MEDICAL MUTUAL®

# Mutual News

First Quarter, 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 2 – Claims Overview: The following sections were revised:
  - Endoscopic Billing Procedures sub-section of Coding Instructions for Selected Services and Related Billing Policies and Procedures section
  - Surgical Procedure Modifiers sub-section of Coding Instructions for Selected Services and Related Billing Policies and Procedures 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

## Reimbursement Policies

Effective May 15, 2022, Medical Mutual is establishing the following Reimbursement Policies:

- Traditional Medicare Non-Covered Services Under Medicare Advantage Plans (Policy Number RP-202203)
- Chiropractic Reimbursement (Policy Number RP-202204)

To view these policies, please visit MedMutual.com/Provider and select Policies and Standards > Corporate Reimbursement Policies.

## Surgical Procedure Modifiers

Effective for dates of service on and after June 1, 2022, Medical Mutual will process claims for partially completed surgical procedures as described below. As already stated in the Provider Manual, if Medical Mutual does not have a policy or procedure that addresses a claim, code or industry standard, Medical Mutual will follow the CMS guidelines that govern that particular standard. The processing of claims for partially completed surgical procedures with the following modifiers follows CMS guidelines.

- Modifier 52 indicates reduced services were performed and the provider will be paid for such services at 50% of the allowed fee schedule.
- Modifier 53 identifies discontinued services. Services billed with this modifier will be clinically reviewed to determine percent of services that were completed. The provider will be paid for such services at the determined percentage of the allowed fee schedule.
- Modifier 54 identifies surgical care only and payment will be based on the CMS Physician Relative Value File intra-op percent. Reduction in payment only applies to codes with an intra-op percent assigned to such codes in the CMS Physician Relative Value File.
- Modifier 55 identifies post op care only and payment to the provider will be based on the CMS Physician Relative Value File post-op percent. Reduction in payment only applies to codes with a post-op percent assigned to such codes in the CMS Physician Relative Value File.
- Modifier 56 identifies pre op care only and payment to the provider will be based on the CMS Physician Relative Value File pre-op percent. Reduction in payment only applies to codes with a pre-op percent assigned to such codes in the CMS Physician Relative Value File.
- Modifier 78 identifies an unplanned return to the operating room and payment to the provider will be based on the CMS Physician Relative Value File intra-op percent. Reduction in payment only applies to codes with an intra-op percent assigned to such codes in the CMS Physician Relative Value File.

## Compliance-level Validation Edits Go into Effect on May 22, 2022

As previously announced in our Oct. 2019 Mutual News Bulletin, which is available at MedMutual.com/ Provider > In The News, Medical Mutual started to expand our compliance-level validation edits on Nov. 1, 2019. As we continue to phase in new edits, we will provide warnings on the summary and detail report and response files when a claim or other electronic request fails validation. This will give you and your staff time to address and correct any issues with the claim. The following three compliance-level validation edits go into effect on May 22, 2022.

**Claim (837) Edits**

To prevent a delay in the processing of a claim, information on specific providers who may have been involved in the healthcare services needs to be reported accurately in the claim transaction. For providers covered under the NPI mandate, the NPI used must be active in the National Plan and Provider Enumeration System (NPPES), also known as the NPI Registry, as of the claim incurred date. If it is not, the claim may be returned to you for correction and resubmission.

**Provider Secondary Identification**

Medical Mutual only requires a secondary identification number to be reported on a claim when a provider is not covered under the NPI mandate. If you are not required to obtain a NPI, please use your Tax Identification Number as your primary identifier and the Medical Mutual assigned provider identification number in the secondary identification segment.

**Rendering/Service Location Name Use**

The rendering/service location name must only be used when it differs from the billing provider. The rendering provider should be reported at the claim level when the same provider performed all services reported. If there are multiple providers rendering services, then report the other providers at the associated service line.

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

## Important HEDIS Measures and Best Practices for Children and Adolescents on Antipsychotic and ADHD Medications

Medical Mutual values the care you provide for our members. We are always looking for ways to work with you to improve the health of our members, including children and adolescents on antipsychotic and attention-deficit/hyperactivity disorder (ADHD) medications.

The following Healthcare Effectiveness Data and Information Set (HEDIS®) measures, along with the best practices, are related to child and adolescent antipsychotic and ADHD medication use.

