MEDICAL MUTUAL®

Mutual News

September 2024

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 or Added— Current updates to the Provider Manual include:

- Section 3 – Clinical Quality and Health Services Overview:
  The following section was revised:
  - The Submitting Prior Authorization Requests sub-section of the Prior Authorization section was revised to remove information about NaviNet, include new information about Cohere Health, and revise contact information for eviCore Landmark.
- Section 9 – Institutional Reimbursement Overview:
  The following section was revised:
  - The Audit Provisions section was revised to include a new Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) sub-section.
- Section 11 – Administrative and Plan Guidelines:
  The following section was revised:
  - The Medicare Advantage sub-section of the Network Products section was revised.

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

NOTICE OF MATERIAL AMENDMENT TO CONTRACT:
Multiple Procedure Payment Reduction - Outpatient Surgical Procedures Reimbursement Policy
Effective Dec. 15, 2024, Medical Mutual is implementing the Multiple Procedure Payment Reduction - Outpatient Surgical Procedures Reimbursement Policy (Policy Number RP-202410).
To view this policy, visit MedMutual.com/Provider and under the Providers menu select Policies and Standards > Reimbursement Policies.

NOTICE OF MATERIAL AMENDMENT TO CONTRACT:
Network Fee Schedule and Medicare Advantage Fee Schedule Update
The Medical Mutual updated Network Fee Schedule and updated Medicare Advantage Fee Schedule will be available for reference on Sept. 15, 2024, on our secure Provider Portal in Availity, which you can access at MedMutual.com/Provider. Revisions will be effective for dates of service on or after Dec. 15, 2024.
In addition to this revision, fees in both the Network Fee Schedule and the Medicare Advantage Fee Schedule for certain codes will continue to be updated on a more frequent basis.

- The Centers for Medicare and Medicaid Services (CMS) updates its fee schedule for J-codes and radiological materials on a quarterly basis. Similarly, Medical Mutual will continue to update the fees in its Network Fee Schedule and Medicare Advantage Fee Schedule for J-codes and radiological materials as described below:
  - The fees for J-codes and radiological materials in Medical Mutual's fee schedule are 100% of the then-current Medicare fee schedule and will be updated on a quarterly basis to be effective on Jan. 1, April 1, July 1, and Oct. 1 of each year. Fees will reflect the quarterly updates made by CMS to the CMS Average Sales Price (ASP) file and by the Medicare Administrative Contractor for the state of Ohio (currently CGS Administrators, LLC) to its ASP file.
  - Each quarter, the updated fee schedules with revised fees for J-codes and radiological materials will be available via Medical Mutual's Provider Portal in Availity, which you can access at MedMutual.com/Provider.
- Medical Mutual will continue to update the fees in its Network Fee Schedule and Medicare Advantage Fee Schedule for immunizations as described below:
  - Fees for immunizations are updated on a semi-annual basis on Jan. 1 and July 1 of each year to be 100% of the then-current average Average Wholesale Price (AWP) for all known and active National Drug Codes (NDCs) associated with a particular immunization code.
  - In addition to the fee updates on Jan. 1 and July 1 of each year, if any, the fees for flu vaccines will be updated to be effective on Aug. 1 of each year to be 100% of the then-current average AWP for all known and active NDCs associated with the particular flu vaccine code.
  - When Medical Mutual makes updates to immunization fees, the updated fee schedules with revised fees for immunizations will be available via Medical Mutual's Provider Portal in Availity, which you can access at MedMutual.com/Provider.

The Medical Mutual Provider Portal in Availity offers search features based on a provider's individual National Provider Identifier and Tax Identification Number to view contract rates by:

- Procedure code submitted by your practice most frequently
- Commonly submitted procedure codes for specialties
- Contracted fees for individual procedure codes

If you have any questions regarding this update, please contact your Medical Mutual Provider Contracting Manager toll free at 1-800-625-2583. If you don't know who your Provider Contracting Manager is, please visit the Contact Us page at MedMutual.com/Provider.

