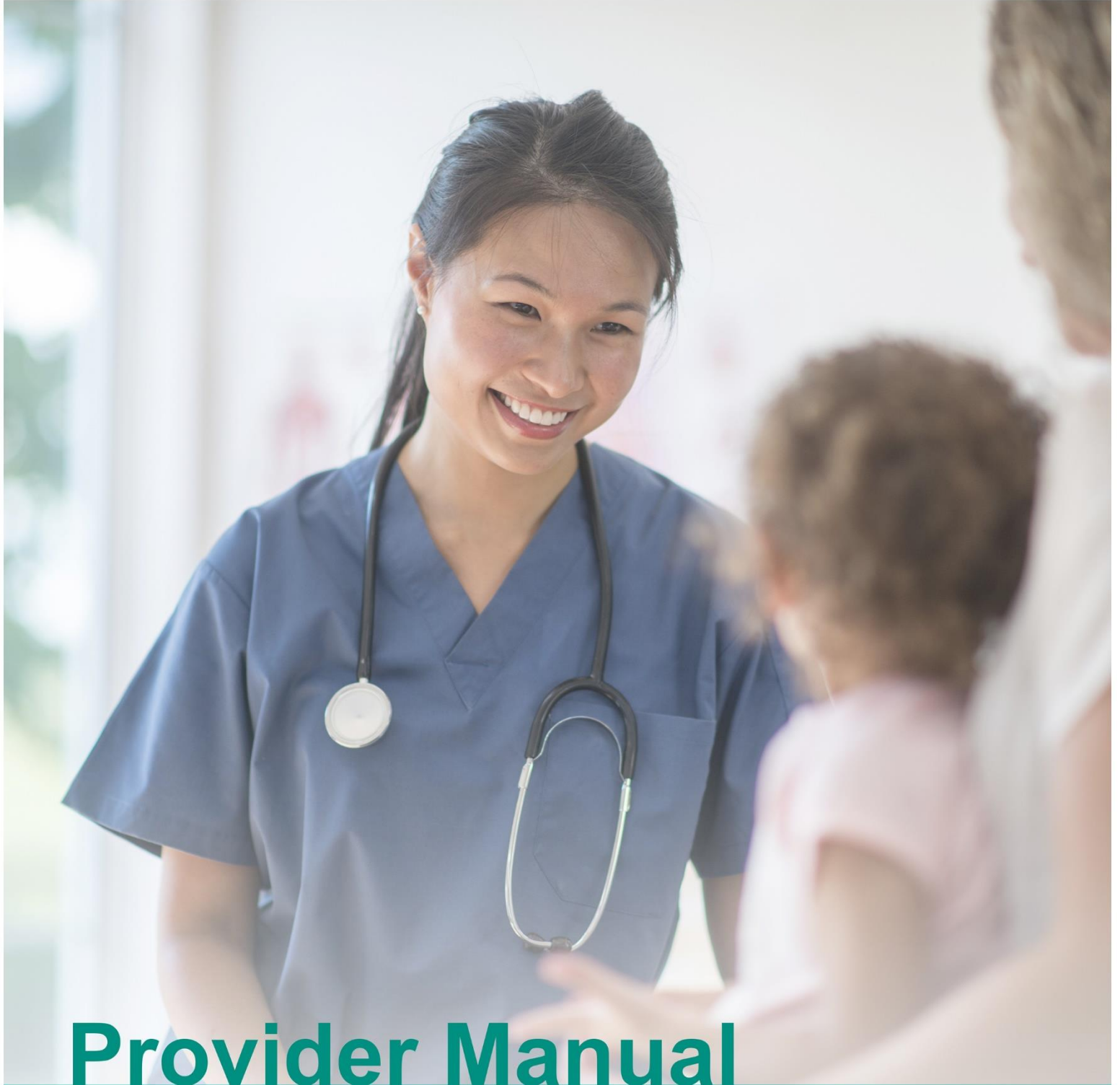




Provider Manual

2025

May 2025



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Section 1 — Overview (Revised)

The Provider Manual (Manual) includes policies for professional and institutional healthcare providers. The Manual is reviewed and updated on a regularly scheduled basis and replaces any earlier versions of this Manual. The Manual applies to preferred provider organization (PPO), point of service (POS), health maintenance organizations (HMO) and traditional products from Medical Mutual of Ohio®, Medical Health Insuring Corporation of Ohio, MedMutual Life Insurance Company™ and any subsidiaries, hereinafter referred to collectively as the “Company.”

