MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, OH 44115-1355

Mutual News

Second Quarter, 2017

Inside This Issue

This material is considered part of the ProviderManual 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 Provider.MedMutual.com.

MEDICAL MUTUAL®

Mutual News

Second Quarter 2017

Stay Informed with the Provider Manual

Our Provider Manual is available at Provider.MedMutual.com under Tools and Resources. The Provider Manual is updated quarterly to include the latest policies, procedures and guidelines providers need to effectively work with Medical Mutual.

During Q2 2017, the following sections of the Provider Manual were revised:

- Institutional Reimbursement Overview (Section 9): Repeat Admissions/Leave of Absence
- Medicare Advantage (Section 12): Providing Covered Persons with Notice of Their Appeal Rights, Billing for Hospital Readmissions, Advance Directive of Covered Person

Contact Us

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

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

Central/SE Ohio
(Columbus Office)
(800) 235-4026

NE Ohio/Pennsylvania
(Cleveland Office)
(800) 625-2583

NW Ohio/NE Indiana
(Toledo Office)
(888) 258-3482

SW Ohio/SE Indiana/Kentucky
(Cincinnati/Dayton Office)
(800) 589-2583

Medical Policy & Claims Processing Updates

Late Charge Claim Clarification

Medical Mutual would like to clarify the process regarding submission of late charges (Frequency Code 5) that was originally published in the Q4 issue of Mutual News.

For Medicare Advantage institutional claims (billed on a UB-04), Medical Mutual will not accept late charges.

For commercial claims, in addition to Medical Mutual not accepting late charges for inpatient claims, Medical Mutual will no longer accept late charges for outpatient claims that are priced using a fixed fee reimbursement methodology.

Late charges for these types of claims should be submitted as corrected or replacement claims (Frequency Code 7).

All claims and charges must be billed within 12 months from the date of service unless otherwise noted in the provider contract. Below are some helpful reminders and guidelines for late charge submission in the limited instances, where Medical Mutual will accept late charges:

- Late charges are charges not previously included in a prior claim submission
- Only bill with the charge not previously included, not the entire claim
- Late charges should be billed with Frequency Code 5

Institutional Claim Billing Guidelines	
EDI	▪ Claim segment field CLM05-3 should be populated with a "5" ▪ These are required fields
Paper	▪ Submit on the UB-04 ▪ Box 4 – Enter "5" in Claim Frequency field—position 3 ▪ These fields are required

1 Medicare Claims Processing Manual, Chapter 4, Section 110 (2016, December). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance Manuals/Downloads/clm104c04.pdf

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised between December 29, 2016 and March 31, 2017 are outlined in the chart below.

CMPs are regularly reviewed, updated, added or withdrawn, and therefore are subject to change. For a complete list of CMPs, please visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies.

Medical

Policy Number		Title
94047	●	Ophthalmic Ultrasound
96018	●	Blepharoplasty, Brow Lift and Blepharoptosis Repair
98009	●	Ambulatory Blood Pressure Monitoring
98015	●	Urological Evaluation Studies
200205	●	Heart-Lung Transplantation
200313	●	Endoscopic Thoracic Sympathectomy for Treatment of Hyperhidrosis
200401	●	Bone-Anchored Hearing Aid
200407	●	In Utero Fetal Surgery
200521	●	Otoplasty
200604	●	Funtional Electrical Stimulation for Rehabilitation of Paralyzed Lower Extremities

Policy Number		Title
200908	●	Thoracic Electrical Bioimpedance
201004	●	Peripheral Nerve Stimulation with Implantable Stimulator
201009	●	Sterotactic Radiosurgery and Sterotactic Body Radiotherapy
201103	●	Vision Training
201318	●	Percutaneous Tibial Nerve Stimulation
201324	●	Thermography
2013-D	●	Electrical Stimulation and Electromagnetic Therapy
201501	●	Real-Time Intra-Fraction Target Tracking System
200406	●	Fetoscopic Laser Surgery for Treatment of Twin-to-Twin Transfusion Syndrome
2005-R	●	Transanal Radiofrequency Therapy for Fecal Incontinence

