MEDICAL MUTUAL®

Mutual News

Fourth Quarter, 2020

Stay Up to Date on Changes to 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
  - Completing the UB-04 Claim Form
  - Attachment 1: Revenue Codes (Item 42)

Contact Us

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

If you have questions, please contact your provider contracting representative:

Central/Southeast Ohio (Columbus Office)
1-800-235-4026

Northeast Ohio (Cleveland Office)
1-800-625-2583

Northwest Ohio (Toledo Office)
1-888-258-3482

Southeast Ohio/Kentucky (Cincinnati/Dayton Office)
1-800-589-2583

General Information

COVID-19 Vaccine Information

In response to the recent U.S. Food and Drug Administration (FDA) emergency use authorizations of COVID-19 vaccines, Medical Mutual has made available a COVID-19 Vaccine Provider FAQ document at MedMutual.com/Provider. The FAQ document will be updated regularly as more information becomes available.

Reminder About Enrolling to Receive Electronic Communications with Availity

Medical Mutual recently transitioned our provider portal to Availity, a multi-payer platform. If you were enrolled to receive electronic (paperless) communications with Medical Mutual through our old provider portal, you must re-enroll through Availity to continue to receive communications electronically. The Communications Preference Application can be found in Availity in the Medical Mutual Payer Space under the Applications tab.

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

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

As was first announced by Medical Mutual in the Third Quarter 2020 Mutual News, eviCore healthcare, a vendor of Medical Mutual, announced an enhancement to the prior authorization process for Medical Mutual members with outpatient therapy and chiropractic coverage.

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

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

Prior Authorization Requests	Starting 1/1/2021
Web	Log onto eviCore web portal at www.evicore.com/pages/ProviderLogin
Telephone	Call 877-531-9139
Fax	eviCore healthcare request form to 855-774-1319

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

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

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

Medical Mutual Working with Aspire Health, Inc. to Make Palliative Care Available for our Members

Medical Mutual wants to work with our providers to have palliative care services available when they are needed to optimize quality of life and provide patients and their families with support.

Medical Mutual's palliative care program is available with the assistance of Aspire Health, Inc. (Aspire Health), a nationally recognized leader in home-based palliative care. The benefits of Aspire Health's palliative care program include:

- Interdisciplinary, physician-led home-based care 24/7
- Collaboration with primary care providers to meet intended goals of care
- Primary care and palliative care physicians share responsibility, co-manage clinical outcomes and provide comprehensive services
- Expert care that includes palliative care specific assessments, pain control and tracking of outcomes

The coordination of care between healthcare providers reduces the number of days members spend in acute-care settings and enables better health outcomes during this difficult time. Medical Mutual supports primary care and palliative care collaboration, and we utilize our resources in early engagement with our members and their families.

You can refer a member to the palliative care program by emailing PopHealthSupport@medmutual.com with the member name, date of birth and program you are recommending. You can also refer, or members can self-refer, by calling toll free 1-800-589-2583 Monday-Friday, 8am-4pm with 24/7 confidential voicemail available.

If you have questions about this program, please contact your Aspire Health team or call toll free 1-877-702-6863 (TTY: 866-669-7707), 24 hours a day, seven days a week.

Medical Mutual Launches New Chronic Condition Management Program for Chronic Obstructive Pulmonary Disease (COPD)

Medical Mutual is launching a newly redesigned Chronic Condition Management program for members with COPD. The program focuses on teaching vital skills to help members self-manage their condition. It also provides ongoing support so they gain the confidence necessary to improve their physical and mental well-being. The program adopts a patient-centered, rather than disease-centered, approach that is tailored to a member's individual needs.

The goal of the COPD Chronic Condition Management program is to help members understand the condition, how preventive strategies can slow the progression of COPD, how to recognize symptoms that may indicate decline and help members gain confidence to act before the need for acute care arises.

An analysis of Medical Mutual data showed extremely low rates of:

- Follow-up care with a primary care provider or specialist after an emergency room visit or hospitalization for COPD-related symptoms

- HEDIS SPR rate (Use of Spirometry Testing in the Assessment and Diagnosis of COPD)

Both measures validate the importance of interventions aimed at improving health outcomes, reducing disease burden and improving quality of life for members with COPD.

The COPD Chronic Condition Management program utilizes telephonic coaching where members work with dedicated nurses to create personalized care plans that include goals and action plans. For those who require more intense support, remote monitoring and case management options are available.

To enroll a Medical Mutual member in our COPD Chronic Condition Management program, you can email PopHealthSupport@medmutual.com with the member name, date of birth and program you are recommending. You can also call toll free 1-800-589-2583 Monday-Friday, 8am-4pm with 24/7 confidential voicemail available.

You may find the following resource useful to help members with COPD manage their condition.

