MEDICAL MUTUAL

# MUTUAL NEWS

Volume 9, Issue 3
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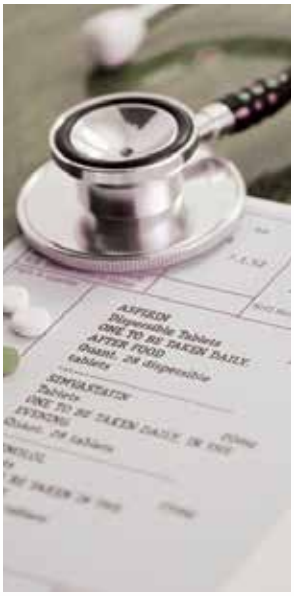
# Notice of Changes to Prior Authorization Requirements



Effective immediately, Medical Mutual will require prior authorization for all of the following drugs filled under the pharmacy benefit:

- All new specialty drugs
- All new drugs with significant safety, clinical or potential abuse or diversion concerns

This change is intended to ensure medications are used safely and will be effective for members. The prior authorization criteria for these drugs are contained in the New Drug Prior Approval policy available at Provider.MedMutual.com. Select Tools & Resources, Care Management, Rx Management. Here you will also find revisions to our prior authorization policies, as well as information about quantity limits, step therapy and formulary updates.

## Updates to Provider Manual

Designated sections of Medical Mutual's Provider Manual are scheduled for review each quarter and updated as needed. Sections that have been reviewed are announced in the corresponding quarterly issue of Mutual News. When topics are added or updated within a section, an annotation of New or Revised appears next to the topics in the section's table of contents.

During third quarter 2016, the following sections of the Provider Manual were reviewed:

- Care Management Programs
- Appeals
- Other Carrier Liability
- Claims Submission
- Adjustments & Inquiries
- Forms & Publications
- Medicare Advantage Plan

To view current updates, visit Provider.MedMutual.com and select Tools & Resources, Provider Manual.

### More News and Info Available Online

Stay in the know. Sign up to get provider publications via email. Log in to the Provider ePortal at Provider.MedMutual.com and select My Account, Subscriptions.

# Next Medical Record Audit Coming Soon

Medical Mutual is preparing for its next medical record data collection. This process will start in the coming months and is necessary for audits related to Medicare Advantage and ACA risk adjustments for 2016 dates of service. Once again, Medical Mutual will employ the services of Altegra Health Operating Co. to conduct the audit on our behalf.

As a provider contracted with Medical Mutual, if you are contacted by Altegra, your immediate attention is required. Correct coding and chart documentation is extremely important. Coding and documentation materials are available upon request from your Medical Mutual Contracting representative.

# Prior Approval Update for Drugs Billed Under the Medical Benefit

Effective October 30, 2016, the following prescription medication will require prior approval when requested under a member's medical benefit through Medical Mutual:*

- Xiaflex® (collagenase clostridium histolyticum)

The list is subject to change. For more information on medications requiring prior approval or that are considered investigational, and to view a complete list of Corporate Medical Policies, visit Provider.MedMutual.com and select Tools & Resources, Care Management.

# Clinical Practice Guidelines

Medical Mutual is committed to partnering with its network providers to deliver the highest quality care to our members. This effort includes adopting nationally recognized, professional organization, peer-reviewed, clinical practice guidelines and making them available on our provider website. All published guidelines have been reviewed carefully by a panel of actively practicing, board-certified, Medical Mutual physician reviewers and can be found on Provider.MedMutual.com by selecting Tools & Resources, Care Management, Clinical Quality, Clinical Practice Guidelines.

Clinical practice guidelines that can be accessed on the provider website include:

- Alcohol Screening
- Asthma
- Attention Deficit/Hyperactivity Disorder
- Depression
- Diabetes
- Preventive Care

*When this medication is provided under a member's prescription drug benefit, please contact the pharmacy benefit manager at the number on the member's identification card for prior approval requirements.

# Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised between April 1, 2016, and June 30, 2016, are outlined in the chart below.