▲ = New ● = Revised ■ = Retired

Pharmacy

Policy Number		Title
201419	●	Alpha 1 Proteinase Inhibitor Aralast NP Glassia Prolastin Prolastin-C Zemaira
201405	●	Avastin (Bevacizumab)
98006	●	Botulinum Toxin Botox Dysport Myobloc Xeomin
201508	●	Cosentyx (Secukinumab)
201703	▲	Ilaris (Canakinumab)
201702	▲	Nulojix (Belatacept)
201701	▲	Xiaflex (Collagenase Clostridium Histolyticum)
201012	●	Stelara (Ustekinumab)
201516	●	Cosmetic Use (Juvederm, Kybella, Radiesse, Restylane and Sculptra)
201010	●	Acthar Gel (Repository Corticotropin)
200913	●	Cimzia (Certolizumab Pegol)
201603	●	Kineret (Anakinra)

Policy Number		Title
201502	●	Lemtrada (Alemtuzumab)
201416-CC	●	Xgeva (Denosumab)
201511-CC	●	Opdivo (Nivolumab)
200807	●	Remicade and Inflectra (Infliximab)
201410-CC	●	Oncology Medications
201711	▲	Darzalex (Daratumumab)
201712	▲	Gazyva (Obinutuzumab)
201705	▲	Spinraza (Nusinersen)
201020	●	Berinert (C1 Esterase Inhibitor)
201006	●	Cinryze (C1 Esterase Inhibitor)
201509	●	Firazyr (Icatibant Acetate)
201021	●	Kalbitor (Ecallantide)
201512	●	Ruconest (C1 Esterase Inhibitor, Recomb)
201606	●	Taltz (Ixekizumab)
201601-CC	●	Nucala (Mepolizumab Recombinant)
201605-CC	●	Cinqair (Reslizumab)
201715	●	Velcade (Bortezomib)
201716	●	Doxil (Doxorubicin)
201717	●	Faslodex (Fulvestrant)

▲ = New ● = Revised ■ = Retired

Pharmacy

Notice of Changes to Prior Authorization Requirements

Effective immediately, Medical Mutual will require prior approval for all of the following drugs filled under medical or pharmacy benefits:

- 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 approval criteria for these drugs are contained in the New Drug Prior Approval policy available at Provider.MedMutual.com.

For Medical Policies

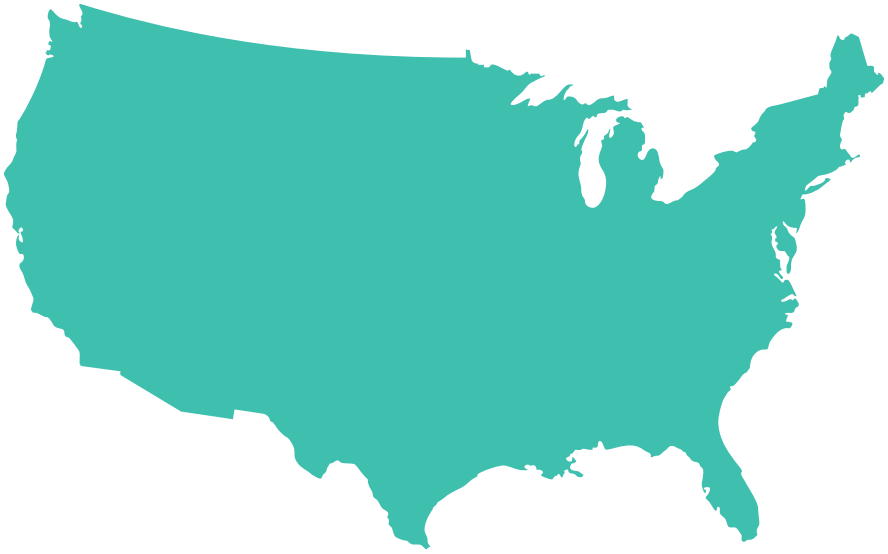
Select Tools & Resources, Care Management, Corporate Medical Policies. Here you will find revisions to our corporate medical policies, as well as information about our prior approval services and ExpressPath, a web-based tool that providers can use to manage prior approval requests for medications covered under the medical benefit.