The Manual is referenced in the participating agreement and is considered an extension of the agreement. It identifies Company administrative and medical policies, procedures, guidelines, and other information aimed at enhancing the provider's relationship with the Company. In the event there are any inconsistencies between the agreement and the Manual, the agreement is the controlling document.

The Manual is reviewed and updated as necessary throughout the year, and providers are notified of changes through our provider communications. Information contained in Company publications is considered part of this Manual. Providers can visit MedMutual.com/Provider, In the News to reference Company newsletters and bulletins.

Additional information about forms referenced in this Manual is located in [Section 7 – Forms and Publications](#).

Definitions for common medical terms can be found in [Section 13 – Glossary of Terms](#).

All uses in this Manual of Current Procedural Terminology (CPT) five-digit codes, descriptions and other data are copyright 2018 (unless another year is cited), American Medical Association, all rights reserved. CPT is a trademark of the American Medical Association (AMA). No fee schedules, basic units, relative values, or related listings are included in CPT codes. The AMA assumes no liability for the data contained herein.

Questions or comments regarding information contained in the Manual should be directed to the appropriate [Provider Contracting office or to the appropriate Company divisions](#).

Company Coverage

Company coverage may include professional services and benefits for a variety of expenses, sometimes referred to as **medical/surgical benefits**.

Professional providers, as defined or limited by each contract, include:

- Advanced Nurse Practitioner
- Certified Nurse Practitioner
- Clinical Nurse Specialist
- Nurse Midwife
- Ambulance
- Anesthetists (including CNRAs)
- Audiologists
- Chiropractors
- Convenience Clinics
- Hearing Centers
- Home Infusion
- Licensed Independent Social Workers
- Licensed Professional Clinical Counselors
- Mobile Radiology — Mammography
- Occupational Therapists
- Opticians
- Optometrists
- Oral Surgeons
- Outpatient Rehabilitation Centers
- Physical Therapists
- Physician Assistants
- Physicians
- Podiatrists
- Psychologists
- Reference Labs
- Sleep Centers
- Speech Therapists
- Suppliers of Durable Medical Equipment (DME)

Institutional Providers, as defined or limited by each contract, include:

- Acute Care Facility
- Acute Care Facility — Rehab
- Ambulatory Surgery Center
- Children's Hospital
- Dialysis Center
- Home Health Agency
- Hospice Services and Centers
- Long Term Acute Care Facility
- Outpatient Psychiatric Center
- Psychiatric Hospital
- Skilled Nursing Facility
- Substance Abuse Hospital

A variety of benefit packages are available, specifically defined by contracts. Covered services usually include certain basic services, such as surgery, maternity, hospital visits and initial emergency care. Other benefits may or may not be available and may be subject to limitations, deductibles, copayments, coinsurance or variations in the covered amount, depending on the benefit package elected by the group or individual policyholder.

PPO, POS and HMO providers are reimbursed at network fee schedules.

Non-network providers are reimbursed at traditional fee schedules. Policies provide maximum benefits when services are provided to patients by network providers. The provider should not assume that certain procedures may or may not be covered services for all policies.

In order for covered persons to receive all available benefits, claims should be submitted according to the instructions included in this Manual for all services rendered.

Please Note: The following information applies throughout this Manual:

- Eligibility/Benefits Verification: Coverage information provided by the Company is subject to change and limited to the provisions of the applicable covered person's contract or group contract. Additionally, such information is not intended to dictate treatment decisions nor create any commitment for the payment of benefits.
- Payment is not guaranteed by prior authorization, and/or compliance with other Company policies and procedures. Payment is subject to the participating agreement and limited to the covered person's contract or group contract provisions.
- Medical Mutual policies and procedures adhere to CPT and ICD-10 coding guidelines. If Medical Mutual does not have a policy or procedure that addresses a claim, code or industry standard, Medical Mutual will follow the CMS guidelines that govern that particular standard as long as the CMS guidelines are not in conflict with the provider agreement, and in the event of conflict between the provider agreement and the CMS standards, the provider agreement will prevail.

Healthcare Reform

As healthcare reform continues to bring about changes in health coverage, Medical Mutual remains focused in its efforts with providers and medical practitioners to offer patients more efficient, effective and affordable

healthcare. Identified below are some of the enhancements Medical Mutual has made with respect to its conformation with ACA requirements. Healthcare Reform updates are also publicized on [MedMutual.com/Provider](https://www.medmutual.com/Provider) under Healthcare Reform at the bottom of the page.

