New Vaccine Administration Codes

As of January 1, 2011, Medical Mutual® and its Family of Companies allow separate reimbursement for administration of each vaccine component in a combination vaccine.

**CPT Code 90460**
Vaccine administration, with counseling by a healthcare professional, of the first vaccine/toxoid component given by any route of administration to patients through age 18.

**CPT Code 90461**
Vaccine administration, with counseling by a healthcare professional, of each additional vaccine/toxoid component given by any route of administration to patients through age 18.

**Examples of Claim Submissions**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Description</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentacel® (DTap-Hib-IPV)</td>
<td>Contains five vaccine components:</td>
<td></td>
</tr>
<tr>
<td>■ Pentacel:</td>
<td>Submit CPT Code 90698</td>
<td></td>
</tr>
<tr>
<td>■ Vaccine Administration:</td>
<td>Submit CPT Code 90460 once <strong>and</strong> 90461 four times</td>
<td></td>
</tr>
<tr>
<td>Prevnar 13™</td>
<td>Contains one vaccine component:</td>
<td></td>
</tr>
<tr>
<td>■ Prevnar 13:</td>
<td>Submit CPT Code 90670</td>
<td></td>
</tr>
<tr>
<td>■ Vaccine Administration:</td>
<td>Submit CPT Code 90460</td>
<td></td>
</tr>
</tbody>
</table>

These codes are recognized for immunizations administered on or after January 1, 2011. For immunizations administered in 2010, use CPT codes applicable in 2010.
Rheumatoid Arthritis — Early Intervention is Key

Rheumatoid Arthritis (RA) is a chronic inflammatory disorder that often results in progressive joint damage. Joint damage can be seen as early as six months after onset and often progresses rapidly early in the course of the disease. It’s not uncommon for patients to develop moderate disability within two years of diagnosis.

RA can be difficult to recognize in its early stages because:
- There is no single test to establish a definitive diagnosis
- Symptoms and the number of affected joints differ among individuals
- Symptoms are similar to other types of joint and muscle conditions
- Only a few minor symptoms may be present in the early stages

RA is usually most appropriately treated with disease-modifying antirheumatic drug (DMARD) therapy which can help slow the destructive effects.

Early, intensive DMARD therapy is the best chance of preventing joint damage. Recent advances in treatment have shown the importance of coordination of care between primary care physicians (PCPs) and joint specialists (rheumatologists) in managing this disease. An educated patient population and ongoing quality improvement activities will most likely result in even greater demand for speedy access to therapy that maximizes outcomes while ensuring patient safety.

PCPs can play an important role in diagnosing early RA and managing its symptoms by:
- Recognizing inflammatory arthritis in patients with new-onset joint pain
- Assessing the patient’s functional status, obtaining appropriate diagnostic studies and measuring the acute-phase response
- Obtaining a rheumatologic consultation when inflammatory arthritis does not resolve within one to two months
- Assisting rheumatologists in ongoing assessment of response to DMARD therapy and early identification of drug toxicity

A variety of approaches may be used to treat RA. Treatment options should address the patient’s individual situation and be geared toward the following goals:
- Relieving pain
- Reducing inflammation
- Slowing or stopping joint damage
- Preserving function
- Improving patient quality-of-life

For more information, visit arthritis.org.
Document Your Quality Diabetes Management

Current Procedure Terminology (CPT) Category II codes are one way to track and report clinical performance measures. These codes facilitate data collection by documenting performance of certain important services and tests supported by nationally established performance measures, such as Healthcare Effectiveness Data and Information Set (HEDIS). Listed below are Category II codes for important components of diabetes management.