For Pharmacy Policies

Select Tools & Resources, Care Management, Rx Benefit Management, Coverage Management (Prior Authorization). Here you will find revisions to our pharmacy prior authorization policies, as well as information about quantity limits, step therapy and formulary updates.

Coming Soon to In the News

In July 2017, Medical Mutual will be releasing news about select Pharmacy programs. Please view these articles by visiting Provider.MedMutual.com, Tools & Resources, In the News, and search by the article titles of "New Drug Surveillance Program" and "Additional Step Therapy Requirements."

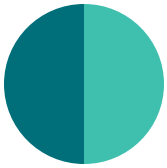


125,000

Annual number of deaths in the U.S.
as a result of medication non-adherence

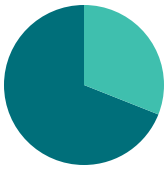
$177 BILLION

Annual direct and indirect healthcare costs in the U.S.
as a result of poor medication adherence



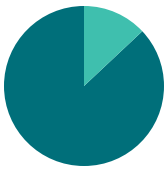
50%

Patients receiving chronic therapy who
do not take their medication as directed



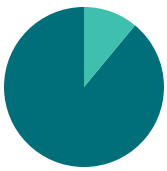
31%

Patients who never fill their original
prescription



13%

Increase in compliant patients when using a
specialty pharmacy



11%

Overall national cost for medical care that could
be avoided with compliant patients

IMS 2015: Understanding and Improving Adherence for Specialty Products

ScreenRx®: Helps improve adherence and patient outcomes while lowering healthcare costs

Medication adherence is a problem nationwide. When patients fail to take their medication as prescribed they often suffer from unnecessary complications and contribute to increased healthcare costs.[1,2] Reports estimate that nonadherence costs the U.S. approximately $317 billion annually.[2,3] We take adherence very seriously at Medical Mutual and have worked with Express Scripts® to offer our members the ScreenRx® program. This program uses advanced analytics to detect the future risk of nonadherence and provides individually tailored interventions to help members stay adherent. Examples of interventions provided free of charge include:

- Medication reminder devices such as pill bottle alarms, organizers, and memory aids
- Specialist pharmacist consultations
- Home delivery with refill and renewal reminders
- Low-cost alternatives
- Adherence education and tips

If you have a patient who would benefit from any of these interventions, please have him or her contact the toll free Rx Member Services phone number located on his or her member ID card and ask to speak to a pharmacist regarding his or her medication.

1 Briesacher BA, Quittner AL, Saiman L, Sacco P, Fouayzi H, Quittell LM. Adherence with tobramycin inhaled solution and health care utilization. BMC Pul Med. 2011;11:5.

2 Badesch DB, Raskob GE, Elliott CG, et al. Pulmonary arterial hypertension - Baseline characteristics from the REVEAL Registry. Chest. 2010;137(2):376-387.

3 New England Healthcare Institute (NEHI). Thinking outside the pillbox: a system-wide approach to improving patient medication adherence for chronic disease. Available at: http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease.

RationalMed: Helps improve compliance, reduces risk of hospitalization

At Medical Mutual, our goal is to help you protect your patient's health and prevent unnecessary hospitalizations caused by improper use of prescription drugs. The RationalMed® program, which is administered by Express Scripts®, integrates medical claims, pharmacy claims, and lab data to build a complete patient profile.

RationalMed uses thousands of clinical rules and predictive modeling to identify and alert prescribers on the safe use of medications and to affect changes in prescription drug therapy based on evidence-based guidelines. Examples of what RationalMed looks for include: potential drug interactions; drug reactions based on medical history; drug duplication due to multiple prescribers; duration issues; and gaps in care problems.

Provider alert letters are issued to you via fax or electronic medical chart notification when the RationalMed system identifies potential problems related to medical therapies. Medical Mutual and Express Scripts have seen an increase in patient safety with this method compared to standard utilization management programs. Please keep an eye out for these valuable alerts.