- **American Lung Association:** My COPD Action Plan available at www.lung.org/lung-health-diseases/lung-disease-lookup/copd

This is a tool designed for you and a patient to complete together. It can help your patient recognize symptoms that may indicate a decline in their COPD and commit to a plan of action.

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.

Ensuring Accurate Information in Our Provider Directory

Medical Mutual's provider directory is the most used tool available to our members and their caregivers to access information about in-network providers. Medical Mutual's network providers are contractually obligated to provide us with accurate information for display in our provider directory, and to promptly notify us of any changes or updates to such information.

To ensure your information in our provider directory is correct and current, please take the following steps:

1. Review your information in the provider directory at https://providersearch.medmutual.com/on a quarterly basis.
2. Update your address, phone number and accepting new patients status when there are changes to your practice by using the Provider Information Form located at Medmutual.com/Provider>Resources>Forms. Your accepting new patients status information is important because it is what members use when choosing a new provider.
3. If your credentialing is delegated to a third party, educate and work directly with the entity responsible for the accuracy of your directory information so they can provide updates if necessary.

Thank you for working with us to ensure our provider directory is up-to-date so our members can find the care they need. If you have any questions about our provider directory, please contact your Provider Contracting Representative. If you are not sure who your Provider Contracting Representative is, go to the Contact Us page of MedMutual.com/Provider to find out.

Medical Record Requests for Risk Adjustment and HEDIS

Your practice may receive an upcoming request for medical records from Ciox Health, LLC on behalf of Medical Mutual. Medical Mutual has contracted with this vendor to obtain medical records to support our risk adjustment activities, and to fulfill our reporting requirements for Healthcare Effectiveness Data and Information Set (HEDIS) and Risk Adjustment Data Validation (RADV) audits.

If you receive a letter requesting medical records from our vendor, Ciox Health, LLC, please submit the requested medical records by the deadline indicated. Records must be provided at no cost. Medical Mutual has executed a business associate agreement with Ciox Health, LLC. As you are aware, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations permit a covered entity, such as a physician practice, to disclose protected health information (PHI) to another covered entity, such as a health plan, without obtaining an enrollee's authorization or consent, for the purpose of facilitating healthcare operations.

Medical Mutual thanks you in advance for your cooperation and prompt response.

Your Flu Vaccination Recommendation is Important

As a provider, your strong recommendation for our members to get a flu shot is important. Research from the Centers for Disease Control and Prevention* indicates that adults are more likely to get their flu vaccine if their doctor or healthcare professional recommends it. While most adults believe vaccines are important, they might need a reminder from you to get vaccinated.

*https://www.cdc.gov/flu/professionals/vaccination/flu-vaccine-recommendation.htm

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 July 1, 2020, and Sept. 30, 2020, are outlined in the following charts. CMPs are regularly reviewed, updated, added or withdrawn, and are subject to change. For a complete list of CMPs, please visit MedMutual.com/Provider and select Policies and Standards > Corporate Medical Policies.

CMP Name	Revised, New or Retired
Abraxane	Revised
Adcetris	Revised
Alimta	Revised
Aranesp	Revised
Bavencio	Revised
Bendka	Revised
Benlysta SC and IV	Revised
Blenrep	New
Blincyto	Revised
Bortezomib	Revised
Cerezyme	Revised
Cosentyx	Revised
Crysvita	Revised
Cyramza	Revised
Darzalex _IV	Revised
Darzalex Faspro SQ	New
Dupixent	Revised
Elelyso	Revised
Empliciti	Revised
Enbrel	Revised
Enhertu	Revised
Enspryng	New
Erbitux	Revised
Faslodex	Revised
General Oncology	Revised
Global PA	Revised
Halaven	Revised
Herceptin	Revised

CMP Name	Revised, New or Retired
Herceptin Hylecta	Revised
Ilaris	Revised
Imfinzi	Revised
Infliximab	Revised
Istodax (Romidepsin)	Revised
Kadcyla	Revised
Kesimpta	New
Keytruda	Revised
Kyprolis	Revised
Lutathera	Revised
Mircera	Revised
Monjuvi	New
Mylotarg	Revised
Nplate	Revised
Opdivo	Revised
Padcev	Revised
Pegfilgrastim	Revised
Perjeta	Revised
Phesgo	Revised
Polivy	Revised
Radicava	Revised
Reblozyl	Revised
Rituxan	Revised
Rituxan Hycela	Revised
Sarclisa	Revised
Simponi_ARIA	Revised
Site of Care	Revised
Spinraza	Revised
Stelara	Revised
Tecartus	New
Tecentriq	Revised
Tepezza	Revised
Tremfya	Revised
Trodelvy	Revised
Uplinza	New
Viltepso	New

CMP Name	Revised, New or Retired
Vectibix	Revised
Velcade	Revised
VPRIV	Revised
Vyondys 53	Revised
Vyxeos	Revised
Xolair	Revised
Yervoy	New
Yondelis	Revised
Zepzelca	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.

