MEDICAL MUTUAL®

Mutual News

Fourth Quarter 2023

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
- Section 9 – Institutional Reimbursement Overview
  - Services – Pre-episode (Pres.)/Same Day (SDS)/Post-episode (POES) Window of Service sub-section of Payment Categories and Methodologies Section
- Section 11 – Administrative and Plan Guidelines
  - Network Products
- Section 12 — Medicare Advantage Plans and Guidelines
  - Pharmacy Programs sub-section of Clinical Quality and Health Services Programs, HEDIS and Stars Section

Contact Us

The phone number for our Medical Mutual Provider Contracting team is now 1-800-625-2583. This number is being used for all 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 Feb. 15, 2024, Medical Mutual is implementing the following Reimbursement Policies:
  - Physical Therapy, Occupational Therapy and E&M (Policy Number RP-202402)
  - Outpatient Rehabilitation Therapy Services (Policy Number RP-202403)
  - Modifier CT (Policy Number RP-202404)
- Effective April 15, 2024, Medical Mutual is implementing the following Reimbursement Policy:
  - Pre-Episode, Same Day, and Post-Episode Services (Policy Number RP-202405)

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

Notice of Changes to Prior Authorization Requirements - Medical Mutual Working with Cohere Health and the Rhyme LiveAuth™ Network to Enhance and Streamline our Prior Authorization Process.

Medical Mutual is working with Cohere Health and the Rhyme LiveAuth™ network to streamline the prior authorization process and decrease provider administrative burden via enhanced workflows and automation. Beginning on March 25, 2024, Medical Mutual contracted providers must submit prior authorization requests for outpatient and investigational/experimental services and procedures through Cohere Health's web-based portal or through the Rhyme application. In addition, prior authorization requests for outpatient diagnostic radiology/imaging can be submitted through Rhyme's EMR application, or through eviCore.

The benefits of Cohere Health and Rhyme include:

- Real-time prior authorization requirement for determinations, resulting in elimination of unnecessary prior authorization requests. (Cohere Health)
- Transparency requirement for prior authorization policy documentation, resulting in less back-and-forth between health plan and provider. (Cohere Health)
- Opportunities for prior authorization real-time auto-approval (in some cases), resulting in faster turnaround times for determinations. (Cohere Health & Rhyme)
- Automatic extraction and population of key data to build the prior authorization request, resulting in less redundant data entry. (Rhyme)

You will be able to access Cohere Health's portal directly at https://login.coherehealth.com. A link to the Cohere Health portal will be available in NaviNet until at least July 1, 2024, however, it is most efficient to access the Cohere portal directly.

If you do not already submit prior authorization requests through the Cohere Health portal for other health plans, you will need to complete the registration process at https://coherehealth.com/register.

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If you already submit prior authorization requests through the Cohere Health portal for other health plans, you can continue logging in as usual. **You will continue to have access to your prior authorizations that were previously submitted through NaviNet/Rhyme until at least July 1, 2024, and you can check their status using your current process.** Existing Rhyme clients will have access to Medical Mutual's expanded modalities beginning on March 25, 2024. Please work with your Client Success Manager at Rhyme to coordinate these additions. New providers interested in EHR integrated prior authorizations should contact Rhyme at https://www.getrhyme.com/get-in-touch.

As we work toward the transition to Cohere Health, we will continue to communicate and work closely with providers to supply onboarding, training and other support needed to ensure a smooth transition. If you would like to find out more about Cohere Health, please visit the following links:

- Webinars: https://coherehealth.com/webinars/
- Learning Center: https://payerinfo.zendesk.com/hc/en-us

Please note that there is no change to the inpatient prior authorization submission process at this time. Please continue to submit requests for inpatient admission through MedCommunity.

We will also be making an update to our prior authorization list, which will go into effect on March 25, 2024, when we transition to Cohere Health. A preview of the new services that will require prior approval with this update can be found at www.medmutual.com/PAL2024.

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

Section 201 of the Consolidated Appropriations Act of 2021 - Reminder

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.

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As a reminder, and as previously communicated to providers in the January 2022 Mutual News, 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 provide access to any cost data, quality of care data, or de-identified claim or encounter data as required by this law. 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.

Notification of Changes to the OhioHealth HMO, Southern Ohio HMO, and Northern Ohio HMO ACA Networks

Starting with the 2024 plan year, Medical Mutual is renaming the OhioHealth HMO, Southern Ohio HMO, and Northern Ohio HMO networks that we use for our Affordable Care Act (ACA) plans offered to individuals in certain counties.