Care Management & Clinical Practice Guidelines

Attention-Deficit/Hyperactivity Disorder Drug Holiday

Children do not have to perform academically during summer vacation, so some parents choose to take their child off of his or her ADHD medication. Other parents feel the interruption may cause a rebound in the child's behavioral problems and/or social functioning. Occasionally, a provider will recommend a treatment interruption to evaluate medication effectiveness or continued necessity. This is known as a drug holiday.

There are mixed reviews regarding the efficacy of Attention-Deficit/Hyperactivity Disorder (ADHD) drug holidays. Please consider the pros and cons of a drug holiday when developing the treatment plan for your ADHD patients.

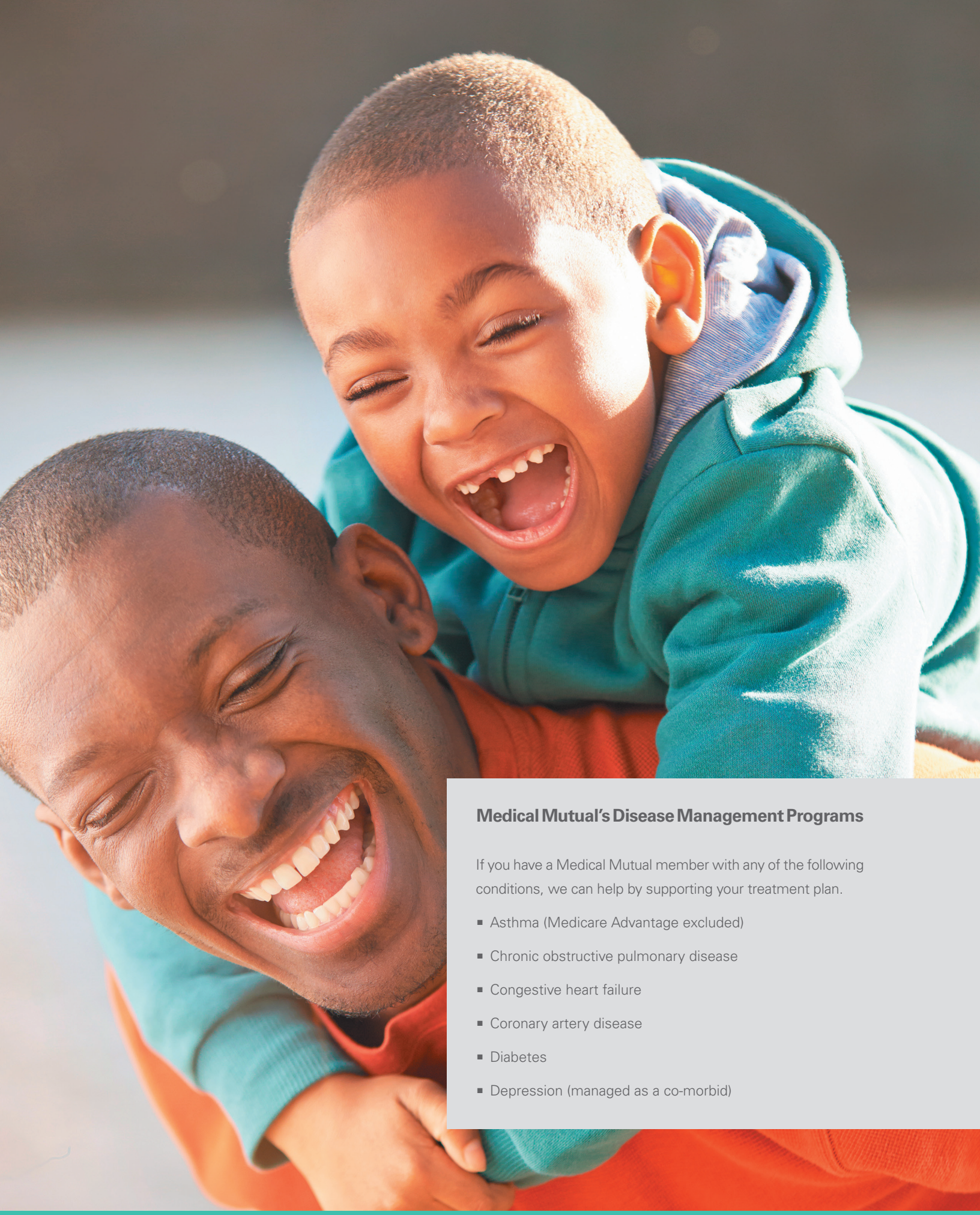
If your patient takes a break from his or her ADHD medication this summer and is planning to restart after returning to school, make sure they have a visit set up within 30 days of restarting the medication. During this visit, the patient should be examined to monitor medication effectiveness and side effects and to make adjustments if needed. Regular checkups throughout the school year are important for ongoing monitoring and to make necessary adjustments as the child grows.