**APM (Metabolic Monitoring for Children and Adolescents on Antipsychotics)**
This measure evaluates the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and who had annual metabolic testing performed. Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

**Best Practices:**

- Complete a past family medical history to evaluate for any conditions that could raise the risk of complications from antipsychotic medications (e.g., tardive dyskinesia, diabetes, hypercholesterolemia, and cataracts).
- Assess health complications such as weight gain and diabetes, which can lead to serious metabolic health complications due to medication usage.
- Obtain a baseline and annual body mass index.
- Monitor renal and liver function as these drugs are metabolized through the kidneys and liver. Annual monitoring of at least one test for blood glucose or HbA1c, and one test for LDL-C.
- Before starting an antipsychotic medication, assess patients for tardive dyskinesia and monitor at regular intervals both during medication use and while tapering doses.
- When prescribing antipsychotics, consider "start low and go slow" to find the most effective dosage for the patient.
- Avoid abruptly stopping of antipsychotic medications as it may cause a relapse.
- Educate the patient and caregivers about common side effects such as increased blood pressure, weight loss, anxiety, agitation, and insomnia.

**APP (Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics)**
The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

**Best Practices:**
- Before initiating any antipsychotic medication, it is recommended that the patient receive an adequate trial of first-line, evidence-based psychosocial therapy, and other appropriate medications.
- Refer patients for individual, group and/or family therapy and follow up with them to confirm they attended.

**ADHD (Management of Pediatric Attention Deficit and Hyperactivity Disorder)**
This measure evaluates the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. Initiation Phase. The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

**Best Practices:**
- Before starting a stimulant medication, the prescribing provider should assess for a cardiac history and perform a physical exam. The American Academy of Pediatrics (AAP) guidelines state an electrocardiogram (ECG) is not recommended unless there is a concern of cardiac risk.
- Height, weight, blood pressure and pulse should be monitored throughout medication therapy.
- Due to a risk for psychoactive drug interactions that are used in the treatment of ADHD, a psychiatry consult is needed if patients are not responding to treatment.
- Education and involvement of the parent is central to treatment and to ensure cooperation to reach goals.

Providing quality care for our members is a team effort. These HEDIS® measures are a tool you can use to ensure timely and appropriate care for our members, and can assist in identifying and eliminating gaps in care for our members. Thank you for working with us to help keep our younger members healthy.

https://www.ndbh.com/Docs/PCP/HEDIS/APM%20Tip%20Sheet.pdf
https://www.nebraskatotalcare.com/content/dam/centene/Nebraska/PDFs/Quality/NTC_Provider_APM-APP-APC_508.pdf
https://www.bcbsil.com/pdf/clinical/qi/hedis_measures_apm.pdf
https://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Behavioral%20Health/HEDIS_APP_2019.pdf
https://www.bcbsil.com/pdf/clinical/qi/HEDIS_Measure_Follow-Up_Care_for_Children_Prescribed_ADHD_Medication.pdf
https://publications.aap.org/aapnews/article-abstract/29/7/17/7789/ECGs-not-necessary-Carefully-assess-all-children?redirectedFrom=fulltext

## Medical Mutual Working with One Inc to Expand Claim Payment Options

Medical Mutual is committed to improving and expanding our payment options for our providers. We are working with One Inc to leverage their ClaimsPay® electronic payment enrollment system, which provides faster, easier and more secure payments. With One Inc, we will be able to provide the following benefits to you.

- Quicker reimbursements
- Expanded payment options, including virtual credit card
- Enhanced communication

This transition will take place in June of 2022 and will affect both providers that currently use electronic funds transfer and those that receive paper checks. Please be on the lookout for additional communications from Medical Mutual and One Inc with information on how to register for this new service.

If you have any questions, please contact your Provider Contracting Manager toll free at 1-800-625-2583.

## Talk to Your Patients about Urinary Incontinence

Urinary incontinence is especially common among older adults. Many patients are hesitant to discuss it with their healthcare providers. They may feel embarrassed or lack 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.

According to the most recent National Committee for Quality Assurance (NCQA) data on responses to the Medicare Health Outcomes Survey (HOS) questions on urinary incontinence, less than 60% of respondents discussed a urinary incontinence problem with a provider, and less than 50% received treatment for their urinary incontinence problem.

Along with talking to your patients about improving their urinary health, here are some other ways you can help your patients address the issue.

- Screen regularly for urinary incontinence.
- Assess the impact on daily life, such as social isolation and sleep.
- Make educational materials visible in your office to prompt a conversation. The American Urologic Association offers free downloadable resources you may print or order for your patients at www.urologyhealth.org/educational-resources.
- Offer self-management resources like behavioral changes or exercises, if appropriate.

For questions or additional information, please contact your Medical Mutual Provider Contracting Manager toll free at 1-800-625-2583.

https://www.ncqa.org/hedis/measures/management-of-urinary-incontinence-in-older-adults/

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.

