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

Mutual News

First Quarter 2019

Inside This Issue

This material is considered part of the Provider Manual 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

First Quarter, 2019

Stay Informed with the Provider Manual

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

Updates to the Provider Manual can be found in the following sections:

- Section 1—Overview
  - Modified the Company Coverage sub-section
- Section 2—Claims Overview
  - Added a new sub-section for Robotic Surgical Systems
  - Modified Completing the UB-04 Claim Form sub-section
- Section 3—Care Management Programs Overview
  - Modified the Prior Approval sub-section
- Section 7—Forms and Publications
  - Modified the Forms sub-section
- Section 8—Professional Reimbursement Overview
  - Added a new sub-section for Corporate Reimbursement Policies
- Section 9—Institutional Reimbursement Overview
  - Modified the Payment Categories and Methodologies sub-section
  - Added a new sub-section for Corporate Reimbursement Policies
- Section 12—Medicare Advantage Plans and Guidelines
  - Modified the Advance Beneficiary Notice of Non-Coverage (ABN) sub-section

The following section of the Provider Manual has been removed:

- Section 3—Care Management Programs Overview: Accreditation Seals of Approval sub-section

Contact Us

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

If you have questions, please contact your Medical Mutual Provider Contracting representative:

Central/SE Ohio (Columbus Office)
1-800-235-4026

NE Ohio/Pennsylvania (Cleveland Office)
1-800-625-2583

NW Ohio/NE Indiana (Toledo Office)
1-888-258-3482

SW Ohio/SE Indiana/Kentucky (Cincinnati/Dayton Office)
1-800-589-2583

General Information

Medical Mutual Implements New Claims Processes

Medical Mutual is implementing two new claims management processes on May 15, and June 1, 2019, to support automated application of correct coding principles.

Claims Pre-payment Processing Changes
Beginning May 15, 2019, Medical Mutual is partnering with Optum to assist with pre-payment claims workflow review. Please continue submitting claims for Medical Mutual members as you do today. You may receive co-branded materials from Optum and Medical Mutual requesting medical records and other documentation to assist in any necessary claim pre-payment reviews. We thank you in advance for your prompt attention and response to these requests.

Claims Editing Processing Changes
In addition, on June 1, 2019, Medical Mutual is implementing new institutional claims editing processes. We are enhancing our existing, internally developed claims editing processes, which we use to administer reimbursement policy and claim edit rules, by passing institutional claims through the Optum Claims Edit System® (CES).

CES uses the following sources for its edits:

- National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
- Federal Register (the Daily Journal of the US Government that contains agency rules, proposed rules and public notices)
- Medicare publications
- Local and National Coverage Determinations (LCDs/NCDs)
- Outpatient Code Editor (OCE)
- Medicare Code Editor (MCE)

What do you need to do?
Because many other carriers with whom you work already use Optum's CES, we do not anticipate this implementation will disrupt how you work with Medical Mutual. CES will replace our legacy edits and automatically review and catch errors, omissions and questionable coding. The end result will be streamlined claims, reduced reimbursement errors and improved payment integrity. All edits are transparent, and you will be able to look up specific claims and see both the edits and the sourced citations.

New Medical Mutual Identification Cards

Please alert your staff that Medical Mutual members received new identification (ID) cards on or around Jan. 1, 2019, which include new national network information. There are two new primary card designs—one for members who reside in Ohio and one for members who reside outside of Ohio.

If you have any questions about this change, please contact your Medical Mutual Provider Contracting representative.