Disease Management Program Updates

Medical Mutual has made significant enhancements to our Disease Management program, effective January 1, 2017. Our program helps to coordinate care and improve overall health and quality of life for individuals with a chronic disease by reducing avoidable complications and preventing, minimizing and slowing the progressive effects of disease.

In addition to working one-on-one with a trained health coach, Medical Mutual members also have access to registered dieticians, diabetic educators, pharmacists, respiratory therapists and social workers. If indicated, Medical Mutual members may receive a home biometric monitoring device. Depending on the condition the device may consist of a scale, blood pressure cuff, glucometer or a peek flow meter. The device allows patients to track and report symptoms daily which are reported back via a tablet directly to the health coach. To help remove the financial barrier of blood sugar testing, we provide diabetic testing supplies such as meters, test strips, control solutions, lancets, lancing devices and syringes at no out-of-pocket cost.

If you think your patient may benefit from these services, please encourage them to enroll in our Disease Management program by calling (800) 861-4826, option 2.



Medical Mutual's Disease Management Programs

If you have a Medical Mutual member with any of the following conditions, we can help by supporting your treatment plan.

- Asthma (Medicare Advantage excluded)
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes
- Depression (managed as a co-morbid)

Medicare Advantage

Office of Inspector General Compliance Requirements

The Office of Inspector General (OIG) maintains a list of individuals and entities that are currently excluded from participation in Medicare and other federal healthcare programs. The effect of an exclusion is that no payment can be made by any federal healthcare program for any items or services furnished, ordered or prescribed by an excluded individual or entity. For the list of excluded individuals and entities, please visit OIG.HHS.gov/Exclusions.

The OIG has several self-disclosure processes that can be used to report potential fraud.

FirstTier, Downstream, and Related Entities (FDRs) are required to review the OIG list prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter, to ensure that none are excluded from participating in federal programs. You are also required to maintain documentation or evidence that you are completing these checks. For more information, please visit MedMutual.com/FDR, Helpful Resources, FDR FAQs.

If you identify an excluded individual or entity employed or contracted by your organization, you must report this to Medical Mutual. This individual or entity must be immediately removed from directly and indirectly servicing Medical Mutual's Medicare products.

To notify Medical Mutual about an OIG issue or any fraud, waste and abuse issue, please contact the Compliance Helpline at (800) 762-8130 or visit the Compliance Connection website at MMO.IntercedeServices.com. Medical Mutual enforces a zero-tolerance policy for retaliation or retribution against anyone who reports suspected misconduct.

In addition, the OIG has several self-disclosure processes that can be used to report potential fraud in Department of Health and Human Services programs. Healthcare providers, suppliers, or other individuals or entities subject to Civil Monetary Penalties can use the Provider Self-Disclosure Protocol, which was created in 1998, to voluntarily disclose self-discovered evidence of potential fraud. Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative litigation. Please visit the Provider Self-Disclosure Protocol webpage at OIG.HHS.gov for more information.

Provider Incentive Program Reminder

Medical Mutual's provider incentive program is well underway. This program was designed to encourage our Medicare Advantage members to receive necessary annual preventive screenings and tests. It compensates providers for submitting medical records for designated services completed between January 1, 2017, and July 31, 2017. The medical record must correspond to claims submitted for either the Welcome to Medicare Visit (G0402), Annual Wellness Visit (G0438), Annual Wellness Subsequent Visit (G0439) or Preventive Service Visit (99381-99397). For more information, please visit Provider.MedMutual.com, In the News, Provider Incentive Program.

