MEDICAL MUTUAL®

Mutual News

January, 2022

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: The following sections were revised:
  - Uniform Claim Processing and Eligibility and Benefits sub-sections of the Healthcare Reform section
- Section 2 – Claims Overview: The following sections were revised:
  - Claims Submission Instructions by Claim Form Type section
  - General Information section
  - Conditions for Payment section
  - Recovery of Claim Overpayments section
  - Tips for Handling Overpayment Adjustments section
  - Claims Filing Tips (Optical Character Recognition Related) section
  - Other Claims Filing Tips section
  - Electronic Claims Processing Program section
  - Electronic Claims Filing Tips section
  - Benefits of Electronic Claims Filing section
  - Financial Investigation section
  - ANSI ASC X12N 837I, 837P section (New)
  - Completing the CMS-1500 Claim Form section
  - Ambulance, Anesthesia, Paper Claims Submission, and Endoscopic Billing Procedures sub-sections of the Coding Instructions for Selected Services and Related Billing Policies and Procedures section
  - Completing the CMS-1500 Claim Form for Crossover and Supplemental Medicare Coverage sub-section of the CMS-1500 Claims Involving Medicare section
  - UB-04 Overview and Instructions section
  - Completing the UB-04 Claim Form section
  - Medicare Claims Submission, Medicare Supplementary Hard Copy Claims, and Medicare Intermediaries (Removed) sub-sections of the UB-04 Claims Involving Medicare section
  - Attachment: Acceptable Inpatient V Codes section (Removed)
- Section 3 – Clinical Quality and Health Services Overview: The following sections were revised:
  - General Guidelines and Medical Necessity Guidelines sub-sections of the Prior Authorization section
- Section 9 – Institutional Reimbursement Overview: The following sections were revised:
  - Payment Categories and Outpatient Ambulatory Payment Classification sub-sections of the Payment Categories and Methodologies section
- Section 12 – Medicare Advantage Plans and Guidelines: The following sections were revised:
  - Pharmacy Programs sub-section of the Clinical Quality and Health Services Programs, HEDIS® and Stars section
  - Offshoring section (New)

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

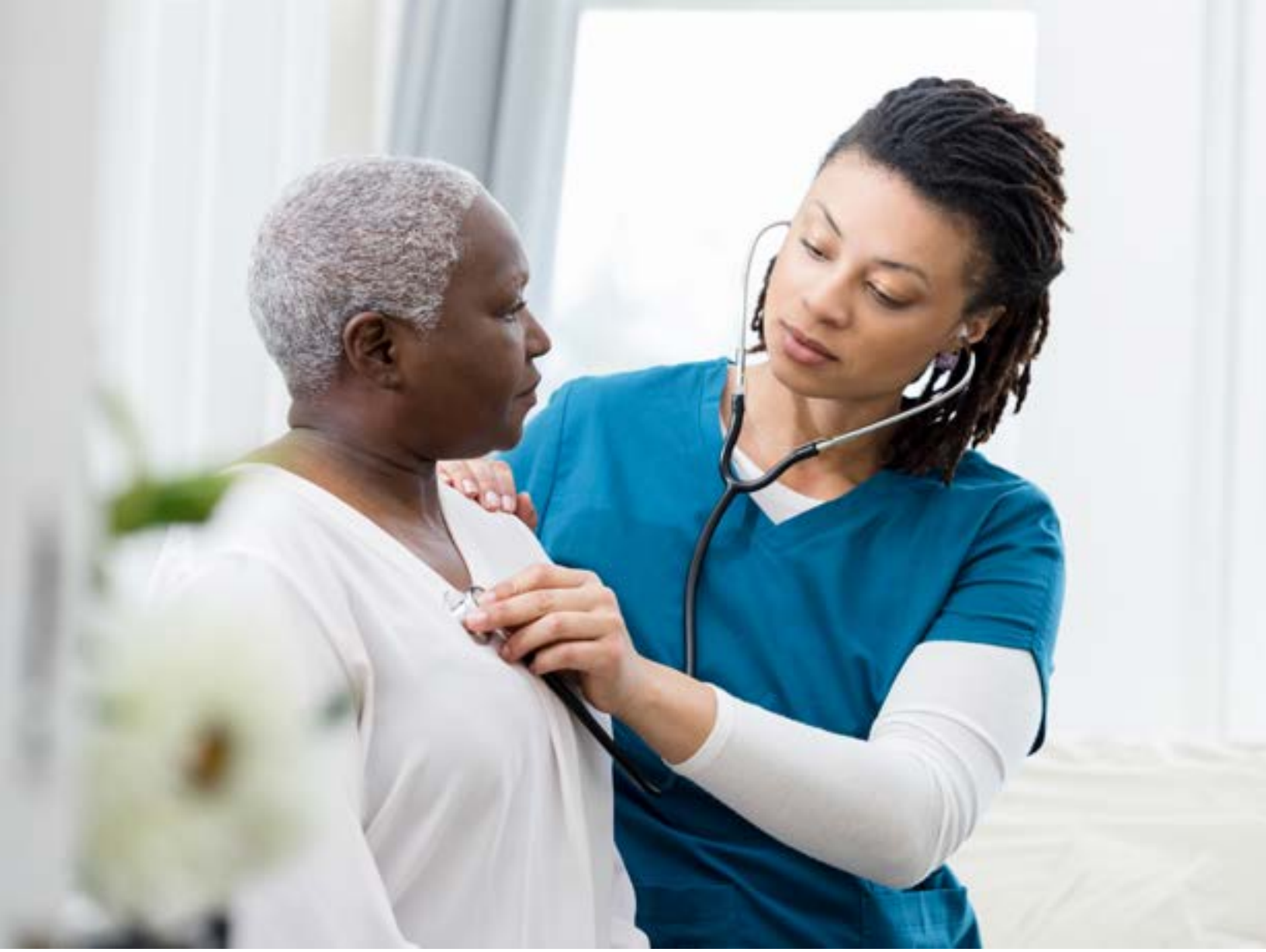
As Medical Mutual already informed its contracted providers via a Notice of Changes to Prior Authorization Requirements dated Oct. 22, 2021, Medical Mutual has expanded its engagement of eviCore healthcare (eviCore) to manage the prior authorization process for radiation oncology services for our fully insured and self-funded group members, including those in commercial, individual and Medicare Advantage plans.