## Sign Up Now for Email Communications from Medical Mutual

If you are currently registered with Medical Mutual in the Availity provider portal, but have not signed up to receive email communications from us, please do so now.

To receive electronic communications, please take the following actions:

- Enroll or login to Availity at Availity.com/medicalmutual.
- Locate the Medical Mutual payer space, go to the Applications Tab and input the applicable email address.

By not signing up for e-communication, you will miss out on:

- Faster and more timely communication of important information
- Easier sharing and referencing of prior communications
- Convenient access to additional information/resources through email links

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.

## Cultural Competency Resources for Providers

Cultural competency is an integral part of delivering exceptional care to Medical Mutual members. According to the American Hospital Association, cultural competency in healthcare is the ability of doctors, nurses and other healthcare professionals to provide care to patients with diverse values, beliefs and behaviors, including tailoring healthcare delivery to meet patients' social, cultural and linguistic needs.[1]

As part of our cultural competency program, we would like to share educational resources with you to help in your efforts to provide culturally competent care. The resources can be found at MedMutual.com/Provider > Resources > Cultural Competency Resources.

1. https://ifdhe.aha.org/system/files/media/file/2021/05/ifdhe_cultural_learning_toolkit_2.pdf

# Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Dec. 1, 2021 and Feb. 28, 2022 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 |
|---|---|
| Abraxane | Revised |
| Adakveo | Revised |
| Adcetris | Revised |
| Aldurazyme | Revised |
| Alpha 1 proteinase Inhibitors | Revised |
| Arranon | Revised |
| Avastin | Revised |
| Bavencio | Revised |
| Benlysta | Revised |
| Botox | Revised |
| Brineura | Revised |
| Cablivi | Revised |
| Compounded Drugs PA | Revised |
| Corticotrophin Gel-ACTH | Revised |
| CSF-Filgrastim | Revised |
| Cyramza | Revised |
| Danyelza | Revised |
| Darzalex IV | Revised |
| Elaprase | Revised |
| Erbitux | Revised |
| Feraheme | Revised |
| Fyarro | New |
| Gamifant | Revised |
| Gazyva | Revised |
| General Oncology | Revised |
| Givlaari | Revised |
| Global PA | Revised |
| Hyaluronic Acid Derivatives | Revised |

| CMP Name | Policy Status |
|---|---|
| Imcivree | Revised |
| Imfinzi | Revised |
| Infliximab | New |
| Injectafer | Revised |
| Jemperli | Revised |
| Kadcyla | Revised |
| Kanuma | Revised |
| Keytruda | Revised |
| Kyprolis | Revised |
| Leqvio | New |
| Libtayo | Revised |
| Lumizyme | Revised |
| Luxturna | Revised |
| Marqibo | Revised |
| Mepsevii | Revised |
| Monoferric | Revised |
| Naglazyme | Revised |
| Nexviazyme | Revised |
| NPlate | Revised |
| Nucala | Revised |
| Onpattro | Revised |
| Opdivo | Revised |
| Orencia IV | Revised |
| Orencia SC | Revised |
| Oxlumo | Revised |
| PAH- Epoprostenol | Revised |
| PAH- Inhaled Prostacyclins | Revised |
| PAH- Remodulin | Revised |
| Pain Management Medications | Revised |
| Pemetrexed | Revised |
| Perjeta | Revised |
| Radicava | Revised |
| Ranibizumab | Revised |
| Revcovi | Revised |
| Rituximab IV | Revised |
| Scenesse | Revised |

| CMP Name | Policy Status |
|---|---|
| SCIG | Revised |
| Skyrizi | Revised |
| Site of Care | Revised |
| Susvimo | New |
| Sylvant | Revised |
| Synagis | Revised |
| Synribo | Revised |
| Tecentriq | Revised |
| Tepezza | Revised |
| Tezspire | New |
| Trastuzumab IV | Revised |
| Ultomiris | Revised |
| Vectibix | Revised |
| Vimizim | Revised |
| Voxogo | New |
| Vyvgart | New |
| Yervoy | Revised |
| Yondelis | Revised |