Notice of Changes to Prior Authorization Requirements: Medical Mutual Changing Prior Authorization from eviCore to Cohere Health for Physical Therapy, Occupational Therapy, Speech Therapy, and Chiropractic Services on Nov. 1, 2024

As we previously communicated, on March 25, 2024, Medical Mutual started working with Cohere Health and Rhyme LiveAuthTM network for prior authorizations for outpatient and investigational/experimental services.

Starting on Nov. 1, 2024, physical therapy, occupational therapy, speech therapy and chiropractic services will be transitioning to Cohere Health for prior authorization as well. After Nov. 1, these services should no longer be submitted through eviCore for prior authorization. Not all plans require prior approval for therapy services (e.g., Mutual Health Services). To verify benefits and authorization requirements, please use the For Providers number on the back of the Covered Person's ID card.

What are your next steps?

- If you are not yet registered with Cohere Health, go to www.coherehealth.com/register.
- To view Cohere Health informational webinars, go to https://coherehealth.com/webinars/.
- To access the Cohere Health Learning Center following registration, please visit https://coherehealth.zendesk.com/hc/en-us.

We will continue to provide information to you on this transition as we get closer to November 1st. If you have any questions for Medical Mutual, please contact your Provider Contracting Manager at 1-800-625-2583. If you'd like to speak with a member of Cohere Health's team, please call 1-855-482-3649 or email mmosupport@coherehealth.com.

Indicating Experience Servicing the LGBTQ+ Community in our Provider Directory

We are always looking for ways to better serve our members, including those in the LGBTQ+ community. One way we are doing this is by having a feature in our provider directory that allows our members to search for LGBTQ+ experienced providers.

If you are a LGBTQ+ experienced provider, the only way that a member will be able to find you with that specialized search is if you indicate in your CAQH application that LGBTQ+ experience is an area of focus for you. The Area of Focus section of the CAQH application is currently not a required field, so it may be easy to overlook this section as you complete the application. However, it is important to complete this part of your application so our members who are part of the LGBTQ+ community can identify you when they do a provider search.

If this applies to you as a provider, and you have not completed this area of the CAQH application, we encourage you complete it so we can better serve our LGBTQ+ members.

Proper Coding for the HEDIS Cervical Cancer Screening (CCS) Measure

We are always looking for ways to work with you to improve the health of our members, your patients. According to the American Cancer Society, cases of cervical cancer are most frequently diagnosed in patients between the ages of 35 and 44, with an average age being 50.1

The Healthcare Effectiveness Data and Information Set (HEDIS) Cervical Cancer Screening (CCS) measure was developed by the National Committee for Quality Assurance (NCQA) as a performance improvement indicator that assesses members who were screened for cervical cancer appropriately. Proper coding and documentation of CCS information can help us identify members who have care gaps so steps can be taken towards screenings and/or treatment to stay healthy.

Documenting for the CCS Measure

Below is information on the CCS measure from our 2024 HEDIS Documentation Reference Guide, which is available at MedMutual.com/Provider > Resources.

HEDIS Measure	Description
Cervical Cancer Screening (CCS)	Percentage of members 21–64 years of age who were screened for cervical cancer. Measure criteria: ▪ Members 21–64 years of age who had cervical cytology performed in the last 3 years. ▪ Members 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) test in the last 5 years. ▪ Members 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing in last 5 years.
Best Practices and Documentation	Educate patients about the importance of cervical cancer screening and human papillomavirus (HPV) testing through age 64 including: ▪ Signs and symptoms of cervical cancer, and individual risk factors ▪ Receiving the HPV vaccinations ▪ Easy to understand patient education tools ▪ Follow up process after testing results received ▪ Fears that patients may have regarding testing, including gender inclusive care need Avoid care gaps: ▪ Use electronic alert reminders to avoid gaps in patient care ▪ Schedule patient follow-up appointments as part of discharge Document one of the following: ▪ Reports for cervical cytology and/or HPV including DOS and result - Biopsies are not compliant for cervical cancer screening ▪ Evidence of cervical agenesis or hysterectomy with no residual cervix - Compliant: total abdominal, vaginal, radical, complete, absence of cervix ▪ Palliative or Hospice care during the measurement year