What Is Changing

The transition to eviCore for radiation oncology prior authorizations will begin for dates of service on or after Feb. 1, 2022. eviCore will start accepting prior authorization reviews on Jan. 17, 2022. If treatment starts prior to Feb. 1st, there are no changes in prior authorization requirements, and providers should continue to submit requests to Medical Mutual directly.

Please note that we have expanded the list of radiation oncology services that will be subject to prior authorization. A complete list of services that require prior authorization through eviCore is available at MedMutual.com/Provider or www.evicore.com/resources/healthplan/medical-mutual-of-ohio under "Solution Resources". Services performed in conjunction with a 23-hour observation, emergency room visits or inpatient hospital stays are not subject to prior authorization requirements. To avoid claim rejections for failure to obtain prior authorization, please note the following:

- Services not authorized prior to billing will result in a claim rejection for both the treating physician and rendering facility. You may not seek reimbursement from our members.
- If prior authorization is not completed prior to the service being performed, you must contact eviCore at 1-888-693-3211 within 15 days post service to obtain a retro authorization.
- If the treatment plan changes during the course of care, you must contact eviCore at 1-888-693-3211 within 15 days after the service for a new authorization.
- If the date of service is outside of the authorization timeframe, you must contact eviCore at 1-888-693-3211 within 15 days after the date of service. Services performed outside of the correct authorization timeframe will be denied for lack of prior authorization, and you may not seek reimbursement from our members.



Requesting Prior Authorization

To request prior authorization for radiation oncology services, access the eviCore web portal and build a case at https://evicore.com/Pages/ProviderLogin.aspx. Prior authorizations will be accepted 24 hours a day, seven days a week, excluding planned down time for system maintenance, through the eviCore website, by phone at 1-888-693-3211 or fax to 1-866-699-8160. eviCore will provide a voice message service for telephone requests received outside the normal operating hours of 8 a.m. to 9 p.m. E.T., Monday through Friday.

Authorization records will contain prior authorization numbers and one or more CPT® codes specific to the services ordered. We recommend ordering providers secure prior authorization and pass the authorization numbers to the service facility at the time of scheduling.

Thank you for caring for our members. If you have questions about this letter or the eviCore procedures, please contact your Provider Contracting Manager or call 1-800-625-2583.

Medical Mutual's Compliance with Section 201 of the Consolidated Appropriations Act of 2021

As stated in the provider agreements between Medical Mutual and providers, reimbursement rates are confidential and proprietary; however, Medical Mutual may provide cost and reimbursement and related information to entities such as:

- Members;
- Reinsurers;
- Customers or potential customers;
- Individuals or groups of individuals for whom Medical Mutual provides health care financing or administrative services;
- Potential individuals or groups of individuals for whom Medical Mutual may provide health care financing or administrative services; and
- Representatives of the foregoing.