<table>
<thead>
<tr>
<th>Code</th>
<th>Performance Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Hemoglobin A1C Control in Type 1 and Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td>3044F</td>
<td>Most recent Hemoglobin A1C level &lt; 7%</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent Hemoglobin A1C level 7 to 9%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent Hemoglobin A1C level &gt; 9%</td>
</tr>
<tr>
<td></td>
<td><strong>Low Density Lipoprotein Control in Type 1 or Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td>3048F</td>
<td>Most recent LDL-C &lt; 100 mg/dL</td>
</tr>
<tr>
<td>3049F</td>
<td>Most recent LDL-C 100 – 129 mg/dL</td>
</tr>
<tr>
<td>3050F</td>
<td>Most recent LDL-C &gt; 130 mg/dL</td>
</tr>
<tr>
<td></td>
<td><strong>Blood Pressure Control in Type 1 and Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td></td>
<td><strong>SYSTOLIC</strong></td>
</tr>
<tr>
<td>3074F</td>
<td>Most recent systolic blood pressure &lt; 130 mm Hg</td>
</tr>
<tr>
<td>3075F</td>
<td>Most recent systolic blood pressure 130 – 139 mm Hg</td>
</tr>
<tr>
<td>3077F</td>
<td>Most recent systolic blood pressure &gt; 140 mm Hg</td>
</tr>
<tr>
<td></td>
<td><strong>DIASTOLIC</strong></td>
</tr>
<tr>
<td>3078F</td>
<td>Most recent diastolic blood pressure &lt; 80 mm Hg</td>
</tr>
<tr>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80 – 89 mm Hg</td>
</tr>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure &gt; 90 mm Hg</td>
</tr>
<tr>
<td></td>
<td><strong>Eye Exams in Type 1 and Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td>2022F</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed</td>
</tr>
<tr>
<td>2024F</td>
<td>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed</td>
</tr>
<tr>
<td>2026F</td>
<td>Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed</td>
</tr>
<tr>
<td>3072F</td>
<td>Low risk for retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
<tr>
<td></td>
<td><strong>Urine Protein Screening in Type 1 and Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test results documented and reviewed</td>
</tr>
<tr>
<td>3061F</td>
<td>Negative microalbuminuria test results documented and reviewed</td>
</tr>
<tr>
<td>3062F</td>
<td>Positive macroalbuminuria test results documented and reviewed</td>
</tr>
<tr>
<td>3066F</td>
<td>Documentation of treatment for nephropathy (e.g., patient receiving dialysis, being treated for ESRD, CRF, ARF or renal insufficiency, any visit to a nephrologist)</td>
</tr>
<tr>
<td>4009F</td>
<td>Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed</td>
</tr>
<tr>
<td></td>
<td><strong>Foot Examinations in Type 1 and Type 2 Diabetes Mellitus</strong></td>
</tr>
<tr>
<td>2028F</td>
<td>Foot examination performed (includes examination through visual inspection, sensory exam with monofilament and pulse exam — report when any of the three components are completed)</td>
</tr>
</tbody>
</table>

For additional information about using CPT Category II codes, contact the American Medical Association (AMA) at ama-assn.org or call 800.366.6968.
2011 Immunization Schedule Highlights

Each year the Advisory Committee on Immunization Practices (ACIP) updates the Recommended Immunization Schedules for children, adolescents and adults. Adherence to the schedules ensures that patients receive timely protection from vaccine-preventable diseases.

### 2011 Adult Schedule Changes

**Influenza Vaccine:**
Recommended for everyone 6 months and older, including pregnant women and healthcare personnel. Healthy non-pregnant adults younger than age 50 can receive the intranasally administered live attenuated influenza vaccine (FluMist) or inactivated vaccine. Others should receive the inactivated vaccine. The high-dose influenza vaccine, licensed in 2010 for adults 65 and older, is an option for this age group.

**One-Time Dose of Td (Tetanus, diphtheria)/Tdap (Tetanus, diphtheria and pertussis) Vaccine:**
- Adults younger than age 65 who have not previously received the Tdap
- Healthcare personnel with direct patient contact
- Postpartum women
- Everyone ages 65 and older, especially those who have close contact with an infant under 12 months

**HPV Vaccine:**
Either the three-dose quadrivalent or the three-dose bivalent vaccine is recommended for females ages 19–26 if not received in childhood.

**PPSV Vaccine:**
Clarification of revaccination: a one-time revaccination after five years is recommended for individuals ages 19–64 with certain high-risk conditions. For people age 65 and older, a one-time revaccination is recommended if vaccinated five or more years previously and were younger than age 65 at the time of vaccination.

