 days of the date of service receive full administrative reimbursement.
- Forms received after 120 days of the date of service receive a reduced administrative reimbursement.

Optum can assist you by providing recommendations for members your office can proactively schedule for an office visit. Optum can also provide a list of members where an additional visit is recommended because they did not address a chronic condition in the current calendar year.

For more information about the Optum IOA program, please contact your Medical Mutual Provider Contracting Manager at 1-800-625-2583.

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Apr. 1 and Aug. 31, 2021, 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.

Medical Drug CMPs

CMP Name	Policy Status
Abecma	New
Abraxane	Revised
Actemra SC	Revised
Aduhelm	New
Amondys 45	New
Anti-Inhibitor_Ab	Revised
Aranesp	Revised
Arcalyst	New
Arzerra	Revised
Bavencio	Revised
Benlysta IV/SC	Revised
Beovu	Revised
Bevacizumab	Revised
Cabenuva	Revised
Cimzia	Revised
Cosentyx	Revised
Cyramza	Revised
Darzalex IV	Revised

CMP Name	Policy Status
Darzalex SQ	Revised
Dupixent	Revised
Empaveli	New
Enbrel	Revised
Entyvio	Revised
Epoetin alfa	Revised
Exondys 51	Revised
Eylea	Revised
Fabrazyme	Revised
Fasenra	Revised
Filgrastim	Revised
General Oncology	Revised
Givlaari	Revised
Global PA	Revised
Growth Hormone	New
Humira	Revised
Ilumya	Revised
Imfinzi	Revised
Infliximab	Revised
Jemperli	New
Jevtana	Revised
Kadcyla	Revised
Kesimpta	Revised
Kevzara	Revised
Keytruda	Revised
Kyprolis	New
Leukine	Revised
Libtayo	Revised
Lucentis	New
Macugen	Revised
Mircera	Revised
Nucala	Revised
Nulibry	New
Ocrevus	Revised
Onivyde	Revised
Opdivo	Revised

CMP Name	Policy Status
Orencia	Revised
Padcev	Revised
Palynziq	Revised
PCSK9 inhibitor	Revised
Pegfligrastim	Revised
Pemetrexed	Revised
Pepaxto	New
Perjeta	Revised
Provenge	Revised
Rituximab_IV	Revised
Rybrevant	New
Rylaze	New
Sarclisa	Revised
Siliq	Revised
Simponi	Revised
Simponi ARIA	Revised
Skyrizi	Revised
SOC	Revised
Spinraza	Revised
Stelara IV/SC	Revised
Taltz	Revised
Trastuzumab IV	Revised
Tremfya	Revised
Trogarzo	Revised
Tysabri	Revised
Ultomiris	Revised
Vectibix	Revised
Viltepso	Revised
Vyepti	Revised
Vyondys53	Revised
Xolair	Revised
Yervoy	Revised
Zynlonta	New

Medical CMPs

CMP Name	CMP Number	Policy Status
Abecma	94022	Revised
Bone Mineral Density Studies	94030	Revised
Bariatric Surgery for Obesity	94055	Revised
Topical Hyperbaric Oxygen Therapy	95037	Revised
Pressure Reducing Support Surfaces	99005	Revised
Allergy Testing	200131	Revised
Contact Lenses	200215	Revised
Auditory Brainstem Response Testing	200310	Revised
Endoscopic and Laproscopic Therapies for Tx of GERD	200403	Revised
Recombinate Human Bone Morphogenetic Protein-2 and Protein-7	200407	Revised
In Utero Fetal Surgery	200501	Revised
Laser Therapy for Treatment of Cutaneous Vascular Lesions	200504	Revised
Intrastromal Corneal Ring Segments for the Treatment of Keratoconus	200515	Revised
Infrared Coagulation and Laser Hemorrhoidectomy	200602	Revised
Spinal Cord Stimulation for Treatment of Chronic Pain	200604	Revised
Funtional Electrical Stimulation for Rehabilitation of Paralyzed Lower Extremities	200613	Revised
Focal Articular Cartillage Defect Treatment Osteochondral Allograft	200616	Revised
Sacral Nerve Stimulation	200704	Revised
Intensity Modulated Radiation Therapy (IMRT)	200802	Revised
Cryoablation of Solid Tumors	200903	Revised
Skin Surveillance Technologies	201009	Revised
Sterotactic Radiosurgery and Sterotactic Body Radiotherapy	201103	Revised
Vision Training	201303	Revised
Genetic Testing and Genetic Counseling General Policy	201527	Revised
Electrothermal Therapy	201537	Revised
Pulsed Radiofrequency for the Treatment of Chronic Pain Syndrome	201607	Revised
Tumor Treating Fields	201617	Revised
Non-wearable automatic external defibrillator (AED)	201621	Revised
Pneumatic Compression Device - Pneumatic Compression of Trunk and Chest	201718	Revised