The provider agreements also require both Medical Mutual and providers to comply with all applicable laws, rules and regulations.

Section 201 of the Consolidated Appropriations Act of 2021 prohibits group health plans and health insurers offering group or individual coverage from entering into agreements with providers, provider networks, or third-party administrators that would restrict group health plans and health insurers offering group or individual coverage from any of the following:

(1) providing provider-specific cost or quality of care data to members, individuals eligible to become members, plan sponsors, referring providers, or a business associate;

(2) electronically accessing de-identified claims or encounter data for each member, upon request and consistent with applicable law, and sharing such data with a business associate;

Medical Mutual may under this law now also provide access to any cost data, quality of care data, or de-identified claim or encounter data. Nothing in the provider agreements will be interpreted or construed as directly or indirectly restricting Medical Mutual's sharing of any information or data as required by this or any other applicable law.

Expanded 270/271 Service Type Codes Supported by Medical Mutual

Medical Mutual expanded the service type codes that it supports in the Health Care Eligibility/Benefit Information Response (271) transaction at the end of the third quarter of 2021. Service type codes are used to identify the type/category of healthcare services or benefits, such as surgical or plan coverage.

Service Type Codes Allowed Per Transaction: 99 occurrences are supported.
**IMPORTANT INFORMATION **
All single STC requests will return a response. Group STCs, however, will return STCs based upon the patient's plan design.
MSG segment is used for pertinent plan information, including specialty copays, as applicable

Grouped Service Type Codes Returned	
STC Code Sent (270)	**STC(s) Returned (271)**
30- Health Benefit Plan Coverage	1 - Medical Care 33 - Chiropractic 35 - Dental Care 47 - Hospitalization 48 - Hospital Inpatient 49 - Hospital - Room and Board 50 - Hospital Outpatient 51 - Hospital - Emergency Accident 52 - Hospital - Emergency Medical 62 - MRI/CAT Scan 86 - Emergency Services 88 - Pharmacy 98 - Professional (Physician) Visit/Office AL - Optometry BY - Physician Visit - Office: Sick BZ - Physician Visit - Office: Well MH - Mental Health UC - Urgent Care
Enhancements implemented	
30 - Health Benefit Plan Coverage - additional STC returned	96 - Physician - Specialist
5 - Diagnostic Lab (new group)	04 - Diagnostic Xray 05 - Diagnostic Lab 62 - MRI/CAT Scan 73 - Diagnostic Medical 81 - Routine Physician
Additional STCs supported	61 - In-vitro Fertilization 78 - Chemotherapy 83 - Fertility 96 - Physician - Specialist BV - Obstetrical/Gynecological BT - Gynecological CF - MH Provider - Outpatient CG - MH Provider Facility - Inpatient CH - MH Provider Facility - Outpatient CI - Substance Abuse Facility - Inpatient CM - Mammogram, High Risk Patient CN - Mammogram, Low Risk Patient DM - Durable Medical Equipment

Below is the complete list of service type codes that can be returned in the 271 response.

STCs that are supported
1, 2, 4, 5, 6, 7, 8, 9, 12, 13, 18, 20, 23, 24, 26, 30, 33, 35, 40, 41, 42, 45, 47, 48, 49, 50, 51, 52, 53, 60, 61, 62, 65, 68, 69, 73, 76, 78, 80, 81, 82, 83, 86, 88, 93, 96, 98, 99, A0, A3, A6, A7, A8, AD, AE,AF, AG, AI, AL, BG, BH, BT, BV, CF, CG, CH, CI, CM, CN, DM, E12, E14, E15, E16, E17,E18, E19, E20, E21, E22, E40, MH, PT, UC
STCs that will return a 30-response based upon the plan design and as defined in the STC(s) returned,
3, 10, 11, 14, 15, 16, 17, 19, 21, 22, 25, 27, 28, 32, 34, 43, 44, 46, 54, 55, 56, 57, 58, 59, 63, 64, 66, 67, 70, 71, 72, 74, 75, 77, 79, 84, 85, 87, 89, 90, 91, 92, 94, 95, 97, A1, A2, A4, A5, A9, AA, AB, AC, AH, AJ, AK, AM, AN, AO, AQ, AR, B1, B2, B3, BA, BB, BC, BD, BE, BF, BI, BJ, BK, BL, BM, BN, BP, BQ, BR, BS, BU, BW, BX, C1, CA, CB, CC, CD, CE, CJ, CK, CL, CO, CP, CQ, DG, DS, GF, GN, GY, IC, NI, ON, PU, RN, RT, TC, TN

If you have any questions, please contact Medical Mutual's Customer Care Department at 1-800-362-1279 or EDISupport@MedMutual.com.