**All Vaccines:**
For all vaccines recommended on the adult immunization schedule, a vaccine series does not need to be restarted, regardless of the time elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine’s other components are not contraindicated.

### 2011 Pediatric Schedule Changes

**Influenza Vaccine:**
Recommended for everyone 6 months and older. Guidance has been added for administration of one or two doses of the seasonal influenza vaccine based on the child’s history of monovalent 2009 H1N1 vaccination.

**HepB Vaccine:**
Infants who did not receive a dose at birth should receive three doses of HepB on a schedule of 0, 1 and 6 months.

**Tdap Vaccine:**
Guidance has been added for the use of Tdap in children ages 7–10 who are incompletely vaccinated against pertussis.

**MCV4 Vaccine:**
Recommendations for a booster dose of quadrivalent meningococcal conjugate vaccine were added. If the first dose of MCV4 is given between ages 11 and 12, the booster should be given at age 16. If the first dose is received between ages 13 and 15, the booster dose should be given between ages 16 and 18.

Detailed recommendations for using vaccines are available at cdc.gov/vaccines/pubs/acip-list.htm.

The complete adult vaccine schedule is available at cdc.gov/vaccines/recs/schedules/adult-schedule.htm.

Source: Centers for Disease Control and Prevention. Recommended immunization schedule for persons aged 0-18 years – United States, 2011, MMWR 2011;60(5).
Routine Imaging—When Less is More

The American College of Physicians (ACP) found strong evidence that routine imaging for low-back pain using radiography or advanced imaging methods does not improve clinical outcomes and may expose patients to preventable harm. However, in a recent survey, approximately 40 percent of family practice and 13 percent of internal medicine physicians reported ordering routine diagnostic imaging for acute low-back pain.

Evidence-based recommendations from the ACP and the American Pain Society (APS) state that imaging is warranted only when patients have:

- Severe or progressive neurologic deficits
- Signs and symptoms implying a serious condition, such as cauda equina or vertebral infection
- A specific underlying condition, such as cancer

The American College of Radiology (ACR) Appropriateness Criteria is consistent with these recommendations.

Treatment plans do not require routine imaging. A meta-analysis of six randomized trials of 1,804 patients with acute or subacute low-back pain and no signs or symptoms of a specific underlying condition did not find a difference in terms of pain, function, quality-of-life or overall patient-rated improvement whether or not routine lumbar imaging was performed.

Routine imaging can expose the patient to unnecessary low-dose radiation. The average radiation exposure from lumbar radiography is 75 times higher than chest radiography—an important consideration in women of child-bearing age—due to the difficulty of effectively shielding the pelvic region.

The decision not to image may be interpreted by your patient as a sign that his or her complaints are not being taken seriously. However, sharing clinically irrelevant imaging results may hinder the patient's recovery because he or she will focus on the minor symptoms, thus increasing their worry and decreasing recommended physical activities in fear of causing more damage.

Adhering to ACP/APS recommendations about the use of imaging can reduce overuse. Most patients do not need immediate imaging and will benefit from an initial trial of therapy. Key management principles to guide imaging decisions include a thorough history and physical examination, as well as effective and compassionate communication to the patient in pain.

Sipuleucel-T (Provenge®, Dendreon Corporation, Seattle, WA) is an autologous cellular immunotherapy product that uses the patient’s own dendritic cells to manufacture a personalized prostate cancer vaccine. Immune cells harvested via leukapheresis (cytapheresis) are conditioned with a proprietary recombinant fusion protein to recognize prostatic acid phosphatase (PAP) as foreign. Administered intravenously, sipuleucel-T is thought to trigger an antigen-antibody response to PAP, a protein found in approximately 95 percent of prostate cancer cells.