Exclusions *The following conditions or services can be captured via claims to exclude members from the measure thus improving your CCS measure rates*	
Code Description/ Category	**Codes**
Hysterectomy With No Residual Cervix CPT codes	757530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
Cervical Agenesis or Acquired Absence of Cervix ICD10 codes	Q51.5, Z90.710, Z90.712
Hospice CPT Codes	99377, 99378
Palliative Care HCPCS Codes	G9054, M1017

Medical Mutual Support Programs

We offer programs that can help to support our members

- **Pharmacy assistance for cost or access to medications** – Express Scripts® Coverage Management 1-800-753-2851. Mail order, 90-day supply prescriptions are available for our members to help avoid any access issues

- **Case Management** – Offers help and support with complex medical needs. Provider referral:
  - For Medicare Advantage Case Management referral, call 1-855-887-2273 or email CaseMgmt-MedAdv@medmutual.com.
  - Commercial Case Management: 1-800-258-3175 option 2 (members) or option 3 (providers) or email CaseMgmt-Triage@medmutual.com.

- **Pelvic Health Care** – Bloom offers digital pelvic floor therapy, which is available at no additional cost as part of Medical Mutual's Total Health Program. Members may learn more and enroll by visiting https://join.hibloom.com/MedMutual or call Sword Health: 1-888-346-0476.

- **Tobacco Cessation Support** – Members may call 1-866-845-7702 or log in to My Health Plan and click Healthy Living, then Quit Tobacco.

Providing quality care for our members, your patients, is a team effort. Thank you for working with us to help support preventative care for our members.

References:
1. American Cancer Society. 2020. "Key Statistics for Cervical Cancer."
https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html Last modified June 28 2024

Best Practices and Coding to Accurately Capture Follow-up Visits for Transitions of Care (TRC) and Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC) HEDIS Measures

For Medicare Advantage patients, following up with a provider after a hospitalization or emergency department (ED) visit, especially when they have chronic medical conditions, is important. When a patient transitions from a healthcare setting (hospital, rehabilitation, skilled nursing facility or emergency room) to home, proper care coordination is vital to improve safety and reduce the chance of readmission.

That is why the National Committee for Quality Assurance (NCQA) developed two coordination of care measures in the Healthcare Effectiveness Data and Information Set (HEDIS®). Those measures are Transitions of Care (TRC) and Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC).

Transitions of Care (TRC)

This measure assesses four key points for Medicare Advantage members ages 18 and older after discharge from an inpatient facility.

1. Notification of Inpatient Admission – Documentation of receipt of notification on the day of admission through 2 days after the admission (3 total days). Documentation of a preadmission exam for a planned inpatient admission is also acceptable.

2. Receipt of Discharge Information – Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

- The discharge information should include the following topics
  - Practitioner responsible for patient's care during the stay
  - Procedures or treatment provided during the stay
  - Diagnosis at discharge
  - Current medication list
  - Documentation of test results, pending tests, or no tests completed
  - Patient instructions upon return to home or other care services

3. Patient Engagement After Inpatient Discharge – Documentation of patient engagement provided within 30 days after discharge.

4. Medication Reconciliation Post-Discharge (MRP) – Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). When documenting a medication reconciliation in the medical record please observe the following guideline:

- Documentation of "post op" does not qualify for compliant documentation

Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC)

This measure assesses emergency department (ED) visits for Medicare Advantage members ages 18 and older who have two or more high-risk chronic conditions and who had a follow-up service within 7 days of an ED visit. Chronic conditions included in this measure are:

- Alzheimer's disease and related disorders
- Atrial Fibrillation
- Chronic kidney disease
- COPD and Asthma
- Depression
- Heart failure
- Myocardial infarction (acute)
- Stroke and Transient ischemic attack