Changes to Private Duty Nursing Medical Necessity Requirements

Effective Jan. 1, 2022, Medical Mutual started utilizing MCG Guidelines for Private Duty Nursing medical necessity requirements. The MCG guidelines can be found at www.medmutual.com/For-Providers/Policies-and-Standards/Medical-Necessity-Criteria-and-Clinical-Review-Guidelines.aspx.

Please continue to submit prior authorization requests for Private Duty Nursing through NaviNet. For more information about this change, please contact your Medical Mutual Provider Contracting Manager at 1-800-625-2583.

Provider Identifiers: Using Your NPI Verses Your TIN in Electronic Transactions

As a provider, you are identified by your Tax Identification Number (TIN) and National Provider Identifier (NPI) when you are covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) NPI mandate. Electronic transactions predominantly require providers to identify themselves using their NPI with code XX in the name segments (NM1). There are some exceptions where the TIN with code FI is required to be used instead of the NPI, or the TIN is reported in a different segment such as in a reference (REF) segment. The exceptions are defined in the applicable X12 standard.

Why your Health Care Eligibility/Benefit Request (270) will reject when using your TIN in the information receiver name segment (Loop 2100B/NM1)

The information receiver name identifier that is required to be reported by providers covered under the NPI mandate is the provider's NPI with code XX. If a TIN with code FI is reported in the information receiver name segment, the 270 will reject. Please correct the error and resubmit.

Why your Health Care Claim Status Request (276) will reject when using your TIN in the provider name segment (Loop 2100C/NM1)

The provider name identifier that is required to be reported by providers covered under the NPI mandate is the provider's NPI with code XX. If a TIN with code FI is reported in the provider name segment, the 276 will reject. Please correct the error and resubmit.

For questions about this information, please contact Medical Mutual's Customer Care Department at 1-800-362-1279 or EDISupport@MedMutual.com.

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.

Guidelines to Follow When Submitting Prior Authorization Requests

There are some important guidelines providers should follow when submitting prior authorization (PA) requests.

- Providers are expected to submit all necessary medical documentation to support the prior authorization of a drug, service or item. Failure to do so may result in Medical Mutual issuing a denial notice with appeal rights.
- Medical Mutual may request additional medical documentation during the PA request process. It is important to promptly send the necessary information by the due date listed in the medical record request so that Medical Mutual can render an appropriate decision.
- A denial for lack of documentation may require additional steps in the appeal process.
- For an expedited appeal, it is necessary for providers to submit all current medical documentation with the appeal since Medical Mutual must provide expedited appeal responses within short turnaround timeframes. Failure to submit all documentation at time of expedited appeal submission may result in the denial of the appeal.

For more information on our PA process, including lists of drugs and services that require prior authorization, go to MedMutual.com/Provider > Policies and Standards > Prior Approval and Investigational Services.

If you have any questions about our PA program, please contact our Provider Customer Care Specialists toll free at 1-800-362-1279.

Colorectal Cancer and Lung Cancer Screening Recommendation Changes for Patients

Staying current with the US Preventive Services Taskforce (USPSTF) recommendations is important. With the two updated guidelines the USPSTF released for Colorectal Cancer Screening (COL) and Lung Cancer Screening, it is important to remind your patients to get their screenings.

- For COL, the USPSTF now recommends that screenings begin at age 45, as opposed to the previous age of 50. Benefits changes will apply to claims processed after Sept. 1, 2021.
- For the Lung Cancer Screening, changes include a new age range of 50-80 years old from the previous age range of 55-80 years old. Benefits changes will apply to claims processed after March 13, 2021.

For more information, go to the USPSTF published recommendations website at www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P.

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.

HEDIS Documentation Reference Guide for Accurate Medical Record Documentation

Medical Mutual values the care you provide to our members, and we want to continue working with you to achieve care gap closures for our members. One way to do this is through accurate medical record documentation. The precise and complete coding of claims is a best practice to ensure data is captured, patient care gaps are closed and record requests are minimized.

Medical Mutual has created a Healthcare Effectiveness Data and Information Set (HEDIS) Documentation Reference Guide, which is available at MedMutual.com/Provider under "Resources". Below are a few important documentation points from this guide.