Uniform Claim Processing

Medical Mutual conforms with the CAQH Committee on Operating Rules for Information Exchange (CORE) Payment & Remittance Uniform Use of CARCs and RARCs (835) Rule vPR.1.0. Under this rule, payers are required to return the same uniform and consistent code combinations as set forth for the same or similar business scenarios. The established code sets are Claim Adjustment Remark Codes (CARCs), Remittance Advice Remark Codes (RARCs), and Claim Adjustment Group Codes (CAGCs). These code sets provide uniform claim processing details under the following four defined business scenarios:

1. Additional information required — missing/invalid/incomplete documentation
2. Additional information required — missing/invalid/incomplete data from the claim submitted
3. Billed service not covered by health plan
4. Benefit for service not separately payable

For additional information about CORE-required code combinations, please visit:
<https://www.caqh.org/core/ongoing-maintenance-core-code-combinations>

Eligibility and Benefits

CAQH CORE Eligibility & Benefits Operating Rules address ambiguities in information given to providers in the transaction process. As a result, the v5010 271 transaction requirements were expanded.

The Company conforms with all specified requirements and is CAQH CORE certified for Eligibility and Benefits.

The CAQH CORE Eligibility & Benefits (270/271) Data Content Rule version EB.1.0 increased the number of service types that require eligibility transaction information. Medical Mutual includes the following eligibility transaction details:

- Deductible or remaining deductible amount
- Deductible start date if different from coverage date

- Patient financial responsibility for copayment and coinsurance
- Appropriate family or individual deductible

For more information about these Operating Rules, please visit: <https://www.cagh.org/sites/default/files/core/Eligibility-Benefits-270-271-Data-Content-Rule-.pdf?token=tQWvGCYF>

Essential Health Benefits

Provisions of the ACA ensure that certain healthcare service categories, known as Essential Health Benefits, are offered within health plans available to individual and small group markets, both inside and outside of the health insurance market. Essential Health Benefits must include items and services within at least the following ten categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Risk Adjustment Data

As of January 1, 2014, the ACA requires insurers to complete and submit accurate risk adjustment data for members of risk adjustment covered plans. Please refer to [Section 2 – Claims Submission Risk Adjustment Data](#) for further explanation about Medical Mutual's compliance with this requirement.

Provider Office Assistance

The Company is dedicated to supporting our providers with various services and departments that assist and facilitate effective participation in our programs.

Provider Contract managers present a thorough orientation regarding the appropriate products for all new providers.

After the initial training session, a representative will visit you as needed to update your office personnel on policies and procedures, respond to any questions, and resolve administrative problems.

Provider Service representatives (PSRs) are also available to assist providers when handling non-routine, global, complicated or reoccurring claims and customer service issues. PSRs additionally provide education and support to providers on electronic and internet-based tools.

Customer Care representatives in the [Provider Inquiry](#) unit are readily available to explain program policies, verify covered person's eligibility, clarify benefits and assist with claim inquiries. For Provider Inquiry phone numbers, refer to the back of the covered person's ID card.

Clinical Quality and Health Services (CQHS) nurse reviewers issue approvals, refer cases to provider advisors for review, facilitate case management, and provide support when appropriate.

Provider Portal

Medical Mutual offers secure online services for network providers registered through the Availity [Provider Portal](#). To register or learn more about the Availity [Provider Portal](#), visit MedMutual.com/Provider.

The following time-saving Provider Portal options are offered to help simplify communications and enhance the efficiency of patient care:

Electronic (Paperless) Communications

Providers can subscribe to newsletters, bulletins and other correspondence electronically through the Availity Provider Portal. The Communications Preference Application can be found in the Availity Provider Portal in the Medical Mutual Payer Space under the Applications tab.

Claims and Eligibility

- Eligibility & Benefits — This feature is used to verify a member's eligibility and benefit information, including copays, coinsurance and deductibles.
- Claims Status — The status of paper claims or electronic claims submitted through the Provider Portal can be viewed with this feature, including member information, date of service, charges and payment date.
- Claims Remit History — This feature allows providers to quickly and easily search claim records.

Fee Schedule

Providers can search online schedules based on NPI and TIN combination.

Update Your Records

Through this Portal option, providers can add, edit or remove service and reimbursement locations or providers associated with their practice using the Provider Information Form. This form can be found through the Availity Provider Portal in the Medical Mutual Payer Space under the Resources tab.