The following are examples of types of institutional edits that will be reviewed through CES beginning June 1:

Outpatient edit examples	Inpatient edit examples
Data validity edits ▪ Invalid diagnosis codes ▪ Diagnosis code requires additional digits ▪ Diagnosis to age or gender conflict ▪ E-code as reason for visit ▪ Invalid CPT®/HCPCS code ▪ CPT/HCPCS to gender conflict ▪ Invalid modifier, service date, age, gender, units, revenue code	▪ Invalid diagnosis code ▪ Diagnosis code requires 3rd or 4th digit ▪ Invalid procedure code ▪ Secondary diagnosis duplicates the principal diagnosis ▪ Diagnosis/procedure conflicts with patient age or gender ▪ Invalid principal diagnosis – Manifestation – Non-specific – V-codes – E-code ▪ Invalid age, gender, discharge status
Medical necessity edits ▪ No supporting diagnosis ▪ Not medically necessary for this age or gender ▪ Missing appropriate secondary diagnosis ▪ Missing appropriate associated procedures	
Coding issues ▪ Inappropriate coding of bilateral services ▪ Evaluation & management (E&M) with surgery without modifier 25 ▪ Claim contains only incidental services ▪ Terminated procedure with units > 1 ▪ Multiple E&M services with same revenue code on same date ▪ Revenue center requires CPT/HCPCS ▪ Implantable device without surgery ▪ Duplicate claim checks	

Edits are applied to all facility types, including, but not limited to, hospitals, skilled nursing, rural health clinics, federally qualified health clinics, hospice facilities, etc.

To model how claims will process through CES, we encourage you to access the Optum Claim Edit Portal on the dashboard of our ePortal. Log in at Provider.MedMutual.com, then click News & Information. This web application allows users to test claims and identify possible edits without submitting a final claim to Medical Mutual. The test portal will be available on or around May 15, 2019, to allow hypothetical claims processing for institutional claims. Data entry points include a patient's gender, year of birth, procedure codes, diagnosis codes and modifiers. After June 1, you will be able to enter your provider ID and a coordinating claim number to see all edits on a processed claim.

Medical Mutual is updating certain sections of our Provider Manual as part of the implementation of these new claims processes. The updates are made in the following sections:

- Section 1 — Overview, Company Coverage sub-section: Added a notation about CPT and ICD-10 coding guidelines, and CMS guidelines.
- Section 2 — Claims Overview, Completing the UB-04 Claim Form sub-section: Added details around type of bill requirements.
- Section 9 — Institutional Reimbursement Overview, Payment Categories and Methodologies sub-section: Added a note about the denial of interim claims.

The updated Provider Manual is available at Provider.MedMutual.com > Tools & Resources > Provider Manual.

Notice of Changes to Prior Authorization Requirements: Medical Mutual Requires Use of NaviNet to Submit Electronic Prior Authorization Requests Beginning June 1, 2019

Medical Mutual will require the use of NaviNet to submit electronic prior authorization requests for most medical services effective June 1, 2019. This includes, but is not limited to, surgical procedures, durable medical equipment and diagnostic services. The only exceptions to this requirement are prior authorization requests for medical drug; radiology; chiropractic services; and physical, occupational and speech therapies. For these exceptions, Medical Mutual will continue to use the following vendors: Care Continuum for medical drugs, eviCore Landmark for chiropractice services and therapies, and eviCore for radiology services.

NaviNet is a web-based solution from NantHealth that facilitates electronic prior authorization request submissions. With NaviNet, you can:

- Receive instant confirmation that your request was submitted
- Access real-time status updates including authorization determinations
- Upload supporting documentation (including photos and X-rays for applicable authorizations)
- Submit appeals online, if applicable

Medical Mutual will no longer accept prior authorization requests by fax or phone.

Register Today

We encourage you to register for NaviNet today by visiting NaviNet.Secure.Force.com. For additional information specific to Medical Mutual, please refer to Support.NaviNet.net/Health-Plans/Medical-Mutual-of-Ohio.

Note: If you are new to NaviNet, the registration process will take approximately 5 to 7 days; please be sure to initiate your registration by May 20, 2019.

Providers who already use NaviNet for other payers will see a Medical Mutual link in their dashboards.

Training and Resources Available

Once you register on the NaviNet website, you will receive a welcome email, which walks you through the resources available, including frequently asked questions, user guides, training demos, reference materials and more.