- Always include as complete a date as possible when documenting the following:
  - History (hysterectomy with no residual cervix, mastectomy, colonoscopy, etc.)
  - Screenings (mammogram, colonoscopy, PAP test, etc.)
  - Immunizations
  - Lab/test results noted in the progress note must have a date and result
- If the exact date is not known, documentation needs to be specific enough to link to a date
  - Specific – "last Wednesday", "yesterday", "last week"
  - Not specific – "recent", "last", "previously"
- If systolic or diastolic blood pressure is equal to 140/90 or greater, retake and document both blood pressures
- Telehealth visits are eligible for most measures

Accurate medical record documentation is important because it creates consistent communication among providers, helps with treatment planning, supports and enhances quality of member care, and improves medical chart reviews for HEDIS clinical care gap closures.

For more information on HEDIS measures and documentation, go to www.ncqa.org/hedis/.

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.

Resources to Help Reduce or Avoid Member Post-Hospital Readmissions

Unplanned hospital readmissions contribute to a significant burden on individuals, families and healthcare systems. Medical Mutual is always looking for ways to work with providers to improve the health of our members, including those needing post-hospital care.

Below are programs, resources and tools for providers and members to help manage post-hospital care and reduce or avoid all-cause unplanned acute hospital readmissions.

- **Primary Care Provider (PCP) Checklists** - Tools for members to use to prepare for their PCP visit and track yearly screenings and immunizations. Includes prompts for crucial conversations. To obtain a copy please contact the Clinical Quality department at 1-800-586-4523 or ClinicalQuality@Medmutual.com.
- **24-hour/7 day a week Conduit NurseLine** - available to answer members' questions and help to guide care - 1-888-912-0636.
- **Transitional Care** - options for certain members to receive health coaching and support for follow-up care after a hospital stay.
  a. Return to Home Telephonic Program - Call Case Management at 1-800-258-3175
  b. Direction Home In-Home/Telephonic Program
- **Case Management** - Offers help and support with complex medical needs. Provider referral:
  a. Medicare Advantage Case Management referral: 1-855-887-2273 or CaseMgmt-MedAdv@medmutual.com
  b. Commercial Case Management: 1-800-258-3175 option 2 (members) or option 3 (providers)
- **Chronic Condition Management** - Offers education and support for Diabetes, COPD, Asthma, CAD, CHF, Hypertension - 1-800-590-2583
  a. Remote Monitoring Program
  b. Lark Diabetes
  c. Lark Hypertension
- **Aspire In-Home Palliative Care** - Refer a member to the palliative care program by emailing PopHealthSupport@medmutual.com with the member's name, date of birth and program you are recommending. You can also refer, or members can self-refer, by calling Aspire toll free at 1-844-232-0500.
- **Dispatch Health In-home Urgent Care Services** (availability based on member location)
- **Care Navigation** - A Medical Mutual program that offers help with community resources or socioeconomic barriers to care. Toll free 1-877-480-3105, option 2
- **Aunt Bertha** - A resource that connects individuals with free or reduced cost services like medical care, food, job training, and more, based on their ZIP Code. This resource can be accessed by visiting MedMutualResourceConnect.com.
- **Health Outcome Survey (HOS) Tip Sheet** - The HOS Tip Sheet is a valuable tool aimed at promoting crucial conversations with our Medicare Advantage members for each of the five HOS measures. It provides questions to ask, as well as Medical Mutual and additional resources for each measure. The tip sheet is available at www.medmutual.com/-/media/MedMutual/Files/Providers/In-the-News/2020/121020-ProviderToolkitHOSMeasuresFlier.pdf
- **My COPD Action Plan** - A comprehensive tool that providers and patients can complete at a visit to develop a care plan. It is available at www.lung.org/getmedia/c7657648-a30f-4465-af92-fc762411922e/copd-action-plan.pdf.

- **STEADI Initiative Tools and Resources for Falls Prevention:** Information at www.cdc.gov/steadi/index.html on screening older patients for fall risk, assessing for risk factors and intervening to reduce risk for falls. Also includes links to CDC tools, brochures and free CEUs for providers. For questions or more information, please contact the Medical Mutual Clinical Quality Department at 1-800-586-4523 or ClinicalQuality@Medmutual.com. You can also contact your Provider Contracting Representative.
- **Institute for Healthcare Improvement (IHI) How-to Guide:** Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx
- **IHI Reduce Avoidable Readmissions** - www.ihi.org/Topics/Readmissions/Pages/default.aspx
- **IHI Ask Me 3®** - An educational program that encourages patients and families to ask three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy. www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

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.