Contact Information (Revised)

Questions regarding information in this Manual should be directed to your **Provider Contract manager. Refer to the Provider Contracting regional office map at [MedMutual.com/Provider](https://www.medmutual.com/Provider), Contact Us to determine the office that supports your county.**

Provider Contracting Offices

Southwest OH (Cincinnati Office)

(800) 625-2583
(513) 684-8121 (fax)

MZ: 05-7502
Centre Pointe Building II
9050 Centre Pointe Drive Suite 225
West Chester, Ohio 45069

Northeast OH (Cleveland Office)

(800) 625-2583
(216) 687-7994 (fax)

100 American Road
Brooklyn, OH 44144

Central/Southeast OH (Columbus Office)

(800) 625-2583
(614) 621-4578 (fax)

MZ: 09-7502
545 Metro Place South Suite 430
Dublin, OH 43017

Northwest OH (Toledo Office)

(800) 625-2583
419-595-6200 (fax)

MZ: 25-3845

9848 Olde Highway US 20
Rossford, OH 43460-1722

Eligibility and Benefits

Provider Inquiry Unit (live response) or Medical Mutual VoiceConnect® for Providers (24-hour voice response system)

(800) 362-1279

Customer Care Hours

Monday – Thursday, 7:30 a.m. – 7:30 p.m. ET
Friday, 7:30 a.m. – 6 p.m. ET • Saturday, 9 a.m. – 1 p.m. ET

New Hours Effective 6/1/25

Monday – Friday, 8:00 a.m. – 5:00 p.m. ET

Coordination of Benefits

(800) 782-5869

Claims

Electronic Claims

Use Payer ID 29076

Claim Inquiries

Provider Inquiry Unit or Medical Mutual VoiceConnect® for Providers: (800) 362-1279

EFT Enrollment

For questions or to make changes to an existing EFT account contact One Inc at (877) 313-4898 or providers@oneinc.com.

Change Healthcare™ Electronic Claims (formerly Emdeon)

(877) 363-3666, option 3

Change Healthcare Payment Manager

(877) 469-3263 or [ChangeHealthcare.com](https://www.ChangeHealthcare.com)

Change Healthcare Fax Enrollment

(615) 231-4843

Paper Claims

Submit paper claims to the address indicated on the member's identification (ID) card.

Clinical Quality and Health Services and Pharmacy

Behavioral Health

(800) 258-3186

Prior Authorizations and Acute and Post-acute Authorizations

(800) 338-4114

Case Management

(800) 258-3175, option 3

Clinical Quality Improvement

(800) 586-4523

Disease and Maternity Management

(800) 258-3175, option 4

Clinical Drug Management

(800) 424-7698

MedCommunity

MedCommunity is the web-based solution that automates the prior authorization process by allowing healthcare providers to easily submit clinical requests for consideration. For more information, visit MedMutual.com/Provider and select MedCommunity.

Pharmacy Benefits

Express Scripts® Coverage Management: (800) 753-2851
Express Scripts Prescriber Service Center: (800) 211-1456
Express Scripts Website: Express-Scripts.com

Certified ePrescribing Partner Locator

SureScripts.com

Web Technical Support

If you have technical problems with our website, please call the Help Desk at (800) 218-2205

Products and Plans

See [Section 11 – Administrative and Plan Guidelines](#) for a description of our Company's products and plans.

Medical Mutual ID cards

Distinctive ID cards make Medical Mutual member identification simple.

- Member copays listed on the front
- Claims, prior authorization and provider assistance information listed on the back
- Print date emphasizes latest version
- SuperMed® logo identifies network members

- EXCH indicator identifies members who signed up for their health plan on the public exchange

The correct ID number (without dashes, hyphens, spaces or suffixes) along with the covered person's accurate date of birth is required on the claim form. Incorrect information may result in delay or denial of payment.

ID cards are group specific and issued to employer groups at the time of renewal. Telephone numbers and other information can vary by group or individual plan. Please reference our [Tools and Resources for Providers](#) brochure at MedMutual.com/Provider, Are You a Provider Outside of Ohio?, to see samples of many of our member ID cards.

ID Card Accessible from Mobile App

Members who download the Medical Mutual mobile app can provide a copy of their ID card at the doctor's office or hospital by simply emailing or faxing their ID card to the healthcare provider. For security purposes, providers must retrieve the patient's ID card image within 60 minutes, or the email will expire.

Medical Mutual Services Accounts

The Company provides network services for various accounts, including self-insured groups, health and welfare funds, third-party administrators (TPAs) and other insurance companies.