Improve Patient Access to Care

The Medicare Advantage (MA) provider directory is the most common tool available to members and their caregivers to access information about providers. This means maintaining a current and accurate MA provider directory is vital for connecting members and their caregivers with providers and access to care.

To help ensure accurate information in our provider directories, we ask you to take the following steps:

1. Review your information in the provider directory on a quarterly basis.
2. Update your address, locations and phone number when there are changes to your practice via the Provider Information Form located at Provider.MedMutual.com, Tools & Resources, Forms.
3. Work directly with the entity responsible for the accuracy of your directory information if your credentialing is delegated to a third-party.

As a Medicare Advantage Organization, Medical Mutual follows the Centers for Medicare & Medicaid Services (CMS) guidelines for what can and cannot be included in an MA provider directory.

These are the general areas where CMS provides guidance regarding provider directories:

- The provider must regularly practice at the specific location listed.
- Providers who are on-call, substituting or rotating cannot be listed.
- Satellite locations cannot be listed unless the provider practices at the location on a regular basis and members can call the location to schedule an appointment.
- Hospital locations for which a member cannot call the phone number listed and make an appointment at the hospital location cannot be listed in the directory.
- The correct office address, including suite number, must be included in the listing.
- The group name printed in the directory must match the group name given when the member calls to make an appointment.
- The listing must include an accurate status of whether the provider is accepting new patients or not.
- Providers must notify Medical Mutual if the services provided at a location are limited to a certain subset of patients.

For questions about providing demographic information for claims payment purposes, contact your Medical Mutual Provider Contracting Representative. To find your Provider Contracting Representative, visit Provider.MedMutual.com, Tools & Resources, Contact Us.

Advance Directive of Covered Person

Advance directives are written instructions, recognized under state law, which relate to the provision of healthcare when the individual is incapacitated and unable to communicate his/her desires. Examples include documents such as a living will, durable power of attorney for healthcare, healthcare proxy or do not resuscitate request.

Medicare Advantage Network providers should discuss advance directives with their patients as appropriate and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that said document is included. Medical Mutual is actively overseeing providers' compliance with this requirements. If deficiencies are identified, corrective action may be taken.

Providers should discuss advance directives with their patients and file a copy in the patient's medical record.

Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage Members

Medical Mutual has established a process to comply with the Centers for Medicare & Medicaid Services (CMS) mandatory requirement for all Medicare beneficiaries enrolled in Medicare Advantage plans to receive a valid Notice of Medicare Non-Coverage (NOMNC) in a timely manner at the termination of skilled care at a Skilled Nursing Facility (SNF).This process gives members the opportunity to appeal to the Quality Improvement Organization (QIO), in the event they disagree with the termination of services.

Medical Mutual SNF providers are responsible for delivering the NOMNC, on behalf of Medical Mutual, to the member or the member's representative and for obtaining signature(s) the same day the provider receives the NOMNC from Medical Mutual, but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the NOMNC and obtain signature(s) the same day Medical Mutual issues the NOMNC for the member or member's representative, the SNF provider is responsible for re-issuing a NOMNC to the member or member's representative with the appropriate Last Approved Day (LAD) to allow the member at least two calendar days in advance of the service ending.

Liability for the stay past the LAD will remain with the SNF in the event the acknowledgement of receipt and delivery of the NOMNC to the member or member's representative is not completed within the same day the NOMNC is received by the SNF from MMO. The authorization for the stay through the LAD will remain the same for the facility. The member or member's representative may receive a new NOMNC with a new LAD from the SNF to extend the covered services, with no liability to the member or Medical Mutual, in order to allow the member the adequate time to appeal to the QIO, should the member disagree with the termination of services.

Liability for the member, who decides to stay past the LAD, will begin the day following the last approved day as specified on the NOMNC, should the member choose not to appeal the termination of services.

Fecal Immunochemical Testing

Medical Mutual is collaborating with BioIQ® to offer home colorectal cancer screenings for our Medicare Advantage members. In the third quarter, we will be mailing at-home Fecal Immunochemical Test (FIT) kits to members who have not completed a colorectal cancer screening test based on our medical claims data as a way to promote prevention and close gaps in care. The goal is to increase the number of colorectal cancers found at an early, more treatable stage, thereby improving health outcomes.