Effective November 3, 2010, Medical Mutual considers sipuleucel-T (HCPCS codes C9273, J3590 and J9999) medically necessary and eligible for reimbursement as long as the patient meets all of the following medical criteria:

- Metastatic, castrate-resistant (hormone-refractory) prostate cancer (CRPC)
- Asymptomatic or minimally symptomatic with Eastern Cooperative Oncology Group (ECOG) performance status of 0–1
- Histologically confirmed prostate adenocarcinoma and at least one of the following:
  - Measurably progressive disease as evidenced by changes in lymph node size, parenchymal mass on physical examination or radiographic studies (e.g., computed tomography [CT], magnetic resonance imaging [MRI])
  - Serial bone scan demonstrates one or more new lesion(s) or increased lesion size (excluding flare occurring at onset of hormonal treatment or chemotherapy)
  - Increased prostate-specific antigen (PSA) level and the following: Prostate-specific antigen progression: two prostate-specific antigen values, obtained on separate days and a minimum of one week after a baseline level, that are both determined to be ≥ 25% and ≥ 5 ng/ml above the baseline prostate-specific antigen level
- Prior surgical castration (bilateral orchietomy) or more than three months of chemical castration (serum testosterone level < 50 ng/dL) treatment with luteinizing hormone releasing hormone (LHRH) agonists (e.g., leuprolide, goserelin, triptorelin, histrelin) or antagonists (e.g., degarelix)
- Not administered concomitantly with chemotherapy, other immunotherapy or radiation therapy
- Administered only to the individual from whom cells were harvested
- No moderate to severe prostate cancer-related pain and/or use of opioid analgesics for cancer-related pain
- Visceral (e.g., liver, lung, brain) metastases are not present
- Life expectancy greater than six months
- Malignant neoplasm of prostate is clinically present

Please visit the Corporate Medical Policy page at Provider.MedMutual.com for the most current version of Corporate Medical Policy 201013.
Medical Policy Update

The following Corporate Medical Policies were developed or revised between October 1, 2010, and December 31, 2010.*

<table>
<thead>
<tr>
<th>Policy</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>94057</td>
<td>Light Therapy for Dermatological Conditions</td>
</tr>
<tr>
<td>95004</td>
<td>Surgical Management of Obstructive Sleep Apnea</td>
</tr>
<tr>
<td>95017</td>
<td>Implantable Infusion Pumps</td>
</tr>
<tr>
<td>98031</td>
<td>Palivizumab (Synagis)</td>
</tr>
<tr>
<td>99002</td>
<td>Intra-articular Viscosupplementation</td>
</tr>
<tr>
<td>200117</td>
<td>Continuous Glucose Monitoring</td>
</tr>
<tr>
<td>200522</td>
<td>Percutaneous or Endoscopic Epidural Adhesiolysis</td>
</tr>
<tr>
<td>201006</td>
<td>Cinryze (C1 esterase inhibitor) <em>(New)</em></td>
</tr>
<tr>
<td>201007</td>
<td>Light Therapies for Treatment of Vitiligo <em>(New)</em></td>
</tr>
<tr>
<td>201010</td>
<td>Repository Corticotropin Injection (H.P. Acthar Gel) <em>(New)</em></td>
</tr>
<tr>
<td>201012</td>
<td>Ustekinumab (Stelara™) <em>(New)</em></td>
</tr>
<tr>
<td>201013</td>
<td>Sipuleucel-T (Provenge®) <em>(New)</em></td>
</tr>
<tr>
<td>201020</td>
<td>Berinert (C1 esterase inhibitor) <em>(New)</em></td>
</tr>
<tr>
<td>201021</td>
<td>Ecallantide (Kalbitor) <em>(New)</em></td>
</tr>
<tr>
<td>201022</td>
<td>Spinal Unloading Device</td>
</tr>
<tr>
<td>201023</td>
<td>Total Ankle Replacement</td>
</tr>
</tbody>
</table>

* Corporate Medical Policies are regularly reviewed, updated, added or withdrawn and are therefore subject to change.

Please visit Provider.MedMutual.com for a complete list of Corporate Medical Policies. For a list of services requiring prior approval or considered investigational, please visit our website and select Providers, Tools & Resources, Care Management and then Prior Approval & Investigational Services.