Best Practices for these HEDIS Measures

- Educate Medicare Advantage members on ED avoidance and other care options like telehealth, telephone, or urgent care.
- Develop a daily notification or EMR work que process for Medicare Advantage members discharged from the ED or hospital.
- Embed support services into ED and schedule follow up appointments prior to discharge.
- Patient Engagement After Inpatient Discharge, Medication Reconciliation Post-Discharge (MRP) and Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC) can be completed via an office, home, telehealth, or telephone visit.
- If the Medicare Advantage member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria for both Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge for TRC.
- Medication Reconciliation Post-Discharge can be added to your claim submission or accepted as supplemental data for TRC. Contact your Medical Mutual provider representative to discuss data exchange opportunities.
- Use the below CPT codes to document follow-up visits for TRC points of Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge, and also the FMC measure.

Measure	Opportunity	Codes System	Code Set**
TRC	Medication Reconciliation Post-Discharge	CPT	99483, 1111F
TRC FMC	Transitional Care Management ▪ Patient Engagement After Inpatient Discharge ▪ Medication Reconciliation Post-Discharge ▪ 7-day Follow-up	CPT	99495, 99496
TRC FMC	Outpatient and telephone visits ▪ Patient Engagement After Inpatient Discharge ▪ 7-day Follow-up ▪ Behavioral Health outpatient and telehealth visits	CPT	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483 98966, 98967, 98968, 99441, 99442, 99443
For the TRC and FMC measures, any members in hospice are excluded from reporting.			

**This is not an all-inclusive list of the value sets codes for TRC and FMC measures

Medical Mutual Programs and Resources

We offer programs and resources that can help support you and Medical Mutual Medicare Advantage members that have chronic health conditions.

- **Case Management** - Offers help and support with complex medical needs. Is available for both medical and behavioral health conditions. Provider referral: Medicare Advantage Case Management referral: 1-855-887-2273 or CaseMgmt-MedAdv@medmutual.com
- **Programs to Help Manage Chronic Conditions** – Offers education and support for Diabetes, COPD, Asthma, CAD, CHF, Hypertension. Please call 1-800-590-2583 to refer a member.
- **Care Navigation** - A Medical Mutual program that assesses for social determinants of health (SDoH) barriers to care and provides interventions related to community resources. Toll free 1-877-480-3105, option 2
- **MedMutual Resource Connect** - A resource that connects members 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.
- **Transitional Care** - options for certain members to receive health coaching and support for follow-up care after a hospital stay. Members are identified through internal process.
  - Return to Home Telephonic Program
  - In-Home/Telephonic Program administered by Area Agency on Aging
- **In-Home Palliative Care** - You can 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, or members can self-refer, by calling toll free 1-844-232-0500.
- **24-hour/7 day-a-week Nurse Line** - available to answer members' questions and help to guide care, 1-888-912-0636.

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.

Important HEDIS Measure and Best Practices for Patients on Antidepressant 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 those on antidepressant medications. Integrating the right antidepressant medication with appropriate behavioral therapy routinely leads to positive benefits and outcomes for members. Medication adherence is an essential component in the treatment guidelines for major depression.

The following Healthcare Effectiveness Data and Information Set (HEDIS®) measure, along with medication management best practices, is related to antidepressant medication use.

AMM (Antidepressant Medication Management)

This measure evaluates the percentage of patients 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment. Two rates are reported:

- Effective Acute Phase Treatment: The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). (Continuous treatment allows gaps in treatment up to a total of 31 days during the Acute Phase).
- Effective Continuation Phase Treatment: The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). (Continuous treatment allows gaps in treatment up to a total of 52 days during the Acute and Continuation Phases combined).

