Managed Care Update Meeting

November 2019

TriHealth

Important Reminders

MEDICAL MUTUAL OF OHIO

Medical Mutual of Ohio MedFlex Plan: NON PARTICIPATING PLAN

Situation

TriHealth received notification of Medical Mutual of Ohio patients presenting SuperMed Plus cards at Point of Service but actually have Medical Mutual' s MedFlex HMO Plan coverage. TriHealth **DOES NOT** participate in this plan. (Mercy & CCHMC plan participation in the region)

Next Steps/Update

- Medical Mutual confirmed new cards were printed for patients.
- Managed Care is working with Medical Mutual on a resolution on outstanding claims.

**Please note patients do have Emergent Coverage that will bill through Medical Mutual and all Emergent to Inpatient notifications need to be processed on ReviewLink.

Lines of Business for Participation:

- ✓ SuperMed POS
- ✓ SuperMed PPO
- ✓ HMO Health Ohio
- ✓ SuperMed HMO/PPPO/OPS/Preferred/ Classic/Traditional
- ✓ Medicare Advantage

Anthem Changes to Clinical Guidelines

Effective **February 9, 2020** Anthem/Aim will be providing updates to the clinical guidelines and appropriateness for certain services. The updates will determine if the service is appropriate and documented in order for services to be rendered.

Please access https://aimspecialtyhealth.com/resources/clinical-guidelines/ for complete details on the updates to the clinical appropriateness for the services.

- Services include:
  - Imaging of the Abdomen and Pelvis
  - Radiation Therapy
  - Spine Surgery
  - Sleep Disorder Management

Anthem Medicare Advantage Plan Changes

Annual benefit changes for Medicare Advantage plan members will be effective **January 1, 2020**.

Complete details can be found in the members Evidence of Coverage. Please review the formularies and benefit summaries or contact Provider Services at the number on the back of the member's ID Card.

Changes/Highlights:

- **Medicare Advantage HMO name change**
  - Anthem MediBlue Dual Advantage (HMO SNP) is changing names to Anthem MediBlue Dual Advantage (HMO D-SNP).
- **IngenioRx** — Effective January 1, 2020, IngenioRx will become the new Pharmacy Benefit Manager (PBM) and manage prescription coverage for Medicare Advantage patients.
- **Medicare Part B step therapy —** Drug step therapy is a type of prior authorization that requires one drug (or drugs) to be tried for a medical condition prior to utilizing other drugs; the steps typically require lower cost drugs or drugs with better clinical outcomes.
- **Continuous glucose monitor**— This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). Anthem will not cover other brands unless medically necessary.
- **Emergency room copays** — Emergency room copay will be waived if a member receives care at a PCP, Urgent Care center or through LiveHealth Online within 24 hours prior to an emergency room visit.

TriHealth

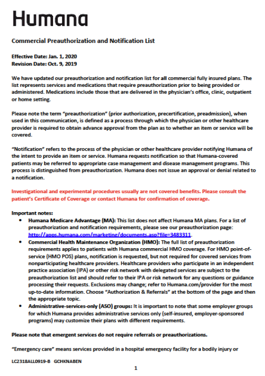
Humana 2020 PreAuthorization and Notification List

New PreAuthorization lists for Humana for Commercial and Medicare Plans are now available and effective January 1, 2020.

PreAuthorizations can be submitted via:

- Humana's IVR system by dialing the number on the back of the card.
- Availity, www.Availity.com

Commercial PreAuth List


Humana

Commercial Preauthorization and Notification List

Effective Date: Jan. 1, 2020
Revision Date: Oct. 9, 2019

We have updated our preauthorization and notification list for all commercial fully insured plans. The list represents services and medications that require preauthorization prior to being provided or administered. Medications include those that are delivered in the physician's office, clinic, outpatient or home setting.

Please note the term "preauthorization" (prior authorization, precertification, preadmission), when used in this communication, is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered.

"Notification" refers to the process of the physician or other healthcare provider notifying Humana of the intent to provide an item or service. Humana requests notification so that Humana-covered patients may be referred to appropriate case management and disease management programs. This process is distinguished from preauthorization. Humana does not issue an approval or denial related to a notification.