Your Reporting Obligations to Medical Mutual

It is imperative that Medical Mutual remain up-to-date on your practice locations, professional certifications and recognition as a provider of excellence in your specialty. Publication of this information in our provider directory helps us to better serve our member population.

Any medical board or hospital action affecting your professional license or privileges must be promptly reported to the Company. Actions may include, but are not limited to, restriction or loss of the following:

- Any professional certification
- Accreditation/recognition of excellence
- Professional license and/or professional privileges

It May be a License Action Requirement to Report

The reporting of license action is contractually required by your network agreement and may also be required by your licensing board. The board may require you to provide a copy of your agreement with the board to employers or entities with which you are under contract to provide healthcare services (including but not limited to third-party payors).
Weight Bias in Women’s Healthcare

Links between excess body fat and cancer have been well documented. Many organizations, such as the American Cancer Society, report that excess body fat is linked to a variety of cancers, including gynecological cancers. Although obese women are at higher risk for gynecological cancers than non-obese women, they are also more likely to delay or refuse cancer screenings.

One study revealed that obese women who reported they were “moderately” or “very concerned” about cancer symptoms delayed receiving care due to perceived barriers. Morbidly obese women in the study had a significantly lower rate (68 percent) of Pap tests compared to others (86 percent). Women indicated several barriers to screenings, such as disrespectful treatment, embarrassment at being weighed, unsolicited advice to lose weight and medical equipment that was too small to be functional.1

Simple strategies can be implemented to improve the patient’s perception of quality of care and improve access to gynecologic services. The process of being weighed can increase the patient’s anxiety and has been cited as a reason patients avoid care. To help patients feel comfortable, place the scale in a private place away from office traffic. Encourage staff to weigh the patient with sensitivity and record the weight without comment to avoid communication that could be interpreted as critical. Make sure appropriate equipment is available and provided without comment (e.g., large blood pressure cuffs, gowns, long vaginal specula).

Being aware that obese patients have probably experienced weight-loss bias in the past should help providers understand the patient’s reluctance or anxiety about discussing weight. Resources to help promote a positive office environment, communicate health risks and promote shared goal-setting with obese patients include YaleRuddCenter.org, win.niddk.nih.gov and ama-aasn.org.

SuperWell® Disease and Maternity Management Program

To assist members who are pregnant or those diagnosed with certain chronic diseases, we offer the SuperWell Disease and Maternity Management Program.

In addition to maternity management, this program is available for eligible members diagnosed with one or more of the following conditions:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease
- Heart failure
- Coronary artery disease
- Chronic pain conditions
- Depression

Many of the above conditions co-exist in the same individual; therefore, this program can provide the intensive support necessary to make patient management more effective. Enrollment in the program provides structured education and support by specially trained health coaches. Patients benefit from routine monitoring, education on complication management and the importance of following the prescribed treatment plan.

To enroll a patient in the SuperWell Disease and Maternity Management Program, call us at 800.861.4826.

Cymbalta® for Chronic Back Pain

In November 2010, the U.S. Food and Drug Administration (FDA) added a new drug for the management of chronic musculoskeletal pain. Duloxetine hydrochloride (Cymbalta), a selective serotonin and norepinephrine reuptake inhibitor (SSRI), is indicated as a medication for the management of chronic musculoskeletal pain based on results of four double-blind, placebo-controlled, randomized clinical trials. Patients who randomly received duloxetine reported a greater reduction in chronic low-back pain and osteoarthritis pain when compared with the placebo.

For more information, visit cymbalta.com and accessdata.fda.gov.

Duloxetine is also approved for the treatment of diabetic peripheral neuropathy, major depressive disorder and fibromyalgia. Although the drug’s exact action is unknown, it is believed that Cymbalta may increase the activity of serotonin and norepinephrine in the brain and spinal cord. Serotonin and norepinephrine are believed to mediate core mood symptoms and regulate pain perception.
Continuous Glucose Monitoring Devices

In October 2010, the American Association of Clinical Endocrinologists (AACE) published a consensus statement for continuous glucose monitoring (CGM) devices for type 1 diabetics.