A coverage indicator of Access on a Medical Mutual ID card denotes a member who uses the SuperMed Network via a Mutual Health Services account.

Examples of ID cards can be accessed at MedMutual.com/Provider, Are You a Provider Outside of Ohio?

Highlights from the Provider Agreement

The following is abbreviated from the Participating agreement:

Non-discrimination

The Company providers will not differentiate nor discriminate in the treatment of, or in the quality of covered services delivered to covered persons based on race, color, religion, sex, sexual preference, age, disability, national origin, Vietnam-era veteran's status, ancestry, health status or need for health services.

Open Communications Policy

Providers are responsible for their own acts or omissions in professional practice, as well as those of their employees and agents. No action by the Company, including the administration of benefits, is intended to infringe upon the provider's care and treatment of a covered person. A determination by the Company that a course of treatment is not a covered service is not a medical determination and does not relieve the provider from providing or recommending that treatment or course of action. The provider may freely communicate with a covered person about their treatment options, regardless of benefit coverage. Nothing in the participating agreement affects the professional relationship between provider and patient, nor does it restrict the provider from exercising the right to treat or refuse to treat any patient for appropriate professional reasons.

Confidentiality

Provider agrees to abide by all federal and state laws, rules and regulations regarding confidentiality and disclosure for mental health records, medical records, other health information, and information regarding a covered person. In addition, provider agrees to abide by the confidentiality requirements established by the Company or the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, HIPAA. Provider agrees to maintain records and ensure accuracy of covered person information and records; to ensure timely access by covered person to the records and information that pertain to him/her; and to safeguard the privacy of any information that identifies a particular covered person.¹

Participation in Quality Improvement, Utilization Management/Clinical Quality and Health Services Activities

Provider will participate in and actively cooperate with the Company's Quality Assurance (QA) Program, Utilization Review (UR), Case Management Programs, and those policies and procedures which the Company determines are necessary to comply with the accreditation standards of the National Committee for Quality Assurance (NCQA) or of similar accrediting bodies, such as The Joint Commission, to improve the quality of care and services and the member's experience.¹ Provider has the right to appeal any UR/QA determination in accordance with the Company's established appeals process.

Medical Records Release

The Company has access to provider medical records, to the extent permitted by state and federal law¹. HIPAA regulations govern the privacy of a member's protected health information (PHI) and establish requirements for the use and disclosure of PHI by Covered Entities, which

includes healthcare providers, healthcare clearinghouses and health plans.

In accordance with 45 C.F.R. § 164.506, a healthcare provider is permitted to disclose a member's PHI, including his/her medical records, to a health plan without a member's authorization or consent for the health plan's payment and healthcare operations activities. This includes, but is not limited to, providing data for quality assessment and improvement activities, disease management, case management and care coordination, evaluating health plan performance, accreditation, and certification and credentialing activities, HEDIS and risk adjustment purposes.

Provider agrees to provide the requested medical records to Medical Mutual or its designee within 14 calendar days from Medical Mutual's or its designee's written request. Such records shall be provided to Medical Mutual or its designee at no additional cost.

Member Rights and Responsibilities

The following reflects the Company's intent to allow our covered persons to receive optimal healthcare.

Medical Mutual members have certain rights and responsibilities. Being familiar with these rights and responsibilities helps our members participate in their own healthcare. Please know as a Company we ensure member rights and member responsibilities, which 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 MedMutual.com, About Medical Mutual, Corporate Profile, [Member Rights and Responsibilities](#) or call the Provider Inquiry Unit at (800) 362-1279 for a printed copy.

Confidentiality of Personal Health Information of Covered Persons

Covered persons have the right to confidentiality in the use and disclosure of their personal health information and records by the Company. The Company complies with all applicable laws and regulations on maintaining confidentiality.

Routine consent is obtained from covered persons through the enrollment process. Routine consent for insured and self-insured covered persons is used to develop product

¹ Indicates NCQA requirement.

pricing, to process claims, to meet certain accreditation standards for utilization review programs, to monitor health services or quality improvement activities and to coordinate benefits, appeals and complaint resolution.

Special written consent is required for all other purposes, such as requests from other insurance carriers, attorneys, auto insurance claims, workers' compensation claims and appeals resolution from non-contracted providers.

The Company holds its employees and consultants to strict policies and procedures protecting covered persons' personal health information. All employees and members of the Company's Board of Trustees are required to sign confidentiality agreements upon hire.