For additional information, please contact the NaviNet service department at 1-888-482-8057 (Eastern). Representatives are available Monday through Friday from 8 a.m. to 5:30 p.m. After hours, please leave a voicemail and your call will be returned the following business day.

The list of services for which Medical Mutual requires prior authorizations is available by visiting Provider.MedMutual.com > Tools & Resources > Care Management > Prior Approval & Investigational Services Resources.

Provider Manual Updates

Medical Mutual is updating the following sections of our Provider Manual as part of the requirement to use NaviNet. The updates are made in the following sections:

- Section 3 — Care Management Programs Overview, Prior Approval sub-section: Added information about NaviNet and deleted the Prior Approval Form bullet in the list of Fax Forms.
- Section 7 — Forms and Publications, Forms sub-section: Deleted Prior Approval Form information.
- Section 12 — Medicare Advantage Plans and Guidelines, Advance Beneficiary Notice of Non-Coverage (ABN) sub-section: Removed reference to Prior Approval Form.

The updated Provider Manual is available at Provider.MedMutual.com > Tools & Resources > Provider Manual.

Medical Mutual Corporate Reimbursement Policies

Under Medical Mutual's provider agreements, providers agree to and are required to comply with Medical Mutual's policies and programs, and the terms of the Provider Manual. Medical Mutual will issue Corporate Reimbursement Policies related to certain services when needed. Corporate Reimbursement Policies are internally developed guidelines used for making payment determinations for specific procedures, therapies, devices, equipment and services, and for providing guidance for the way a service should be billed to Medical Mutual. These Corporate Reimbursement Policies will be available to providers at Provider.MedMutual.com > Tools & Resources > Payment Policies. Providers will be required to review Medical Mutual's Corporate Reimbursement Policies disclaimer, and upon acceptance, access to the site will be granted. When Medical Mutual issues a new or revised Corporate Reimbursement Policy, Medical Mutual will notify providers of the new or revised policy.

Section 8, Professional Reimbursement, and Section 9, Institutional Reimbursement, of the Provider Manual are being modified to refer to Medical Mutual's Corporate Reimbursement Policies and where they can be accessed on Medical Mutual's website.

Robotic Surgical Systems Reimbursement Policy

Medical Mutual is implementing a Reimbursement Policy, Robotic Surgical Systems (Policy Number RP-201901), which will be effective June 1, 2019. To view this policy, please visit Provider.MedMutual.com and select Tools & Resources > Corporate Reimbursement Policies. This policy will replace, and be a re-statement of, Medical Mutual's already existing Medical Policy, Robotic Surgical Systems (Policy Number 200902).

The Coding Instructions for Selected Services and Related Billing Policies and Procedures sub-section of Section 2, Claims Overview, of the Provider Manual will be updated to include the following text, which reiterates the reimbursement policy:

> "*Robotic Surgical Systems*
> *Medical Mutual considers reimbursement for utilization of a robotic surgical system (including, but not limited to, HCPCS code S2900 and applicable ICD-10-PCS codes) included in the payment for the primary procedure. No additional payment will be made when charges associated with robotic surgery are billed, including but not limited to, increased or additional operating room charges for the use of robotic surgical systems.*"

Member Rights and Responsibilities

Medical Mutual members have certain rights and responsibilities. Being familiar with these rights and responsibilities helps our members participate in their own healthcare. Member rights and member responsibilities are defined as the member's role in working with us to achieve a quality, cost-effective health outcome.

For a copy of the Member Rights and Responsibilities, visit Provider.MedMutual.com and select the Member Rights and Responsibilities link under Quick Links, or call the Medical Mutual Provider Inquiry unit at 1-800-362-1279 to ask for a paper copy.

MCG Health Replaces InterQual as Part of Medical Mutual's Medical Necessity Determination Process

Effective Jan. 1, 2019, Medical Mutual discontinued use of InterQual in our medical necessity determination process. We are now using industry-leading, evidence-based, care guidelines vendor, MCG Health.