Professional Devices
- Equipment owned by the healthcare professional and typically worn by the patient for three to five days
- The patient remains unaware of blood glucose monitoring results until they are downloaded and analyzed by a healthcare professional

Personal Device
- Device owned by the patient
- Glucose values are always visible, allowing for immediate therapeutic adjustments based on real-time glucose results

The AACE recommends use of a personal CGM device by type 1 diabetics with the following characteristics:
- Hypoglycemic unawareness or frequent hypoglycemia
- A1C levels over target or with hypoglycemia judged to be excessive, potentially disabling or life-threatening
- Requiring A1C lowering without increased hypoglycemia
- During preconception and pregnancy
- Children and adolescents with type 1 diabetes who have achieved A1C levels < 7.0%
- Children and adolescents with type 1 diabetes and A1C levels > 7.0% able to use the device on a near-daily basis

Consistent use of a CGM device improves patient involvement in diabetes self-management. Patients can adjust medications, nutrition and physical activity to improve glucose management. The information can be downloaded and assessed by the physician and shared with the patient, allowing for individualized medical interventions.

Coverage for CGM devices is dependent on the employer group. Please refer to our website, Provider.MedMutual.com, for Corporate Medical Policy 20017: Continuous Glucose Monitoring and Continuous Glucose Monitoring Systems for additional information about prior approval requirements.

The AACE consensus statement is available online at aace.com.

Contact Care Management

Questions about Care Management Processes
The Care Management department is available to address inquiries about utilization management functions, such as inpatient admissions, denials, appeals and referrals (including Behavioral Health services), Monday through Friday, excluding holidays, from 8:15 a.m. to 4:15 p.m. (Eastern). Refer to the numbers on the member’s identification card.

Case Management services are available to help coordinate care, provide information about community services and provide patient education. Please call 800.258.3175 for more information.

Comments and Feedback
Do you have a comment or suggestion you would like to share with us? We are always interested in hearing from providers about our efforts to partner with you to provide the highest quality of care to our members. Contact the Clinical Quality Improvement (CQI) department at 800.586.4523 or write to us at:

Medical Mutual
MZ: 01-5B-7501
2060 East 9th Street
Cleveland, OH 44115
Member Rights and Responsibilities

We developed a Member Rights and Responsibilities statement to help members actively participate in their healthcare. These member rights and responsibilities are defined as the member’s role in working with us, and you, to achieve a quality, cost-effective health outcome.

The Member Rights and Responsibilities statement was recently updated to make the information easier to read by grouping topics. To access the entire updated statement, visit Provider.MedMutual.com. From the bottom of the page select Corporate, then Our Mission.

For Your Information

We remain committed to supplying providers with the programs, information and support needed to ensure the health and well-being of our members and the communities we serve. Access our website, Provider.MedMutual.com, for the following:

Select Tools & Resources for:
- Forms
- Provider E-Services
- Provider Manual
- Provider Publications
  - Eye on Quality
  - Mutual News
  - Mutual News Bulletin
  - Quality Connection
  - Archived Provider Publications

Select Tools & Resources, Care Management, Clinical Quality for:
- Accessibility Standards
- Guidelines
- Mission
  - Quality Improvement Program Description
  - Quality Improvement Program Evaluation
  - Technology Assessment Program Description
  - Affirmation Statement
- Documentation Standards and Related Forms

Select Tools & Resources, Care Management, Corporate Medical Policies for:
- Prior Approval
- Prior Approval Form
- Investigational Services

Select Tools & Resources, Care Management, Discharge Planning for:
- Discharge Planning Guidelines
- Discharge Planning Instruction Sheet

Select Tools & Resources, Care Management, Medical Necessity Criteria for:
- Acute Inpatient
- Behavioral Health
- Chiropractic
- Home Healthcare
- Imaging
- Long-Term Acute Care (LTAC)
- Occupational Therapy
- Physical Therapy
- Private Duty Nursing
- Rehab – Inpatient
- Skilled Nursing (SNF)
- Speech Therapy

Select Tools & Resources, Care Management, Patient Safety for:
- Patient Safety Statement

Select Tools & Resources, Care Management, Prior Approval and Investigational Services for:
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