These three networks are being combined and renamed to the MedMutual Individual HMO network. If you are currently an OhioHealth HMO, Southern Ohio HMO, and/or Northern Ohio HMO network provider under your existing provider agreement, you will continue to be a network provider in the renamed MedMutual Individual HMO network. The terms and conditions of your participation, including terms related to reimbursement, will remain the same under the network's new name.

Please advise your staff of these changes since members in these plans will have identification cards with the new network name.

The Network Products Section of Section 11, Administrative and Plan Guidelines, of the Provider Manual will be updated to reflect these network name changes.

Questions concerning these changes should be directed to our provider contracting office at 1-800-625-2583.

Help Reduce Administrative Burden by Utilizing HEDIS CPT II Codes

What are HEDIS CPT II Codes?

Current Procedural Terminology Category II (CPT II) codes are supplemental tracking codes used for Healthcare Effectiveness Data and Information Set (HEDIS) performance measurements. Submitting CPT II codes on claims can help close care gaps and support overall patient care quality.

What are the benefits of utilizing CPT II Codes?

- Reduces administrative burden by eliminating the need for medical record requests and chart reviews.
- Assists in identifying patients who may need increased clinical care management.
- Improves quality of care and supports a proactive approach to addressing clinical care opportunities.
- It is a best practice for code-level outcome specificity.

HEDIS focus measures that require CPT II codes on claims for care gap closure.

Blood Pressure		
Controlling Blood Pressure (CBP)	Systolic ▪ 3074F: less than 130 mmHg ▪ 3075F: btn 130–139 mmHg ▪ 3077F: greater than or equal to 140 mmHg	Diastolic ▪ 3078F: less than 80 mmHg ▪ 3079F: 80–89 mmHg ▪ 3080F: greater than or equal to 90 mmHg

Diabetes Care			
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Systolic ▪ 3044F: Most recent HbA1c level < 7.0% ▪ 3046F: Most recent HbA1c level > 9.0% ▪ 3051F: Most recent HbA1c level ≥ 7.0% and < 8.0% ▪ 3052F: Most recent HbA1c level ≥ 8.0% and ≤ 9.0%		
Eye Exam for Patients with Diabetes (EED)	Definition	Without evidence of retinopathy	With evidence of retinopathy
	▪ Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed.	▪ 2023F	▪ 2022F
	▪ Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed.	▪ 2025F	▪ 2024F
	▪ Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed.	▪ 2033F	▪ 2026F
	▪ Low risk for retinopathy (no evidence of retinopathy in the prior year)	▪ 3072F	

Medication Reconciliation	
Medication Reconciliation Post Discharge (MRP)	▪ 1111F: Discharge medications reconciled with current medication list in the outpatient medical record

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.

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Sep. 1, 2023 and Nov. 30, 2023 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
Actemra IV	Revised
Aliqopa	Revised
Amvuttra	Revised
Beovu	Revised
Besponsa	Revised
Beta Interferons (MS)	Revised
Botox	Revised
Breyanzi	Revised
Calcitonin Gene-Related Peptide (CGRP) Antagonist	Revised
Carvykti	Revised
Cinqair	Revised
Copaxone & Glatopa	Revised
Dupixent	Revised
Empaveli	Revised
Enjaymo	Revised
Enspryng	Revised
Fasenra	Revised
Firazyr	Revised
General Oncology	Revised
Global Prior Authorization	Revised
Growth Hormones	Revised
Ilaris	Revised
Infliximab	Revised
IVIG	Revised
Kalbitor	Revised
Kesimpta	Revised
Keytruda	Revised

CMP Name	Policy Status
Kimmtrak	Revised
Krystexxa	Revised
Kymriah	Revised
Lemtrada	Revised
Lumoxiti	Revised
Macugen	Retired
Medicare Part B Step	Revised
Monjuvi	Revised
Mylotarg	Revised
Nucala	Revised
Onpattro	Revised
Opdivo	Revised
Oxlumo	Revised
Pain Management Medications	Revised
Pegfilgrastim	Revised
Pombiliti	New
Poteligeo	Revised
Ranibizumab	Revised
Reblozyl	Revised
Rituximab IV	Revised
Rivfloza	New
Roctavian	Revised
Rolvedon	Revised
Romidepsin	Revised
Rylaze	Revised
SCIG	Revised
Simponi ARIA	Revised
Soliris	Revised
Spevigo	Revised
Susvimo	Revised
Syfovre	Revised
Takhzyro	Revised
Tecartus	Revised
Tegsedi	Revised
Testosterone Injectables	Revised