CMPs are reviewed, updated, added or withdrawn on a regular basis and, therefore, are subject to change. For a complete list of CMPs, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies. For a list of services requiring prior approval or considered investigational, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Prior Approval and Investigational Service Resources.

| Policy Number | Title |
|---|---|
| **200218** | Carpal Tunnel, Tendon Sheath or Ligament, Tendon and Trigger Point Injections |
| **200231** | Air Ambulance Transportation |
| **200408** | Radiofrequency Thermal Ablation for Chronic Spinal Pain |
| **200508** | High-Frequency Chest Wall Oscillation System and Intrapulmonary Percussive Ventilation System |
| **200601** | Flucinolone Acetonide Intravitreal Implant |
| **200606** | Radiofrequency Ablation for Treatment of Trigeminal Neuralgia |
| **200613** | Focal Articular Cartilage Defect Treatment:<br>– Osteochondral Allografts<br>– Osteochondral Autografts |
| **200616** | Sacral Nerve Stimulation |
| **201009** | Stereotactic Radiosurgery and Stereotactic Body Radiotherapy |
| **2011-B** | Bioimpedance Spectroscopy |
| **201302** | Transcatheter Aortic Valve Replacement/Implantation |
| **201318** | Percutaneous Tibial Nerve Stimulation |
| **201324** | Thermography |
| **94002** | Breast Reconstruction |
| **95029** | Manipulation under Anesthesia |
| **99005** | Allergy Testing |
| **99006** | Immunotherapy |
| **200805** | Enbrel (etanercept) *Revised* |
| **200806** | Humira (adalimumab) *Revised* |
| **200807** | Remicade (infliximab) *Revised* |
| **200809** | Orencia (abatacept) *Revised* |
| **200913** | Cimzia (certolizumab pegol) *Revised* |
| **201001 & 201403** | Simponi and Simponi Aria (golimumab) *Revised* |
| **201003** | Enzyme Replacement Therapy *Revised* |
| **201006** | Cinryze (C1 esterase inhibitor) *Revised* |
| **201010** | Acthar Gel (repository corticotropin injections) *Revised* |

| Policy Number | Title |
|---|---|
| **201012** | Stelara (ustekinumab) *Revised* |
| **201020** | Berinert (C1 esterase inhibitor) *Revised* |
| **201021** | Kalbitor (ecallantide) *Revised* |
| **201101** | Actemra (tocilizumab) *Revised* |
| **201107** | Benlysta (belimumab) *Revised* |
| **201108** | Krystexxa (pegloticase) *Revised* |
| **201210** | Pegylated Interferon — Hepatitis C *Revised* |
| **201312** | Erythropoiesis Stimulating Agent *Revised* |
| **201316-CC & 201317-CC** | Immune Globulins *Revised* |
| **201406** | Prostanoid Infusion Therapy and Inhalation Therapy *Revised* |
| **201410-CC** | Oncology Medications *Revised* |
| **201419** | Alpha1 Proteinase Inhibitors *Revised* |
| **201421** | Soliris (eculizumab) *Revised* |
| **201423-CC** | Enytvio (vedolizumab) *Revised* |
| **201424** | Colony Stimulating Factors *Revised* |
| **201508** | Cosentyx (secukinumab) *Revised* |
| **201509** | Firazyr (icatibant injection) *Revised* |
| **201510** | Mircera (methoxy polyethylene glycol-epoetin beta) *Revised* |
| **201512** | Ruconest (recombinant C1 esterase inhibitor) *Revised* |
| **201534** | Lysosomal Storage Disorders *Revised* |
| **201602** | Testosterone Injection and Pellet: *New*<br>1. Depo-Testosterone<br>2. Aveed<br>3. Delatestryl<br>4. Testopel pellet |
| **201603** | Kineret (anakinra) *New* |
| **201605-CC** | Cinqair (reslizumab) *New* |
| **201606** | Taltz (ixekizumab) *New* |
| **95015** | Growth Stimulating Drugs *Revised* |
| **99002-CC** | Hyaluronic Acid Derivatives, Intra-articular *Revised* |

# Modifier JW Required When Billing for Discarded Drugs

As a reminder, Medical Mutual requires the modifier JW on claims submissions for drugs and biologicals supplied in single-use packages (including single-use vials) that are appropriately discarded. The modifier JW describes a drug amount discarded or not administered to a patient. The modifier is necessary for processing claims for single-use packages of drugs subject to Medical Mutual's prior approval process.

The modifier JW ensures the patient received the dosage approved during the prior approval process. It also ensures providers are reimbursed appropriately for the entire single-use package.

When billing for drugs and biologicals supplied in single-use packages, report the amount discarded on a separate line with the modifier JW added to the associated Health Care Procedure Coding System (HCPCS) code. This process will provide payment for the discarded drug or biological in cases when the administered drug is a covered benefit.

The modifier JW may not be submitted when the actual dose of the drug or biological administered is less than the billing unit. For example:

- One billing unit for a drug is equal to 10mg of the drug in a single-use vial
- A provider administers a 7mg dose to a patient and discards the remaining 3mg of the drug
- The provider bills the 7mg dose using one billing unit that represents 10mg on a single line item. Medical Mutual will process the single line item of one unit for payment of the total 10mg of drug administered and discarded.

Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, HCPCS modifier JW may not be submitted.

We expect providers to use the most cost-effective vial of drug when procuring and preparing a dose for administration. The JW modifier cannot be used for drugs or biologicals administered from multi-use packages. Medical Mutual does not pay for waste associated with multi-use packages.

Medical Mutual will deny claims not submitted as requested above.

# Body Mass Index Is a Quality Measure

It is recommended that body mass index (BMI) be recorded at all member encounters. The presence of a documented BMI is a measure used to evaluate the quality of care provided to members. Use the table below to see what documentation must be updated at least every two years to ensure compliance with this quality measure.

| Age | Weight | Height | BMI | BMI Percentile or plotted on growth chart |
|---|---|---|---|---|
| 19 and younger | ✓ | ✓ | | ✓ |
| 20 and older | ✓ | ✓ | ✓ | |

# Is Your Information Up to Date?

Medical Mutual is committed to providing its members with accurate information about provider networks. Providers are asked to validate the demographic and other information displayed in Medical Mutual's online provider directory at ProviderSearch.MedMutual.com on a quarterly basis.

Providers should confirm the following information:

- Name
- Address, including county
- Phone number
- Group name
- Gender
- Hospital affiliations
- Accepting new patient status
- Languages spoken
- Board certification status

Any changes should be submitted to the Provider Contracting department by visiting Provider.MedMutual.com and selecting Tools & Resources, Forms, Provider Information Form. Providers enrolled in the Provider ePortal also have the option to add, edit or remove providers, service locations and reimbursement addresses.

# Outpatient Hospital Services Must Be Medically Necessary

All outpatient hospital observation services must be reasonable and medically necessary to be covered by a Medical Mutual plan. Decisions on the setting for delivery of healthcare services should be based on industry-accepted guidelines.

The length of time for most medically necessary observation care services is usually 24 to 48 hours. At this point, members who are determined to require continuing treatment are generally appropriate for inpatient admission or care outside the hospital.

Observation care services do not require prior authorization. Claims for observation care for longer than 48 hours without an inpatient admission could be subject to retrospective review for medical necessity.

# Care Coordination Still Infrequent between Behavioral Health and Primary Care Providers

A 2015 Medical Mutual care coordination study demonstrated that documentation of communication between behavioral health providers and primary care providers (PCPs) continues to be infrequent. After an initial evaluation by a behavioral health provider, clinical information was shared with the member's PCP only 12 percent of the time in 2015, compared with 29 percent of the time in 2014. On a positive note, when communication did occur, it was often timely and included detailed plans for treatment and follow-up care.

The frequency and quality of summary communications sent by behavioral health providers to PCPs were evaluated by examining a sample of medical records. The sample only included members who completed an initial visit to a behavioral health practitioner within the measurement year. The results are summarized in the table below.

| Measure | 2015 | 2014 |
|---|---|---|
| Documentation of summary communication present | 12% | 29% |
| Of the 12% above, the following was present | | |
| Summary communication occurred within 30 days | 78% | 65% |
| Summary communication includes: | | |
| Test results (when applicable) | 73% | 38% |
| Detailed treatment plan | 78% | 74% |
| Detailed plan for follow-up | 74% | 70% |

Collaboration between behavioral health providers and PCPs can improve follow-up care and promote patient compliance with the prescribed treatment plan. Comprehensive summary communications between providers are essential to successful care coordination, and can be accomplished through various avenues, including a phone call, email or letter. Regardless of the format, it is crucial that communication occur and be documented in the medical record.

Medical Mutual recognizes that a major barrier to summary communications is the need for a release of information from the member. While some members may be hesitant to have their clinical information shared, behavioral health providers should stress the importance and benefits of open communication and care coordination between providers. **Member refusal to permit communication with the PCP should be noted in the medical record.**

To download or request copies of the Behavioral Health Patient Summary Form, which includes an area to record signed patient consent for communication, visit Provider.MedMutual.com and select Tools and Resources, Forms, Behavioral Health.

# Reminder about Part D Prescriber Enrollment Requirements

As a reminder, the Centers for Medicare & Medicaid Services (CMS) delayed enforcement of the Part D Prescriber Enrollment Requirements until February 1, 2017. At that time, Medicare may not cover drugs prescribed for Medicare Advantage Part D patients by providers who are not enrolled in or validly opted out of Medicare.