Best Practices

- Involve patients in decision making of their treatment plan.
- Help patients understand that most antidepressants take 4 to 6 weeks to work.
- Give your patients written instructions about the proper use of the medication and what to do if they experience side effects.
- Follow up with patients within 30 days from when the prescription is first filled for any side effects and their response to the treatment.
- Encourage your patients to continue any prescribed medication, even if they feel better. If they take the medication for less than six months, they are at a higher risk of recurrence of their symptoms.
- When applicable, ask your patient why they are not taking their medication.
  - Did they experience a change in symptoms or tolerability of the medication?
  - Is cost a barrier?
  - Are they using any substances that might be interfering with the medication?
  - Are they forgetting to take their medication? Would a daily reminder alarm or using a pill box be helpful?
  - Does the patient have adequate family and friends support?
- Reach out to patients who cancel appointments and assist them with rescheduling as soon as possible.
- Encourage the use of telephone and/or telehealth appointments for convenience to follow up with patients.
- Encourage your patients to get a 90-day supply of their medications or use auto refills to decrease the risk of running out and missing a dose.
- Coordinate care between behavioral health provider and primary care physician by sharing progress notes and updates.
  - Use the Behavioral Health Patient Summary Form available at https://www.medmutual.com/For-Providers/Continuity-and-Coordination-of-Care.aspx to help facilitate care.

Coding Instructions

These medications are part of the AMM measure:

Description	Prescription
SSRI antidepressants	Citalopram, Fluoxetine, Paroxetine, Escitalopram, Fluvoxamine, Sertraline
SNRI antidepressants	Desvenlafaxine, Levomilnacipran, Duloxetine, Venlafaxine
Tricyclic antidepressants	Amitriptyline, Desipramine, Nortriptyline
Tetracyclic antidepressants	Maprotiline, Mirtazapine
Monoamine oxidase inhibitors	Isocarboxazid, Selegiline, Phenelzine, Tranylcypromine
Psychotherapeutic combinations	Amitriptylinechlordiazepoxide, Amitriptylineperphenazine, Fluoxetineolanzapine
Phenylpiperazine antidepressants	Nefazodone, Trazodone
Miscellaneous antidepressants	Bupropion, Vilazodone, Vortioxetine

Behavioral Health Resources

- The Ohio Department of Mental Health & Addiction Services https://mha.ohio.gov/supporting-providers. These resources help providers across the continuum of care.
- The WACO Guide – https://wacoguide.org/all-tools
- To connect with a Medical Mutual behavioral health case manager, email BehavioralHealthDepartment@MedMutual.com or call 1-800-258-3175 (TTY:711).
- Behavioral Health Patient Summary Form - https://www.medmutual.com/For-Providers/Continuity-and-Coordination-of-Care.aspx
- Clinical Practice Guidelines for Treatment of Depression - https://www.apa.org/depression-guideline

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 Mutual Is Working with Optum to Introduce a New Claim Management Portal for Providers

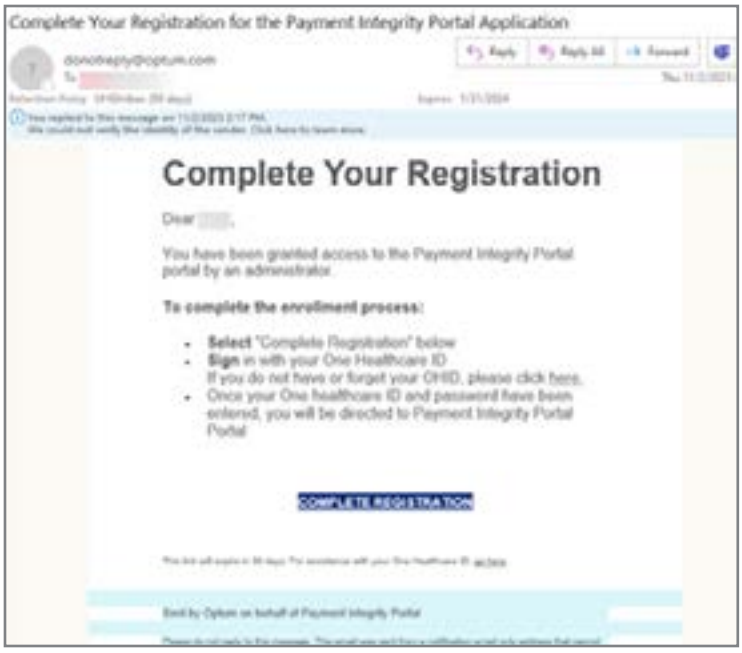
Medical Mutual is working with Optum to introduce a new claim management portal for providers. The portal allows users to review all claims that are awaiting medical records and offers a streamlined process for uploading documents.