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Sept. 1 and Nov. 30, 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	Revised
Abraxane	Revised
Actemra_IV	Revised
Adcetris	Revised
Aliqopa	Revised
Asparlas	Revised
Bavencio	Revised
Beovu	Revised
Berinert	Revised
Besponsa	Revised
Bevacizumab_ONCO	Revised
Botox	Revised
Breyanzi	Revised
Cerezyme	Revised
Cinqair	Revised
Copaxone & Glatopa	Revised
Cyramza	Revised
Dupixent	Revised
Elelyso	Revised
Empaveli	Revised
Enspryng	Revised
Erbitux	Revised
Erwinaze	Revised
Eylea	Revised
Firazyr	Revised
Gazyva	Revised

CMP Name	Policy Status
General Oncology	Revised
Global PA	Revised
Growth Hormone	Revised
Hemlibra	Revised
Humira	Revised
Ilaris	Revised
Imfinzi	Revised
Interferon Beta	Revised
IVIG	Revised
Jemperli	Revised
Kadcyla	Revised
Kalbitor	Revised
Keytruda	Revised
Krystexxa	Revised
Kymriah	Revised
Kyprolis	Revised
Lemtrada	Revised
Libtayo	Revised
Lucentis	Revised
Lumizyme	Revised
Macugen	Revised
Med B Step	Revised
Monjuvi	Revised
Mylotarg	Revised
Nexviazyme	New
Kyprolis	New
Opdivo	Revised
Orencia IV	Revised
Panhematin	New
Pemetrexed	Revised
Perjeta	Revised
Poteligeo	Revised
Ranibizumab	Revised

CMP Name	Policy Status
Rituximab_IV	Revised
Romidepsin	Revised
Saphnelo	New
SCIG	Revised
Site of Care (SOC)	Revised
Soliris	Revised
Spravato	Revised
Sylatron	Retired
Synagis	Revised
Takhzyro	Revised
Tecartus	Revised
Tecentriq	Revised
Tegsedi	Revised
Testosterone Injectables	Revised
Tivdak	New
Trastuzumab_IV	Revised
Uplizna	Revised
Vectibix	Revised
Viscos - Hyaluronic Acid Derivatives	Revised
Visudyne	Revised
VPRIV	Revised
Yervoy	Revised
Yescarta	Revised
Yondelis	Revised
Zilretta	Revised
Vyondys53	Revised
Xolair	Revised
Yervoy	Revised
Zynlonta	New