MCG's care guidelines are well-known as a common basis for care planning decisions between providers and health plans. Medical Mutual has implemented MCG's care guidelines for the following services:

- Inpatient
- Observation
- Surgical
- Ambulatory care
- Home care
- Behavioral health care

In addition, we are using MCG's length-of-stay benchmarks and discharge planning guides in our processes.

You can access the MCG guidelines through a tool available on the Medical Mutual provider portal by clicking Tools & Resource > Care Management > Medical Necessity Criteria, then choosing the MCG Guidelines link.

This information has been updated in Section 3—Care Management Programs Overview of the Provider Manual, in the Prior Approval > Medical Necessity Guidelines sub-section.

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised between Oct. 1 and Dec. 31, 2018, are outlined in the following charts. 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 and Resources > Care Management > Corporate Medical Policies.

Medical		
Policy Number		**Title**
2015-A	●	Prostatic Urethral Lift
2018-B	▲	Relizorb
2018-C	▲	Actigraphy

▲ = New ● = Revised ■ = Retired

Pharmacy					
Policy Number		**Title**	**Policy Number**		**Title**
98006	●	Botulinum Toxin Botox (onabotulinumtoxinA) Dysport (abobotulinumtoxinA) Myobloc (rimabotulinumtoxinB) Xeomin (incobotulinumtoxinA)	201417	●	Zometa (zolendronic acid)
98031-CC	●	Synagis (palivizumab)	201421	●	Soliris (eculizumab)
201819	●	Adcetris (brentuximab vedotin)	201703	●	Ilaris (canakinumab)
201013	●	Provenge (sipuleucel-T)	201734	●	Zilretta (triamcinolone ER)
201411-CC	●	Alimta (pemetrexed)	201108	●	Krystexxa (mogamulizumab-kpkc)
201605	●	Cinqair (reslizumab)	201833	●	Poteligeo (glatiramer acetate)
201711-CC	●	Darzalex (daratumumab)	200808-CC	●	Rituxan (rituxumab)
200805	●	Enbrel (etanercept)	201529	●	Repatha (evolocumab)
201720-CC	●	Global PA	201528	●	Praluent (alirocumab)
200806	●	Humira (adalimumab)	201730	●	Fasenra (benralizumab)
201835	●	Actemra SC (tocilizumab)	201420	●	Xolair (omalizumab)
201101	●	Actemra IV (tocilizumab)	201601-CC	●	Nucala (mepolizumab)
201704	●	Dupixent (dupilumab)	201620	●	Jevtana (cabazitaxel)
200913	●	Cimzia (certolizumab pegol)	201519	●	Sandostatin/Sandostatin LAR Depot (octreotide acetate)
201508	●	Cosentyx (secukinumab)	201712	●	Gazyva (obinutuzumab)
200809	●	Orencia IV (abatacept)	201602-CC	●	Testosterone Injection and Pellet Depo-Testosterone (testosterone cypionate) Delatestryl (testosterone enanthate) Aveed (testosterone undecanoate) Testopel (testosterone) pellet Xyosted (testosterone enanthate)
201410-CC	●	Oncology Medications	201713	●	Siliq (brodalumab)
201603	●	Kineret (anakinra)	201725	●	Orencia SC (abatacept)
201534	●	Lysosomal Storage Disorders Aldurazyme (laronidase) Elaprase (idursulfase) Fabrazyme (agalsidase beta) Kanuma (sebelipase alfa) Lumizyme (alglucosidase alfa) Mepsevii (vestronidase alfa-vjbk) Myozyme (alglucosidase alfa) Naglazyme (galsulfase) Vimizim (elosulfase alfa)	201403	●	Simponi Aria (golimumab)
201001	●	Simponi SC (golimumab)	201715-CC	●	Velcade (bortezomib)
201820	●	Empliciti (elotuzumab)	201840-CC	▲	Aliqopa (copanlisib)
201805	●	Hemlibra (emicizumab-kxwh)	201839-CC	▲	Blincyto (bendamustine)
201012	●	Stelara (ustekinumab)	201815	●	Calcitonin Gene-Related Peptide (CGRP) Antagonist Aimovig (erenumab) Ajovy (fremanezumab) Emgality (galcanezumab-gnlm)
201731	●	Tremfya (guselkumab)	201720	▲	Gamifant (emapalumab-lzsg)
201606	●	Taltz (ixekizumab)	201846-CC	▲	Halavan (eribulin mesylate)
201810	●	Ilumya (tildrakizumab-asmn)	201822-CC	▲	Kyprolis (carilzomib)
201003	●	ERT for Gaucher Cerezyme Elelyso Vpriv	201841-CC	▲	Libtayo (cemiplimab-rwlc)
			201842-CC	▲	Lumoxiti (moxetumomab pasudotox-tdfk)
			201844-CC	▲	Revcovi (elapegademase-lvlr)
			201836	▲	Tegsedi (inotersen)
			201827	●	Colony Stimulating Factors—Pegfilgrastim Neulasta (pegfilgrastim) Fulphilia (pegfilgrastim-jmdb) Udenyca (pegfilgrastim-cbqv)
201316-CC	●	Immune Globulins (IVIG)			
201724	●	Kevzara (sarilumab)			