Investigational and experimental procedures usually are not covered benefits. Please consult the patient's Certificate of Coverage or contact Humana for confirmation of coverage.

Important notes:

- **Humana Medicare Advantage (MA):** This list does not affect Humana MA plans. For a list of preauthorization and notification requirements, please see our preauthorization page: http://apps.humana.com/marketing/documents.asp?file=3483311.
- **Commercial Health Maintenance Organization (HMO):** The full list of preauthorization requirements applies to patients with Humana commercial HMO coverage. For HMO point-of-service (HMO POS) plans, notification is requested, but not required for covered services from nonparticipating healthcare providers. Healthcare providers who participate in an independent practice association (IPA) or other risk network with delegated services are subject to the preauthorization list and should refer to their IPA or risk network for any questions or guidance processing their requests. Exclusions may change; refer to Humana.com/provider for the most up-to-date information. Choose "Authorization & Referrals" at the bottom of the page and then the appropriate topic.
- **Administrative-services-only (ASO) groups:** It is important to note that some employer groups for which Humana provides administrative services only (self-insured, employer-sponsored programs) may customize their plans with different requirements.

Please note that emergent services do not require referrals or preauthorizations.

"Emergency care" means services provided in a hospital emergency facility for a bodily injury or

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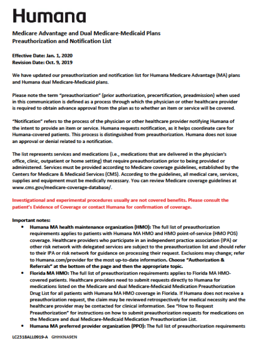
Medicare PreAuth List


Humana

Medicare Advantage and Dual Medicare-Medicaid Plans
Preauthorization and Notification List

Effective Date: Jan. 1, 2020
Revision Date: Oct. 9, 2019

We have updated our preauthorization and notification list for Humana Medicare Advantage (MA) plans and Humana dual Medicare-Medicaid plans.

Please note the term "preauthorization" (prior authorization, precertification, preadmission) when used in this communication is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered.

"Notification" refers to the process of the physician or other healthcare provider notifying Humana of the intent to provide an item or service. Humana requests notification, as it helps coordinate care for Humana-covered patients. This process is distinguished from preauthorization. Humana does not issue an approval or denial related to a notification.

The list represents services and medications (i.e., medications that are delivered in the physician's office, clinic, outpatient or home setting) that require preauthorization prior to being provided or administered. Services must be provided according to Medicare coverage guidelines, established by the Centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies and equipment must be medically necessary. You can review Medicare coverage guidelines at www.cms.gov/medicare-coverage-database/.

Investigational and experimental procedures usually are not covered benefits. Please consult the patient's Evidence of Coverage or contact Humana for confirmation of coverage.

Important notes:

- **Humana MA health maintenance organization (HMO):** The full list of preauthorization requirements applies to patients with Humana MA HMO and HMO point-of-service (HMO POS) coverage. Healthcare providers who participate in an independent practice association (IPA) or other risk network with delegated services are subject to the preauthorization list and should refer to their IPA or risk network for guidance on processing their request. Exclusions may change; refer to Humana.com/provider for the most up-to-date information. **Choose "Authorization & Referrals" at the bottom of the page and then the appropriate topic.**
- **Florida MA HMO:** The full list of preauthorization requirements applies to Florida MA HMO-covered patients. Healthcare providers need to submit requests directly to Humana for medications listed on the Medicare and dual Medicare-Medicaid Medication Preauthorization Drug List for all patients with Humana MA HMO coverage in Florida. If Humana does not receive a preauthorization request, the claim may be reviewed retrospectively for medical necessity and the healthcare provider may be contacted for clinical information. See "How to Request Preauthorization" for instructions on how to submit preauthorization requests for medications on the Medicare and dual Medicare-Medicaid Medication Preauthorization List.
- **Humana MA preferred provider organization (PPO):** The full list of preauthorization requirements

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