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.

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

Effective January 1, 2021, certain drugs are now considered non-preferred medications under the Medical Mutual commercial and Affordable Care Act (ACA) medical benefit. Members who are on existing therapy will be required to try the preferred drug at the time of prior approval renewal. For members new to the therapy, Medical Mutual will require a trial of the preferred drugs before a non-preferred drug can be prescribed. 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 follow the Medical Mutual coverage determination process to request the non-preferred drug.

A list of the preferred and non-preferred drugs for Medical Mutual commercial and ACA plans is available at www.medmutual.com/-/media/MedMutual/Files/Providers/In-the-News/2020/111920_Commercial-and-ACA-Medical-Benefit-Product-Coverage-for-Medical-Mutual-Plans_FINAL.pdf. Preferred products are subject to any benefit limitation set forth in a member's benefit plan.

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

Medicare Advantage

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

Effective January 1, 2021, additional drugs will become non-preferred medications under the Medical Mutual Medicare Advantage (Part B) medical benefit. For members new to the therapy, Medical Mutual will require a trial of the preferred drugs before a non-preferred drug can be prescribed. 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 follow the Medical Mutual coverage determination process to request the non-preferred drug.

A list of the new preferred drugs and the non-preferred drugs for Medical Mutual Medicare Advantage plans is available at www.medmutual.com/-/media/MedMutual/Files/Providers/In-the-News/2020/111920_Update-to-Medical-Benefit-Drug-Coverage-for-Medical-Mutual-Medicare-Advantage-Plans.pdf.

The Part B Step Therapy policy and all Part B drugs that require step therapy are available at https://www.medmutual.com/-/media/MedMutual/Files/Providers/CorporateMedicalPolicies/201936_Medicare-Part-B-Step-Therapy.ashx. Preferred products are subject to any benefit limitation set forth in a member's benefit plan.

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

Dual Eligible Beneficiaries

Federal law prohibits Medicare providers from balance billing beneficiaries who have dual eligibility. Medicare Advantage providers cannot collect Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from an individual who is eligible for both Medicare and Medicaid. Medicare providers must either accept Medical Mutual's payment as payment-in-full, or bill the State of Ohio for the applicable Medicare cost-sharing.

Verify that your practice has procedures in place to ensure that Medicare Advantage providers do not discriminate against enrollees based on their payment status (e.g., Qualified Medicare Beneficiary). Specifically, Medicare Advantage providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Medicare Outpatient Observation Notice Reminder

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and critical access hospitals to provide written and oral notice, within 36 hours after observation services begin, to Medicare and Medicare Advantage patients who are in observation as outpatients for more than 24 hours. The Medicare Outpatient Observation Notice (MOON) is a standardized CMS document that all hospitals and critical access hospitals must provide a Medicare or Medicare Advantage patient or their representative. The MOON explains the reason the patient is receiving observation services and must explain the implications of receiving outpatient observation services, such as cost sharing and subsequent eligibility for coverage in a skilled nursing facility (SNF).

An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice. The patient or representative must sign the MOON to acknowledge receipt. If he or she refuses to sign, hospital staff must document delivery of the MOON and the patient's refusal.

For additional information, or to download a copy of the MOON, visit cms.gov, Regulations-and-Guidance, Legislation, PaperworkReductionActof1995, PRA-Listing and search for form CMS-10611.

None of the information included in this article is intended to be legal advice.

Use this Health Outcomes Survey Tip Sheet in Discussions with your Medicare Advantage Patients

Medical Mutual values the expert care you provide for our Medicare Advantage members, and recognize the daily challenges you face. We want to partner with you by providing the resources needed to help our members maintain or improve their physical and mental health.

The Health Outcomes Survey (HOS) is a yearly random sample survey for Medicare Advantage members from the Centers for Medicare & Medicaid Services (CMS). The HOS evaluates how effective Medicare Advantage plans are in helping Medicare Advantage members maintain or improve their physical and mental health. Information from this survey helps drive Medical Mutual's quality improvement activities.

Medical Mutual's Medicare Advantage members' interactions with their healthcare providers have a direct impact on how they respond to the HOS questions.

A Health Outcomes Survey Provider Tip Sheet, which can be found at MedMutual.com/Provider > In The News, is a tool aimed at promoting crucial conversations between providers and Medical Mutual Medicare Advantage members for each of the five HOS measures. The tip sheet provides questions to ask, as well as Medical Mutual and additional resources for each measure.

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.

These recommendations in the Health Outcomes Survey Provider Tip Sheet 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 MUTUAL®
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Inside This Issue

This material is considered part of the Provider Manual for Medical Mutual of Ohio® and its subsidiaries. Mutual News and Mutual News Bulletin are published for network providers serving Medical Mutual. To contact us or for more information, visit MedMutual.com/Provider.