▲ = New ● = Revised ■ = Retired

For a list of services requiring prior approval or considered investigational, please visit Provider.MedMutual.com > Tools and Resources > Care Management > Prior Approval & Investigational Services.

Pharmacy

Prior Approval Requirements

Medical Mutual requires prior approval (PA) for the following drugs, regardless of whether they are covered under 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 prescribed safely and effectively for members. The PA criteria for these drugs are detailed in the New Drug Prior Approval Policy available at Provider.MedMutual.com.

To view drugs covered under the medical benefit, please visit Provider.MedMutual.com > Tools & Resources > Care Management > Corporate Medical Policies, and search for Global PA under the Review Policies section. This page also includes all current Corporate Medical Policies and information about PA services and ExpressPAth, a web-based tool providers can use to manage PA requests for medications.

To view drugs covered under the pharmacy benefit, please visit Provider.MedMutual.com > Tools and Resources > Care Management > Rx Management, then click Coverage Management (Prior Authorization). This page also includes information about other coverage management programs (e.g., step therapy, quantity limits) and formularies, as well as a link to the ExpressPAth tool.

Risk Adjustment

Prepare for Upcoming Medical Records Requests

Your practice may receive a request for medical records from CIOX Health, LLC (CIOX) or Advantmed, LLC (Advantmed) on behalf of Medical Mutual. Medical Mutual has contracted with these two vendors to obtain medical records for our Affordable Care Act (ACA) and Medicare Advantage members for risk adjustment purposes. In addition, Medical Mutual is required to participate in the annual HHS-CMS Risk Adjustment Data Validation (RADV) audit, which is led by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). This government-mandated audit has a defined start and finish timeline that Medical Mutual must strictly follow. If you are contacted for this audit, you must comply with the deadline indicated.

Using a secured or encrypted delivery method, your practice will receive a list of requested patient names/medical records. There are several options for chart retrieval that will be detailed in the letter accompanying the patient list.

Network providers are contractually required to provide medical records expeditiously and at no cost. To help streamline medical record collection for risk-adjustment purposes and simplify these requests, we are offering the opportunity for you to grant direct secure access to Medical Mutual to your medical records through your electronic medical record (EMR) system. You will no longer need to gather information, copy medical records and package them for submission. Instead, our medical record retrieval specialists can download clinical information such as progress notes, lab reports, radiology results, histories, physicals and more—without involving you and your office.