Key portal features:

- **View Provider Claims:** View claim status for claims with outstanding medical record requests. Viewable claims are limited to a provider-specific TIN.
- **Upload Medical Records:** Drag-and-drop upload for medical records with a formal notification process after an upload is successful.
- **Claim Filter:** Search and filter viewable claims by claim number, TIN and/or account number.
- **Set Request Preferences:** Set up your digital delivery preference with a download option to eliminate paper letters. The portal can be accessed at https://paymentintegrityportal.optum.com/.

First time users will need to follow the following steps for registration:

1. Email pi_portal_support@optum.com with the below information.
   a. Name
   b. Email
   c. Organization Name & TIN(s)
2. Follow the instructions once an email response is received from Optum to complete registration.



Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Mar. 1, 2024 and July 31, 2024 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 SC	Revised
ACTH	Revised
Adbry	Revised
Adstiladrin	Revised
Aflibercept	Revised
Alpha-1_Proteinase inhibitors	Revised
Amondys45	Revised
Amtagvi	New
Amvuttra	Revised
Anti-Inhibitor_Ab	Revised
Antikva	New
Aranesp	Revised
Bavencio	Revised
Bendamustine	Revised
Beqvez	New
Besponsa	Revised
Bevacizumab _ONCO	Revised
Blincyto	Revised
Breyanzi	Revised
Cabenuva	Revised
Carvykti	Revised
Cimzia	Revised
Cinqair	Revised
Cinryze/Haegarda	Revised
Columvi	Revised
Compounded Drugs	Revised
Copaxone, glatiramer acetate, Glatopa	Revised

CMP Name	Policy Status
Cosela	Revised
Cosmetic Use policy	Revised
Coverage of New and Unproven Drug policy	Revised
Crysvita	Revised
Cyramza	Revised
Darzalex_IV	Revised
Darzalex_SQ	Revised
Dupixent	Revised
Dysport	Revised
Eculizumab	Revised
Elahere	Revised
Elrexfio	Revised
Elzonris	Revised
Empaveli	Revised
Empliciti	Revised
Enbrel	Revised
Enhertu	Revised
Enjaymo	Revised
Entyvio IV	Revised
Entyvio SC	Revised
Epkinly	Revised
Epoetin_alfa	Revised
Erbitux	Revised
Evenity	Revised
Evkeeza	Revised
Exondys51	Revised
Fasenra	Revised
Gazyva	Revised
GCSF-Long acting	Revised
GCSF-Short acting	Revised
General Oncology	Revised
Global PA	Revised
Hemgenix	Revised
Hemlibra	Revised
Hepzato	New

CMP Name	Policy Status
Imdelltra	New
Imfinzi	Revised
Imjudo	Revised
Imlygic	Revised
Inhaled Nitric Oxide	Revised
IVIG	Revised
Izervay	Revised
Jelmyto	Revised
Jemperli	Revised
Kadcyla	Revised
Kevzara	Revised
Keytruda	Revised
Krystexxa	Revised
Kyprolis	Revised
Lamzede	Revised
Lenmeldy	New
Leqvio	Revised
Leukine	Revised
Levoleucovorin	Revised
Libtayo	Revised
Loqtorzi	Revised
Lutathera	Revised
Margenza	Revised
Medicare Part B ST	Revised
Mircera	Revised
Monjuvi	Revised
Myobloc	Revised
Nucala	Revised
Nulibry	Revised
Ocrevus	Revised
Onivyde	Revised
Onpattro	Revised
Opdivo	Revised
Orencia SC	Revised
Paclitaxel Albumin-Bound	Revised