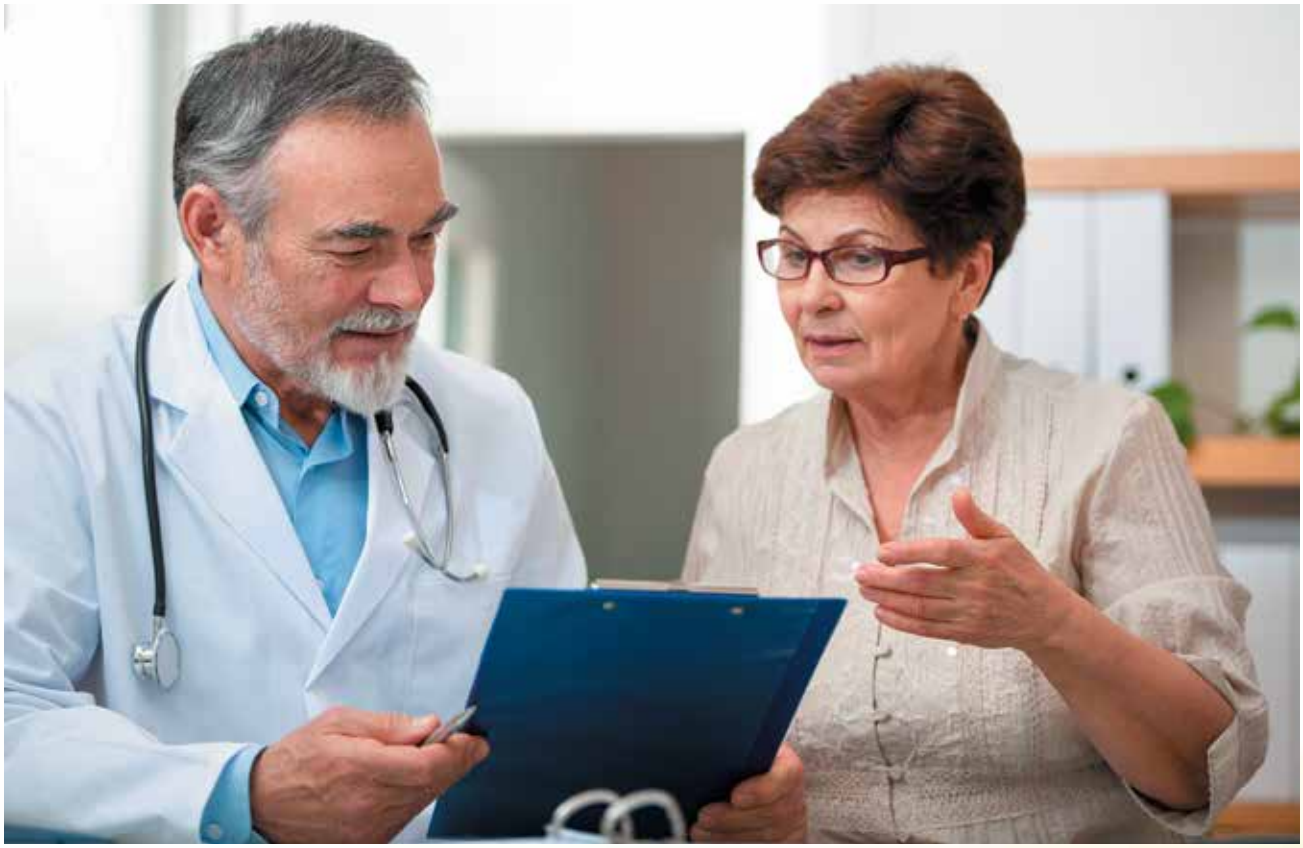
According to CMS, the goal of this requirement is to ensure basic quality protection for Medicare Part D beneficiaries. It is important providers take action to minimize disruption in their patients' access to needed Part D medications. CMS encourages prescribers to submit their enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) as soon as possible.

To enroll, follow one of these processes:

- Use the PECOS system at go.cms.gov/pecos. Step-by-step instructions are available at go.cms.gov/PECOSsteps. A video tutorial can be found at go.cms.gov/PECOSVideo.
- Complete the paper application for limited enrollment at go.cms.gov/cms855o and submit it to the MAC in your geographic area. A list of MACs by state is available at go.cms.gov/partdmaclist.

To opt out of Medicare, visit go.cms.gov/optoutinfo. Please direct any questions to CMS at ProviderEnrollment@CMS.HHS.gov.

Please note: Medical Mutual may remove from its Medicare Advantage networks any provider who fails to fully enroll in Medicare, or who fails to partially enroll as a prescriber. In addition, any provider who opts out of Medicare cannot be part of our MedAdvantage networks.



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## In This Issue





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