All medical record transfers are secure and compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy statutes and regulations. If you are interested in learning more, or if you have preferred retrieval preferences, please contact Susan McLaughlin at 1-216-687-7518.

Please note: Medical Mutual's agreements with CIOX and Advantmed stipulate explicit criteria for working with our providers' offices in a respectful, non-disruptive and efficient manner. The agreements also ensure that any information shared by you during chart retrieval activities remains confidential in accordance with all applicable state and federal laws, including HIPAA. As you are aware, 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.

Medicare Advantage

2019 Medicare Part D Opioid Policies

In alignment with requirements and recommendations from the Centers for Medicare & Medicaid Services (CMS), Medical Mutual has implemented several new opioid policies that apply to our Medicare Advantage members. These new policies went into effect Jan. 1, 2019, and include information about safety alerts at point of dispensing and Medical Mutual's Drug Management program, as described in more detail below. Safety alerts are prompted for opioid prescriptions at the point of dispensing for members determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs. Members residing in long-term care facilities, members in hospice care, members receiving palliative or end-of-life care, and members being treated for active cancer-related pain are exempt from these interventions. These policies will not affect patients' access to medication-assisted treatment (MAT), such as buprenorphine.

Opioid Safety Alerts

Following CMS requirements, Medical Mutual has implemented multiple safety alerts through pharmacy claim edits for pharmacists to review at the point of sale when dispensing opioid medications. These safeguards are intended to prevent the inappropriate utilization of opioid drugs. We are requesting that prescribers respond to outreach from pharmacists and/or Medical Mutual in a timely manner to help resolve opioid safety alerts quickly and avoid disruption of therapy for their patients. Below are some examples of the safety alerts:

Opioid Safety Alert	Prescriber's Role
Seven-day supply limit for opioid naïve patients ("hard edit") Medicare Part D members who have not filled an opioid prescription recently (such as within the past 108 days) will be limited to a supply of seven days or less. Limiting the amount dispensed with the first opioid prescription may reduce the risk of a future dependency or overuse of these drugs. Important Notes: This alert should not affect members who already take opioids. This may affect new Medical Mutual members for whom Medical Mutual has no previous opioid claims on file. These members will appear as naïve in the system because Medical Mutual has no prior opioid claims for the member. If a member does not refill an opioid prescription after 108 days, he/she will be considered naïve and the seven-day limit will apply.	Members may receive up to a seven-day supply or request a coverage determination for the full days' supply as written. The physician or other prescriber has the right to request a coverage determination on the member's behalf, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid. Prescribers may provide information to Medical Mutual indicating the days' supply is medically necessary. For members on continuous opioid therapy, subsequent opioid prescriptions written by prescribers will not be subject to the seven-day supply limit, as the members will no longer be considered opioid naïve.
Opioid care coordination alert at 90 morphine milligram equivalent (MME) When a Medicare Part D member presents an opioid prescription at the pharmacy and his/her cumulative MME per day across all his/her opioid prescription(s) reaches or exceeds 90 MME AND the member has a history of opioid fills from more than two unique prescribers, a care coordination alert will be displayed to the pharmacist. Pharmacists may override this alert at the point of sale if it is clinically appropriate to do so. Please be aware that prescribers may be contacted to help resolve these alerts, and to learn of other unique opioid prescribers and/or increasing level of opioids. Important Notes: This is not a prescribing limit. Unique prescribers are based on National Provider Identifier (NPI).	Regardless of whether individual prescriptions are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. The prescriber who writes the prescription will trigger the alert and will be contacted even if that prescription itself is below the 90 MME threshold. Once a pharmacist consults with a prescriber on a member's prescription for a plan year, the prescriber will not be contacted for every subsequent opioid prescription written for the same member unless the plan implements further restrictions. Please note that the physician or other prescriber has the right to request a coverage determination for a drug, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.
Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy edits. These alerts will trigger if a Medicare Part D member has concurrent fills for an opioid and benzodiazepine prescription or if the member has duplicate long-acting opioid prescriptions.	The pharmacist will conduct additional safety reviews at the point of sale to determine if the member's opioid use is safe and clinically appropriate. The prescriber may be contacted to assist with this process.