CMP Name	Policy Status
PAH- Remodulin	Revised
Palynziq	Revised
Pedmark	Revised
Pemetrexed	Revised
Perjeta	Revised
Phesgo	Revised
Polivy	Revised
Portrazza	Revised
Praluent	Revised
Provenge	Revised
Qalsody	Revised
Radicava_IV	Revised
Reblozyl	Revised
Repatha	Revised
Rituximab_IV	Revised
Rituximab_SQ	Revised
Roctavian	Revised
Ruconest	Revised
Rybrevant	Revised
Ryplazim	Revised
Rytelo	New
Saphnelo	Revised
Sarclisa	Revised
Simponi	Revised
Skyrizi IV	Revised
Skyrizi SC	Revised
SOC	Revised
Soliris	Revised
Somatuline Depot	Revised
Spevigo	Revised
Spinraza	Revised
Spravato	Revised
Taltz	Revised
Talvey	Revised
Tecentriq	Revised

CMP Name	Policy Status
Tecvayli	Revised
Tevimbra	New
Tivdak	Revised
Tocilizumab _IV	Revised
Trastuzumab_IV	Revised
Trastuzumab_SQ	Revised
Tremfya	Revised
Trisenox	Revised
Trodelvy	Revised
Ultomiris	Revised
Uplizna	Revised
Ustekinumab	Revised
Vectibix	Revised
Viltepso	Revised
Viscos - HAD	Revised
Vyjuvek	Revised
Vyondys53	Revised
Vyvgart_SQ	Revised
Vyxeos	Revised
Winrevair	New
Xeomin	Revised
Xgeva	Revised
Xolair	Revised
Yervoy	Revised
Yondelis	Revised
Zaltrap	Revised
Zepzelca	Revised
Zolgensma	Revised
Zymfentra	Revised
Zynlonta	Revised
Zynteglo	Revised
Zynyz	Revised

Medical CMPs

CMP Name	CMP Number	Policy Status
Cryoablation of Solid Tumors	200802	Revised
Vertebral Body Tethering	202013	Revised
Peripheral Nerve Stimulation and Electrical Stimulation for Pain and Other Conditions	201004	Revised
Anesthesia Services for Dental Procedures in the Facility Setting	202010	Revised
Functional Electrical Stimulation for Rehabilitation of Paralyzed Lower Extremities	200604	Revised
Vertebral Axial Decompression (VAX-D)	200002	Revised
Tumor Treating Fields	201607	Revised
FoundationOne Liquid CDx	202403	Revised
Focal Articular Cartilage Defect Treatment Osteochondral Allograft	200613	Revised
Skin Surveillance Technologies	200903	Revised
Pancreatic Islet Cell Transplant	201102	Revised
Wireless Gastrointestinal Motility Monitoring System	2011-C	Revised
Ultrasound Transient Elastography	201935	Revised
Bariatric Surgery for Obesity	94030	Revised
Vision Training	201103	Revised
Contact Lenses	200131	Revised
Intrastromal Corneal Ring Segments for the Treatment of Keratoconus	200504	Revised
Surgical Treatments for Glaucoma	201721	Revised
Allogeneic, xenographic, synthetic, and composite nerve grafts and conduits	2019-F	Revised
Microsurgical Treatments for Lymphedema	202011	Revised
Bariatric Surgery (FEHB)	94030-CSTM2	Revised
Bone Graft Materials	200403	Revised
Genetic Testing and Genetic Counseling General Policy	201303	Revised
Dry Needling	202009	Retired
Oncotype DX AR-V7 Nucleus Detect Assay	201924	Revised
Treatments for Benign Prostatic Hypertrophy	201913	Revised
Rethymic	202201	Revised
Gender Affirming Surgery (FEHB)	201609-CSTM	Revised
Peroral Endoscopic Myotomy	202101	Revised
Eustachian Tube Balloon Dilation	202305	Revised
Manipulation Under Anesthesia	95029	Revised