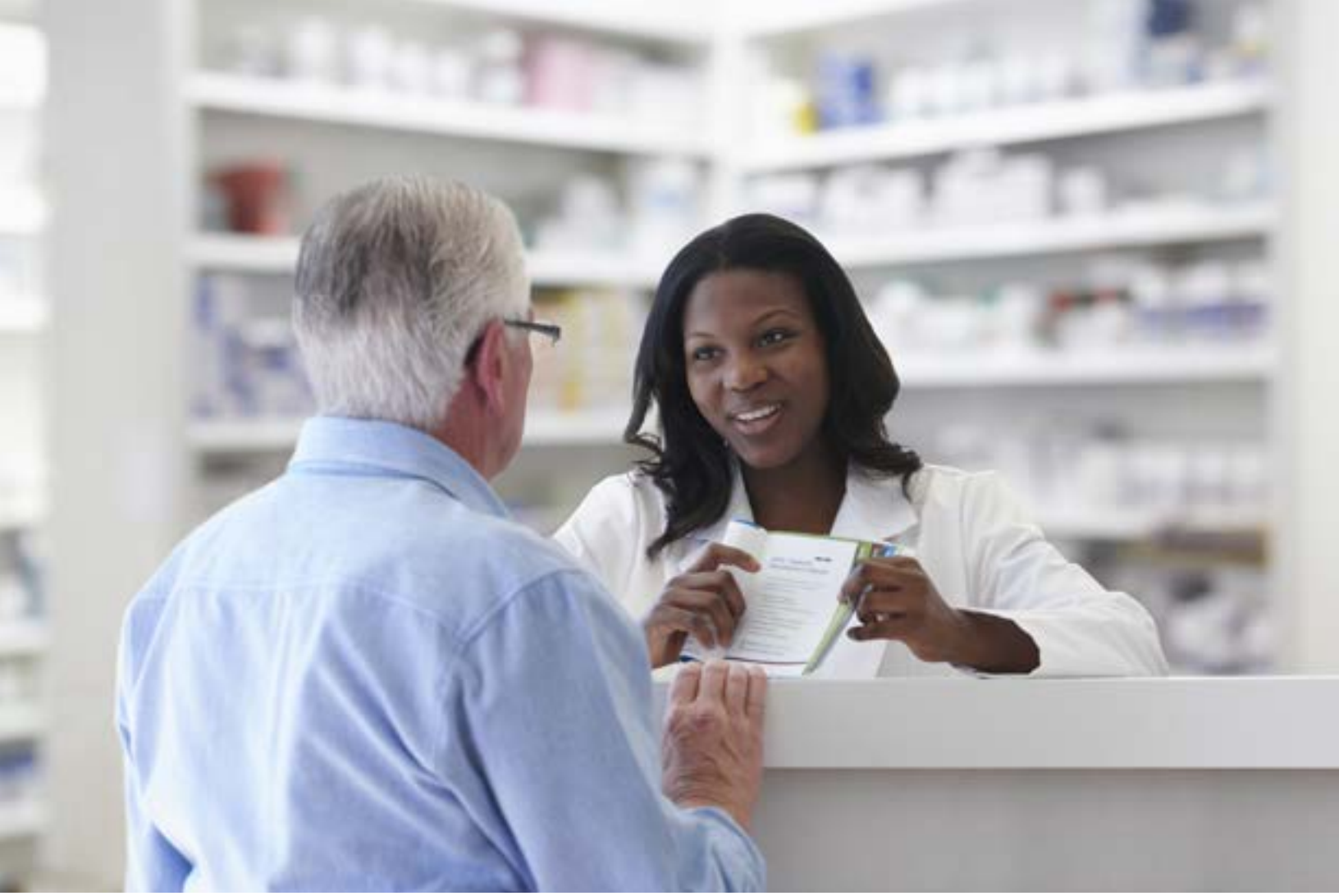
Medical CMPs

CMP Name	CMP Number	Policy Status
Breast Reconstruction and Related Procedures	94002	Revised
Evaluation of Vestibular Disorder	94007	Revised
Bariatric Surgery for Obesity	94030	Revised
Esopageal pH Monitoring Procedures	94059	Revised
Implantable Infusion Pumps	95017	Revised
Adult Strabismus Surgery	95034	Revised
Continuous Glucose Monitoring	200117	Revised
Breast Cancer Screening and Diagnostic Procedures - Breast Ductal Lavage	200211	Revised
Air Ambulance Transportation	200231	Revised
Chelation Therapy	200237	Revised
Disabled Dependent Medical Necessity Determination Guidelines	200307	Revised
High-Frequency Chest Wall Oscillation System and Intrapulmonary Percussive - DME	200508	Revised
Urinary Incontinence A. Pelvic Floor Electrical Stimulation	200520	Revised
Epidural Adhesiolysis for Chronic Low Back Pain	200522	Revised
Meniscal Allograft Transplantation	200714	Revised
Implantable or Percutaneous Peripheral Nerve Stimulation for Chronic Intractable Pain	201004	Revised
Prolotherapy - Musculoskeletal Conditions	201105	Revised
Thermography	201324	Revised
Vectra DA Blood Test	201504	Revised
Low Level Laser (Light) Therapy	201526	Revised
Noninvasive Rupture of Membranes Testing in Pregnancy	201535	Revised
Gender Affirming Surgery	201609	Revised
Next-Generation Sequencing for Detection and Quantification of Lymphoid Cancers	201923	Revised
Tumor Chemosensitivity and Chemoresistance Assays	201926	Revised
Laser Interstitial Thermal Therapy	201928	Revised
MCG Care Guidelines Frequency Limitations	202014	Revised

Medical CMPs

CMP Name	CMP Number	Policy Status
Irreversible Electroporation (IRE)	202015	Revised
Cryoablation with ClariFix	202016	Revised
Digestive Enzyme Cartridge (Relizorb)	202017	Revised
Flow Cytometry	202106	Revised
Stem Cell Harvesting and Storage	202107	Revised
Electrical Stimulation for Treatment of Dysphagia	2003-C	Revised
Fluid-Ventilated Gas-Permeable Contact Lenses	2006-G	Revised
Tenex Health TX Procedure	2013-C	Revised
Myoelectric Upper Limb Orthotic Devices	2016-B	Revised
Leadless Cardiac Pacemaker (i.e., MICRA Transcatheter Pacemaker System)	2017-B	Revised
Actigraphy	2018-C	Revised
REGENETEN Bioinductive Implant	2019-C	Revised
Microvolt T-Wave Alternans Testing	200503	Retired
Thoracic Electrical Bioimpedance	200908	Retired
Hormone Testing For Menopause - Salivary, Serum & Urinary	201531	Retired
Laser Interstitial Thermal Therapy	202105	Retired
Suit Therapy	2011-E	Retired
Implanted Continuous glucose monitor (CGM) devices	2018-A	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