| Medical CMPs | | |
|---|---|---|
| **CMP Name** | **CMP Number** | **Policy Status** |
| Light Therapies for Dermatological Conditions | 94057 | Revised |
| Blepharoplasty, Brow Lift and Blepharoptosis Repair | 96018 | Revised |
| Autonomic Nervous System Testing | 200002 | Revised |
| Diabetes Management | 200117 | Revised |
| Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions | 200139 | Revised |
| Pancreas Transplantation | 200210 | Revised |
| Sublingual Immunotherapy | 200224 | Revised |
| Bone-Anchored Hearing Aid | 200401 | Revised |
| Otoplasty | 200521 | Revised |
| Artificial Intervertebral Disc Replacement | 200813 | Revised |
| Surgical Repair of Pectus Deformities | 200905 | Revised |
| Intraperitoneal Hyperthemic Chemotherapy | 201005 | Revised |
| Spinal Unloading Device-Low Back Pain-Scoliosis | 201022 | Revised |
| Lumbar Spinal Fusion | 201208 | Revised |
| Transcatheter Pulmonary Valve Implantation | 201426 | Revised |
| Gender Affirming Surgery | 201609 | Revised |
| Transanal Radiofrequency Therapy for Fecal Incontinence | 201709 | Revised |
| Cochlear Implants | 202020 | Revised |
| Liposuction for lipedema | 202103 | Revised |
| Wireless pulmonary artery pressure monitoring-CardioMEMS | 2019-A | Revised |
| Eustachian tube dilation | 2019-E | Revised |
| Pancreas - Kidney Transplantation | 200209 | Retired |
| Radiofrequency Therapy for Treatment of Stress Urinary Incontinence in Women | 201011 | Retired |
| Electromagnetic Navigational Bronchoscopy | 2017-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.

# Risk Adjustment

## Webinar: Risk Adjustment Data Validation Audit (RADV) Findings Deep Dive – Documentation and Coding Impact

Earn ONE FREE CME (Continuing Medical Education) or CEU (Continuing Education Unit)

Medical Mutual is hosting a webinar on risk adjustment coding and documentation and how it affects RADV outcomes.

The webinar is scheduled for one hour and will provide an opportunity for live questions and answers. You must be present for the entire webinar to earn one CME or CEU.

Learning objectives include:

- The most recent RADV findings
- Documentation importance
- Coding guidance (including real coding examples)

Please register for a time that best suits your schedule:

- Thursday, Apr. 28, 2022 from 12:00 – 1:00 PM ET
- Friday, May 13, 2022 from 12:00 – 1:00 PM ET

To register, email Rebecca McFarland at Rebecca.mcfarland@medmutual.com. A link to the meeting will be provided at that time.

# Medicare Advantage

## Supporting Access to Care via Telehealth for Older Adults

With the COVID-19 health crisis, there has been a large increase in telehealth services and utilization, including among seniors. Recent studies have found the following:

- The share of Medicare visits conducted through telehealth in 2020 increased 63-fold, from approximately 840,000 in 2019 to 52.7 million in 2020.
- Behavioral health telehealth visits increased to comprise one-third of the total visits in 2020, as compared to 8% of primary care provider visits.[1]

Telehealth services can provide seniors with essential care without additional expense or the need for travel. The following tips can help you overcome some of the challenges you may face in providing telehealth services:

**Making Telehealth Work for Elderly Patients[2]**

- **Challenge:** Patients who lack access to the internet or appropriate devices.
  **Solution:** Enlist health coaches or use mobile medical assistants or caregivers to set up telehealth visits.
- **Challenge:** Patients with medical conditions such as vision loss, hearing impairment or dementia that make it difficult to use telehealth.
  **Solution:** Enlist caregivers such as family members or friends to help with communication.
- **Challenge:** Patients who have the technology, like devices and the internet, but don't understand how to use them.
  **Solution:** Set up practice visits with staff so patients feel comfortable with a telehealth appointment.
- **Challenge:** High-risk patients who need regular monitoring of their vital signs
  **Solution:** Encourage the use of monitoring devices like blood pressure cuffs, pulse oximeters and weight scales at home. Provide remote coaching to patients and caregivers on how to measure vital signs and identify and report problems.

The Annual Wellness Visit (AWV) is considered an important component of developing a personalized plan of care focused on prevention of disease and disability. The Centers for Medicare & Medicaid Services (CMS) allows for self-reported vitals to be used if the individual is at home and has access to the appropriate equipment.[3]
The AWV HCPCS codes G0438 and G0439 are on the list of approved Medicare Telemedicine services.
The Welcome to Medicare visit code G0402 is not on this list.

**Key Components and Documentation Requirements for Telehealth Services**

The following are important telehealth coding and documentation guidelines:

### 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
- Per CMS requirements, for telehealth visits to be considered risk-adjustable for Medicare Advantage members, they must include both an audio and video component.
- 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.

1. www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic
2. hbr.org/2020/11/4-strategies-to-make-telehealth-work-for-elderly-patients
3. https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/medicare_awv_vitals.html

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## Inside This Issue



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Enroll or login to Availity at Availity.com/medicalmutual, locate the Medical Mutual payer space, go to the Applications Tab and input the applicable email address.



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