Medical CMPs

CMP Name	CMP Number	Policy Status
Endoscopic Thoracic Sympathectomy for Treatment of Hyperhidrosis	200313	Revised
Magnetic Resonance-Guided Focused Ultrasound	202308	Revised
Endoscopic and Laproscopic Therapies for Tx of GERD	200310	Revised
Gender Affirming Surgery	201609	Revised
Light Therapies for Dermatological Conditions	94057	Revised
Rebyota	202301	Revised
Skin Substitutes	200233	Revised
Cochlear Implants	202020	Revised
Implanted cardiac contractility modulation generator - Optimizer	202205	Revised
Rhinoplasty & Septoplasty	200509	Revised
Bulking Agents for Fecal Incontinence - Solesta®	201942	Revised
Rapid Desensitization	99006	Revised
Computer Assisted Musculoskeletal Surgical Navigation System	2019-D	Revised
Subchondroplasty (SCP)	2019-B	Revised
Temporary Ventricular Assist Device	201804	Revised
Electrothermal Therapy	201527	Revised
Outdated Jaw Reconstruction Procedures	202401	Retired
Sacroiliac Joint Injections	202402	Revised
Leadless Cardiac Pacemaker (i.e., MICRA Transcatheter Pacemaker System)	2017-B	Revised
Spinal Unloading Device-Low Back Pain-Scoliosis	201022	Retired
Sacroiliac Joint Injections	202402	Revised
Leadless Cardiac Pacemaker (i.e., MICRA Transcatheter Pacemaker System)	2017-B	Revised
Spinal Unloading Device-Low Back Pain-Scoliosis	201022	Retired
Diabetes Management	200117	Revised
Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions	200139	Revised
Investigational Spinal Procedures	2019-G	Revised
Vectra DA Blood Test	201504	Retired
Drug Testing	201506	Retired
Tumor Chemosensitivity and Chemoresistance Assays	201926	Retired
Flow Cytometry	202106	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

Using Artificial Intelligence in Risk Adjustment

With the transition from fee-for-service to value-based reimbursement, some payers and providers have turned to the use of artificial intelligence (AI) systems to enhance the capture of hierarchical condition categories (HCC) for reimbursement. With the use of AI comes risk, and we encourage all providers using this type of tool to be diligent with compliance, as these tools cannot replace coders and do not always follow the guidelines set forth by the Centers for Medicare & Medicaid Services (CMS) for substantiating diagnoses: ICD-10-CM Official Guidelines for Coding and Reporting, the AHA Coding Clinic®, and protocols for Affordable Care Act and Medicare Advantage Risk Adjustment Data Validation (RADV) auditors.

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.

Centers for Medicare & Medicaid Services Risk Adjustment Data Validation Protocols

At the May 29, 2024 meeting, held for Issuers and Initial Validation Auditors to review HHS-CMS Risk Adjustment Data Validation (RADV) protocols for the 2023 benefit year RADV audit, the Centers for Medicare & Medicaid Services (CMS) insisted that providers indicate the purpose of prescribed medications that are being used to manage chronic conditions (in lieu of other support).

There are several ways this can be addressed in the medical record, with a few suggestions below.

1. List the condition and medication. For example:

- Hypertension
  - Blood pressure checks have been high.
  - Increase hydrochlorothiazide to 50mg daily.
- Hypercholesterolemia
  - Continue fenofibrate.
- Generalized anxiety disorder
  - Begin treating with Zoloft.

2. Keep medications in a table that is reviewed/updated each visit. For example:

- Date of service 5/17/2024

Medications as of 5/17/2024:

Start Date	Medication	Dosage	Reason	Comment	Stop Date
11/16/2018	Losartan	50mg/day	HTN	Refilled, 6 mos	
11/16/2018	Amaryl	1mg/day w/ breakfast	DM	Refilled, 6 mos	Amaryl
5/16/2019	Lexapro	5mg/day	GAD	11/17/2019	Discontinued due to limb pain
11/17/2023	Zoloft	100mg/day	GAD	Refilled, 6 mos	

We encourage providers to report all chronic conditions they are managing or overseeing on the day of service. For risk adjustment purposes, those conditions require supporting documentation unless stated in the provider's assessment and not contradicted elsewhere in the provider's notes. Examples of supporting documentation include:

- A medication linked to the condition
- Current condition status
- Referral for the condition
- Testing related to the condition (e.g., hyperlipidemia – check lipid panel)
- Counseling related to the condition

Thank you for working with us to care for our members.

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