Billing Changes for COVID-19 Vaccine Services for Medicare Advantage Members Started on Jan. 1, 2022

Original Medicare, through your Medicare Administrative Contractor (MAC), has been directly covering the costs of the COVID-19 vaccines and their administration, including member cost sharing. The Centers for Medicare & Medicaid Services (CMS) has extended benefit coverage for the COVID-19 vaccines and their administration into 2022; however, since Jan. 1, 2022, Medicare Advantage plans must cover the costs of the COVID-19 vaccines and their administration (including approved booster doses) without member cost sharing. Therefore, for COVID-19 vaccines administered on or after Jan. 1, 2022, please send vaccine billing for Medical Mutual Medicare Advantage members directly to Medical Mutual for processing.

In-Home Vaccine Administration

CMS also continues to encourage, and offer additional reimbursement for, in-home vaccine administration for certain Medicare enrollees that have difficulties leaving their home or are hard to reach.

When billing for the additional payment for home administration, use Healthcare Common Procedure Coding System (HCPCS) Level II code M0201 in addition to the appropriate Current Procedural Terminology (CPT) code for the product- and dose-specific COVID-19 vaccine administration. Additional guidelines include:

- Only report the HCPCS Level II code for home vaccine administration once per home per date of service
- If you administer the COVID-19 vaccine to more than one Medicare patient in a single home on the same day, you should:
  - For dates of service between June 8, 2021, and Aug. 24, 2021, only report the HCPCS Level II code M0201 once per individual home or living unit.
  - For dates of service on or after Aug. 24, 2021, if you administer the vaccine to fewer than ten Medicare patients at the same group living location on that date, report the HCPCS Level II code M0201 for each Medicare patient vaccinated in an individual home that day, and up to a maximum of five times if multiple Medicare patients are vaccinated in the same home or communal space
  - Report the appropriate CPT code for the product- and dose-specific COVID-19 vaccine administration for each Medicare patient vaccinated in the home that day

For more information about the COVID-19 vaccine policies and guidance, please see the toolkits found at http://www.cms.gov/COVIDvax and https://www.cms.gov/files/document/vaccine-home.pdf.

Medical Mutual Changed Medication Therapy Management Vendors Effective Jan. 1, 2022

The Medication Therapy Management (MTM) program is a Centers for Medicare & Medicaid Services (CMS) required program, and is a free service for qualified Medicare Advantage members with multiple health conditions who take multiple medications.

The MTM program gives Medicare Advantage members the opportunity to talk one-on-one with trained pharmacists to review their prescriptions and over-the-counter medications, and ask any questions they may have about their medications.

Beginning Jan. 1, 2022, CSS Health has taken over the administration of Medical Mutual's MTM program. With CSS Health, there will be enhanced clinical coordination with our prescribers and more targeted member interventions. This will lead to enhanced provider engagement and collaboration in keeping our members healthy.

Eligibility for the MTM Program

Medicare Advantage members may qualify for the MTM program if:

1. They have 3 or more chronic health problems, which may include:
   a. Asthma
   b. Chronic Heart Failure (CHF)
   c. Chronic Obstructive Pulmonary Disease (COPD)
   d. Diabetes
   e. End-Stage Renal Disease (ESRD)
   f. High blood lipid (fat) levels
   g. High blood pressure
   h. Osteoporosis

2. They take 7 or more daily medicines covered by Medicare Part D.

3. They spend $4,696 or more per year on Part D covered medications

Eligible Medicare Advantage members will be automatically enrolled in the program, and the service is provided at no additional cost. Members may choose not to participate in the program and can opt out on a yearly basis.

Medicare Advantage members that qualify for the MTM program will receive a welcome letter by mail and/or a phone call to tell them how to get started.

For providers, CSS Health interventions will primarily be sent via fax, but may also be sent by mail or phone calls. We ask that you look for faxes from CSS Health with the Medical Mutual logo, and take action as needed. If you need to reach CSS Health about a member, the number to call is 1-877-205-8550.

Examples of MTM interventions include adverse drug events, adherence, care coordination, alternative lower cost formulary drugs, and therapeutic monitoring.

If you have questions about this change, please contact your Medical Mutual Provider Contracting Manager at 1-800-625-2583.

MEDICAL MUTUAL®
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