Medical Mutual's Drug Management Program

In accordance with CMS requirements, Medical Mutual has implemented a Drug Management Program (DMP) that limits a member's access to opioids and benzodiazepines if the member is identified as at-risk for prescription drug abuse.

The goal of our DMP is to achieve better care coordination that supports the safe use of opioids and other frequently abused medications. Medical Mutual's coverage limitations under our DMP include requiring the member to receive these medications from a specified prescriber and/or pharmacy, or putting in place a point-of-sale edit limiting the amount of these medications that will be covered for the specific member. We will apply these coverage limitation tools for 12 months and extend them for an additional 12 months (total of 24 months) as needed.

Medical Mutual identifies potential at-risk members based on their previous use of opioids, which involves prescriptions from multiple doctors and/or pharmacies. We typically conduct case management with the prescribers of members who meet the following criteria:

> Members who use opioids with average daily MME greater than 90 mg for any duration during the most recent six months AND either a or b:
>
> a. Use of three or more opioid prescribers AND three or more opioid dispensing pharmacies, OR
>
> b. Use of five or more opioid prescribers (regardless of the number of opioid dispensing pharmacies).

Medical Mutual always attempts to contact prescribers before implementing a coverage limitation and will notify both the prescriber and member in writing. If neither the prescriber nor the member contacts Medical Mutual within a 30-day period, the member will be deemed at-risk and a limitation may be implemented. If this occurs, Medical Mutual will send the member a second written notice confirming the specific limitation and its duration.

Under Medical Mutual's DMP, the member and his or her prescriber have the right to appeal our decision to implement a limitation. The member or prescriber should contact Express Scripts to begin the appeal process. Call 1-800-935-6103 (TTY 1-800-716-3231), 24 hours a day, seven days a week.

For additional information about the above 2019 Medicare Part D opioid requirements, please refer to CMS.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/RxUtilization.html.

Medicare Advantage Wellness Rewards Program Coding

The Wellness Rewards program is a Medical Mutual Medicare Advantage member benefit that includes health and wellness activities designed to help Medicare Advantage members manage conditions they may have, prevent illness and improve their overall health, all at no additional cost to the member. All Medicare Advantage members are eligible to participate in the Wellness Rewards Program. To qualify for rewards, Medicare Advantage members must complete all eligible health and wellness activities between Jan. 1, 2019, and Dec. 31, 2019. The eligible wellness activities are: Breast Cancer Screening, Colorectal Cancer Screening, Retinal Eye Exam for Comprehensive Diabetes Care and a Wellness visit. The following NCQA-approved CPT codes for HEDIS measures and HCPCS codes will be used to award Medicare Advantage members credit for their completion of the wellness activities.

Use the screening codes below when submitting a claim:

Screening	Codes
Breast Cancer	77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067, G0202, G0204, G0206
Colonoscopy, Colorectal Cancer	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398, G0105, G0121
Comprehensive Diabetes Care, Retinal Eye Exam	67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245, S0620, S0621, S3000
Wellness Visit	G0402, G0438, G0439

None of the information included in this article is intended to be legal advice and, as such, 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.

Plan-directed Care

Medical Mutual follows CMS guidelines for our plan-directed care policy. When referring a Medical Mutual Medicare Advantage member to another provider (e.g., physician, dental, vision, rehab centers, lab work, durable medical equipment (DME) providers, specialist), we ask that you help the member find an in-network provider. You can do this by accessing our online directory at Providersearch.MedMutual.com or call our Customer Care Center at 1-800-362-1279. Additionally, you can help your Medical Mutual members with this process by letting them know they can call the member Customer Care number on their ID cards or log in to their My Health Plan accounts at MedMutual.com/Member and use the Find a Provider tool.