CMP Name	Policy Status
Tocilizumab IV	Revised
Trastuzumab	Revised
Tysabri	Revised
Uplizna	Revised
Vabysmo	Revised
Voxzogo	Revised
Xolair	Revised
Yescarta	Revised
Zilretta	Revised

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

Medical CMPs

CMP Name	CMP Number	Policy Status
Bariatric Surgery for Obesity	94030	Revised
Transanal Radiofrequency Therapy for Fecal Incontinence	201709	Revised
Adult Strabismus Surgery	95034	Revised
Implantable Infusion Pumps	95017	Revised
Air Ambulance Transportation	200231	Revised
Evaluation of Vestibular Disorder	94007	Revised
Urinary Incontinence A. Pelvic Floor Electrical Stimulation	200520	Revised
MCG Care Guidelines Frequency Limitations	202014	Revised
Medical Policy Development Update Archive	2017.002	Revised
Medical Policy Communications	2017.004	Revised
Medical Policy Technology Assessment	2017.000	Revised
Disabled Dependent Medical Necessity Determination Guidelines	200307	Revised
Tumor Chemosensitivity and Chemoresistance Assays	201926	Revised
Laser Interstitial Thermal Therapy	202207	Revised
Esophageal pH Monitoring Procedures	94059	Revised
Epidural Adhesiolysis for Chronic Low Back Pain	200522	Revised
Medical Policy Tech Assessment Medical Case Review Hierarchy	2017.003	Revised
Cryotherapy or RF Therapy for Rhinitis	202016	Revised
Electrical Stimulation for Treatment of Dysphagia	2003-C	Revised
Chelation Therapy	200237	Revised
Breast Reconstruction and Related Procedures	94002	Revised
Flow Cytometry	202106	Revised
Breast Cancer Screening and Diagnostic Procedures - Breast Ductal Lavage	200211	Revised
Allergy Testing	99005	Revised
Laser Therapy for Treatment of Cutaneous Vascular Lesions	200501	Revised
In Utero Fetal Surgery	200407	Revised
Bone Mineral Density Studies	94022	Revised
Stem Cell Harvesting and Storage	202107	Revised
REGENETEN Bioinductive Implant	2019-C	Revised

Medical CMPs		
CMP Name	**CMP Number**	**Policy Status**
Peripheral Electrical Stimulation to Reduce Tremor (e.g. Cala Trio)	202202	Revised
Irreversible Electroporation (IRE)	202015	Revised
Myoelectric Upper Limb Orthotic Devices	2016-B	Revised
Virtual Reality Cognitive Behavioral Therapy Device	202307	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

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

Medical Mutual has made changes to select corporate medical policies. The following drugs have moved to a non-preferred status in their step therapy category, which is detailed in the table below with their respective effective dates.

- Kanjinti
- Ogivri
- Herzuma
- Eylea HD
- Soliris (for all FDA approved indications)
- Rolvedon
- Asceniv
- Pemfexy

Medical Mutual will require a trial of a preferred drug(s) before a non-preferred drug can be prescribed. The non-preferred drugs require prior authorization. If the provider believes that a member has already satisfied the step therapy requirement or a non-preferred drug is medically necessary, the provider should ensure that the information is submitted with the request for prior authorization. Please follow the Medical Mutual prior authorization process to request a non-preferred drug.

Preferred Drug(s)	Non-Preferred Drug(s)
Trazimera (Q5116) Ontruzant (Q5112) *Change in preferred products effective Feb. 1, 2024*	Herceptin (J9355) Ogivri (Q5114) Herzuma (Q5113) Kanjinti (Q5117)
Avastin (J9035) *Change in preferred products effective Dec. 15, 2023*	Byooviz (Q5124) Cimerli (J3590) Eylea (J0178) Visudyne (J3396) Beovu (J0179) Macugen (J2305) Vabsymo (J2777) Susvimo (J2779) Eylea HD (C9399, J3590)
Trazimera (Q5116) Ontruzant (Q5112) *Change in preferred products effective Feb. 1, 2024*	Herceptin Hylecta (J9356) Kanjinti (Q5117) Ogivri (Q5114) Herzuma (Q5113)
Ultomiris (J1303) *Change in preferred products effective Dec. 15, 2023*	Soliris (J1300) [ST applies to all FDA approved Indications]
Neulasta (J2505) Fulphila (Q5108) *Change in preferred products effective Dec. 15, 2023*	Nyvperia (Q5122) Udenyca (Q5111) Ziextenzo (Q5120) Flynetra (J3590) Stimufend (J3590) Rolvedon (J1449)