Medical CMPs

CMP Name	CMP Number	Policy Status
Percutaneous left atrial appendage closure (LAAC) for non-valvular atrial fibrillation	201723	Revised
Applied Behavioral Analysis	201843	Revised
Transcranial Magnetic Stimulation	201913	Revised
Prostatic Urethral Lift	201914	Revised
Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea	201924	Revised
Oncotype DX AR-V7 Nucleus Detect Assay	201929	Revised
Cosmetic Procedures	201931	Revised
Fractional flow reserve derived from computed tomography (FFRCT)	201935	Revised
Ultrasound Transient Elastography	201946	Revised
Corneal Cross Linking	202009	Revised
Dry Needling	202010	Revised
Anesthesia Services for Dental Procedures in the Facility Setting	202011	Revised
Microsurgical Treatments for Lymphedema	202012	Revised
Transcatheter Mitral Valve Repair (TMVr)	202013	Revised
Vertebral Body Tethering	202104	Revised
Vertebral Artery Angioplasty	2005-E	Revised
Pulsed Electrical Stimulation - Osteoarthritis of Knee	2005-J	Revised
Vertebral Axial Decompression (VAX-D)	2006-D	Revised
Radiofrequency Microtenotomy	2009-C	Revised
Anal Fistula Plug	2009-D	Revised
Microcurrent Electrical Therapy	2012-A	Revised
Interferential Stimulation	2014-A	Revised
Nonsurgical Treatment of Obstructive Sleep Apnea: Oral Pressure Therapy	2015-D	Revised
Hydrogen Breath Test for Irritable Bowel Syndrome	2016-B	Revised
Myoelectric Upper Limb Orthotic Devices	2018-D	Revised
Varicose Vein Treatment Procedures: Mech[a]nochemical Ablation and Medical Adhesive Therapies	2019-E	Revised
Eustachian tube dilation	2019-F	Revised
Allogeneic, xenographic, synthetic, and composite nerve grafts and conduits	2019-G	Revised
Disc Decompression Procedures	94022	Revised
Retinal Imagining	200506	Retired

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.

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 also includes all current Corporate Medical Policies and information about our prior approval services and Magellan Rx's secure provider portal, a web-based tool at www1.magellanrx.com that providers can use to manage prior approval requests for medications.

For drugs covered under the pharmacy benefit: Select Policies and Standards > Prescription Drug Resources, then click the link under Prior Authorization to see the list. 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.

Medicare Advantage

Requirements for Continuous Glucose Monitors for Medicare Advantage Members

Continuous glucose monitoring (CGM) devices covered by Medicare under the durable medical equipment (DME) benefit are defined in CMS Ruling 1682R as therapeutic CGMs. Medicare Advantage members prescribed a therapeutic CGM device must meet Medicare's Local Coverage Determination (LCD) criteria, which can be found at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33822.

In order to dispense a CGM device and supplies, a DME vendor must have a record that the LCD criteria listed below have been met. Even when a Medical Mutual prior authorization approval is on file, the DME vendor must receive the member's six-month office visit notes, including blood glucose monitoring logs, with the initial prescription. The member may be at risk for a delayed shipment if the six-month office visit notes are not sent to the DME vendor in a timely manner.

Continuous Glucose Monitors Medicare Local Coverage Determination Criteria

Therapeutic CGMs and related supplies are covered by Medicare when ALL of the following coverage criteria are met:

1. The beneficiary has diabetes mellitus (Refer to the ICD-10 code list at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33822 for applicable diagnoses)
2. The beneficiary is insulin treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump
3. The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary based on Blood Glucose Monitoring (BGM) or CGM testing results
4. The treating practitioner and the beneficiary have had an in-person visit within the last six months to evaluate the beneficiary's diabetes control and determine that items one through three have been met
5. Every six months following the initial prescription of the CGM device, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan

If you have questions, or for additional information about CGM requirements, please contact your Medical Mutual Provider Contracting Manager at 1-800-625-2583.

New Statin Use in Persons with Diabetes Star Measure Exclusions

Effective Jan. 1, 2021, the Centers for Medicare & Medicaid Services (CMS) added new exclusions to the statin use in persons with diabetes (SUPD) star measure. Patients with the new exclusions will not be counted as part of the measure population. This is important because accurately reporting exclusions helps you improve quality and your score relative to the goals set by CMS. If you are part of a value-based contract (VBC) with Medical Mutual, it can also help improve your performance in related measures that are part of your VBC.

The SUPD Star Measure

This measure shows the proportion of patients, ages 40-75, who were dispensed two diabetes medications within a year that also receive one of the statin medications listed below. The measure is based on recommendations from the American Diabetes Association and the American College of Cardiology/American Heart Association[1,2]. It is a Pharmacy Quality Alliance (PQA) endorsed measure used by CMS.

Statin Medications
Atorvastatin (+/- amlodipine)
Fluvastatin
Lovastatin (+/- niacin)
Pitavastatin
Pravastatin
Rosuvastatin
Simvastatin (+/- ezetimibe, niacin)

New Exclusions

As of Jan. 1, 2021, patients with diagnoses from the categories listed below will be excluded from SUPD reporting. Select example ICD-10 codes are provided; however, this is not a comprehensive list of all exclusion codes.

Diagnosis	ICD-10 Codes Examples
Rhabdomyolysis and Myopathy	G72.0, G72.89, G72.9, M60.80, M60.9, M62.82, T46.6X5A
Pregnancy	O22.30, O99.210, O99.310, O99.810, Z34.80
Liver diseases	B18.2, K70.30, K72.90, K74.3, K74.60
ESRD	I12.0, N18.6, N19, Z91.15, Z99.2
Pre-Diabetes	R73.03, R73.09
Lactation and Fertility	Z39.1
Polycystic Ovary Syndrome	E28.2

Patients are also excluded if they have hospice care during the measurement year.

Please help make sure your patients with an eligible exclusion are recognized for removal from the measure by coding these exclusions on the appropriate claim(s). This will help reduce unnecessary outreach to your office from Medical Mutual regarding your patient having an omission in statin therapy.

References

1. American Diabetes Association. 9. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2018. Diabetes Care. 2018; 41(Suppl1): S86-S104. PMID: 29222380.
2. Stone NJ, Robinson JG, Lichtenstein AH, et al. American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol. 2014; 63(25 Pt B):2889-934. PMID: 24239923.

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Mutual News

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Inside This Issue

Receive this Newsletter in Your Email!
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