Eligible members will receive an introductory letter prior to receiving the kit which will arrive via USPS. Members have the option to opt out. For members who choose to receive the kit, reminder calls will be made to encourage completion and return of the test kit.

The member, his or her primary care physician (PCP) and Medical Mutual will receive test results. PCPs are encouraged to reach out to members with positive test results to discuss the results and recommendations.

Medical Record Requests for Risk Adjustment

Medical Mutual participates in risk adjustment for Affordable Care Act and Medicare Advantage (MA) members. There may be times throughout the year when we will request medical records from your practice that help identify members who have medical conditions that qualify for risk adjustment. As a contracted provider, we expect you to submit the requested medical record as quickly as possible.

In addition, Medical Mutual is required to participate in Risk Adjustment Data Validation (RADV) audits. These are government mandated audits that have defined start and finish timelines that must be strictly followed by Medical Mutual and by you. If you are contacted regarding a RADV audit, you must comply with the request by the deadline indicated.

Medical Mutual employs the services of Altegra Health Operating Co. to retrieve medical records on our behalf. Altegra will work with your office in a respectful, non-disruptive, and efficient manner. Any information you share with Altegra will remain confidential in accordance with all applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

When Altegra contacts you for medical records, please know you do not need to obtain the member's authorization or consent in order to submit the record. 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.

Altegra has multiple methods by which you can submit medical records, including mail, fax, on-site retrieval, drop-box and remote access. Please be sure to talk to Altegra about the method that works best for your practice. Medical Mutual thanks you in advance for your cooperation in all of our risk adjustment projects.

Annual Wellness Visit Coding Tips

In the chart below, please review Centers for Medicare & Medicaid Services' (CMS) guidelines when conducting and billing for a Medicare Annual Wellness Visit (AWV) exam.

AWV Exam Requirements

- Administer Health Risk Assessment (HRA)
- List of Current Providers and Suppliers
- Personal, Family, Social History (PFSH)
- Medication Reconciliation
- Risk Factors for Depression
- Functional Ability: ADLS, Fall Risk, Hearing Impairment, Home Safety
- Height, Weight, BMI, BP
- Assess Cognitive Function
- Written Screening Schedule (5-10 year checklist)
- List of Risk Factors and Treatment/Intervention Options
- Personalized Health Advice, Referral as appropriate, Education or Preventive Counseling

AWV Billing Requirements

- Initial G0438 and Subsequent G0439 (subsequent visits do not require full list above)
- Diagnosis Z00.00 or Z00.01
- Current Diagnoses that are being treated or managed by provider and status of condition/disease. Example: stable, improving, worsening or referred to another provider.

Common Medical Documentation Errors to Avoid

- Copy of HRA not supplied to plan in documentation
- Five- to ten-year screening plan, risk factor analysis, personalized health advice not included in documentation
- Medications prescribed and not linked to a condition or disease
- No provider signature, credential, date signed
- Patient identifiers not included on every page
- BMI and obesity underreported
- PFSH and current providers listed as somewhere else in Electronic Medical Record but not pulled into date of service
- Illegible handwriting or poor copy quality
- Unspecified diagnosis when it could be more specified
- Diagnosis code does not match written description for the code
- Claim form does not match information in documentation (provider, coding, patient's DOB)
- History of used when condition/disease is still active, current, or chronic

For additional information, please visit cms.gov, Outreach & Education, Medicare, Medicare Learning Network® (MLN) Homepage, Publications, The ABCs of the Annual Wellness Visit (AWV)

Reminders & Tips

Register for the Provider Portal and Go Paperless

If you have not registered for an account on the Provider Portal, register today by following these simple steps:

1. Visit Provider.MedMutual.com
2. Select Register Here in the upper-right corner
3. Complete the required fields and log in to your new account

Enrollment gives you access to demographic information, fee schedule lookup, and electronic remittance advice. Additionally, you can opt-in to receiving all provider publications and updates via email.

If you have already registered, please take a few moments to review your communications preferences, catch up on news, and check your information in the provider directory to ensure it's accurate.