Preferred Drug(s)	Non-Preferred Drug(s)
Flebogamma (J1572) Gamunex-C (J1561) Gammagard Liquid (J1569) Gammagard S/D (J1566) Gammaked (J1561) Gammaplex (J1557) Octagam (J1568) Privigen (J1459) *Change in preferred products effective Dec. 15, 2023*	Bivigam (J1556) Panzyga (J1576) Asceniv (J1554)*
Pemetrexed (J9297, J9296, J9294, J9323) *Change in preferred products effective Dec. 15, 2023*	Pemfexy (J9304)

For more information, please visit Medmutual.com/For-Providers, Policies and Standards, Corporate Medical Policies.

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

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

Risk Adjustment Coding and Documentation Tip Sheets

We want to provide you with resources to help make your job easier. That is why we have developed some Risk Adjustment Coding and Documentation Tip Sheets that cover the following topics:

- ACA HHS RADV Protocols for Benefit Year 2021 – Coding resources and examples, plus medical record requirements for the Affordable Care Act
- ACA Risk Adjustment Telehealth: Benefit Year 2022-23 – Reporting telehealth services for patients with coverage under the Affordable Care Act
- Acute Care Follow-Up – Accurate reporting of diagnoses in the office after an acute event/hospitalization
- Cancer and Metastatic Cancer – Coding resources and examples
- Deep Vein Thrombosis and Pulmonary Embolism – Diagnosis coding and supporting documentation with examples for accurate reporting of DVT and PE
- Diagnosis Coding of Annual Wellness Visits – Information on the diagnosis and coding of annual wellness visits
- Major Depressive Disorder – Coding resources and examples
- Medicare Advantage Risk Adjustment Telehealth – Benefit Years 2023 & 2024 - Reporting telehealth services for patients with coverage under Medicare Advantage

These tip sheets can be found in the Resources menu on our MedMutual.com/Provider webpage under Risk Adjustment Information.

None of the information included in this article or in the Risk Adjustment Coding and Documentation Tip Sheets referenced above 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.

Medicare Advantage

CMS Requiring New 90-Day Transition Period for Active Courses of Treatment for Part C Drugs and Services Beginning Jan. 1, 2024

Beginning Jan. 1, 2024, the Centers for Medicare & Medicaid Services (CMS) is requiring new Medicare Advantage Plan members to be offered a 90-day continuity of care, or transition period, for active courses of treatment for Part C drugs and services. To ensure that your patients who are Medical Mutual Medicare Advantage Plan members do not experience any disruption in treatment after the 90-day transition period, please initiate an organization determination at your earliest convenience. See the Policy and Standards section of our MedMutual.com/Providers website for additional information.

This is different than our Part D transition policy. For more information on our Part D transition policy see Medicare Part D Drug Transition Policy (MedMutual Advantage Plan Formulary and Other Plan Information).

Medicare Advantage (MA) Updated Appointment Wait Time Standards, Effective Jan. 1, 2024

The Centers for Medicare & Medicaid Services (CMS) has codified appointment wait time standards for primary care services and behavioral health services, including mental health and substance use disorder services. The wait time standards for appointments must meet the following:

- Urgently needed services or emergency - Immediately
- Services that are not emergency or urgently needed, but in need of medical attention - Within seven business days
- Routine and preventive care - Within 30 business days

Medical Mutual is updating our standards with those outlined by CMS and noted above. Additional resources will soon be available for 2024. We appreciate your continued cooperation and support with these improvements to member care.

Update to Medical Benefit Drug Coverage for Medical Mutual Medicare Advantage Plans

Medical Mutual has made changes to the Medicare Part B Step Therapy Policy. The following drugs have moved to a non-preferred status in their step therapy category which is detailed in the table below with their respective effective dates.

- Kanjinti
- Ogivri
- Herzuma
- Eylea HD
- Soliris (for all FDA approved indications)
- Rolvedon
- Asceniv
- Pemfexy

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For more information, please visit Medmutual.com/For-Providers, Policies and Standards, Corporate Medical Policies.

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Mutual News

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