The Company does not release personal health information to outside parties without the covered person's or legal guardian's advanced written consent, except as permitted by law. Release of information is done only on a need-to-know basis for the purposes of full participation in benefits and services.

Covered persons may access their medical records to the extent allowed by state and federal regulations by directly contacting each healthcare provider and following the specific procedures those providers outline.

Whenever the Company works with an outside party, including vendors, it will ensure that the outside party is informed of the Company's policies on protecting covered persons' personal health information as obtained through routine or special consent and provider-specific information. The Company will also make sure it has appropriate agreements in place with such outside parties to permit data sharing.

The Company has comprehensive policies to protect data. Various security methods are in place to prevent unauthorized access to data. Any data obtained during various quality improvement activities or the healthcare provider credentialing process are not released to the public.

To ask a question or voice a concern about confidentiality, please call the appropriate Customer Care representative at the telephone number on the covered person's ID card.

Policy on Special Needs

Addressing Special Needs or Preferences

The Company recognizes that some covered persons have special needs or preferences that may affect the administration of their health plan or their ability to obtain medical services.

If you become aware of covered persons in need of special services, please encourage them to contact us for assistance by calling the Customer Care phone number on their ID card or (800) 700-2583 or (800) 982-8109 for the hearing and speech impaired. The Company uses bilingual telephone and document translation services for covered persons who are limited-English proficient and uses the Ohio Relay Service for the hearing impaired. For covered persons who are visually impaired, Customer Care will read written materials by telephone.

Provider Directories

Medical Mutual is committed to providing our members with accurate information about our provider networks. Provider directories are available by visiting ProviderSearch.MedMutual.com.

Provider Directory Changes

We request that providers validate the demographic and other information displayed in our 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 Medical Mutual by visiting MedMutual.com/Provider, Resources, Forms and selecting Provider Information Form.

- Providers enrolled in the Provider Portal also have the option to add, edit or remove providers, service locations and reimbursement addresses associated with their practices.
- The Company recognizes a provider may choose at some point to change his/her practice status and limit it to current patients only or to open his/her practice to accept new patients. To allow ample time to update directories, providers are required to notify Medical Mutual in writing at least 90 days prior to the effective date of the practice status change. Updates should be communicated to Provider Contracting by using the Provider Information Form.
- Provider Information Forms should be submitted to the respective Provider Contracting office as the form instructs

Section 2 — Claims Overview (Revised)

Claims Submission Instructions by Claim Form Type

Claims for healthcare services provided to Covered Persons may be submitted to the Company on either the CMS-1500 for professional claims or for facility claim forms the UB-04 Claim Form if not submitted electronically.

For ease of reference, the Claims Submission section of this manual has divided its instructions into two parts. The first half of the section references the CMS-1500 Claim Form and the second half of the section references the UB-04 Claim Form. Samples of the forms and the crosswalk from paper to electronic may be obtained from the National Uniform Claim Committee (NUCC) at NUCC.org and the National Uniform Billing Committee (NUBC) at NUBC.org, respectively. Electronic claim requirements are licensed products which can be purchased from X12 at <https://products.x12.org/>.

Please refer to the section that references the claim form that corresponds to your office's needs.

National Correct Coding Initiative (CCI) Edits

The Company applies Medicare National Correct Coding Initiative (CCI) edits to its professional and institutional outpatient claims. The Centers for Medicare and Medicaid Services (CMS) developed the CCI to promote national correct coding methods and to control improper coding that led to inappropriate payments. These coding policies are based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

The edits evaluate whether a comprehensive or major code (column 1) can be used with a specific secondary or component code (column 2) or whether the usage of a code is mutually-exclusive to another code billed. The edits apply

to services billed by a single provider for a single patient on the same date of service.

Please use the Healthcare Common Procedural Coding System (HCPCS)/CPT codes that most comprehensively describe the services performed. Do not use "unbundled" codes, i.e., multiple procedure codes billed for a group of procedures that are covered by a single, comprehensive code.

Correct coding requires reporting a group of procedures with the appropriate comprehensive code. Examples of unbundling include but may not be limited to:

- Fragmenting one service into component parts and coding each component part as if it were a separate service.
- Reporting separate codes for related services when one combined code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service to use an additional code when one more comprehensive, higher-level code is appropriate.
- Separating a surgical access from a major surgical service.

Correct coding also excludes procedures that cannot reasonably be performed together based on code definitions or anatomic considerations. Examples of mutually exclusive codes include but may not be limited to:

- Reporting services that cannot reasonably be done in the same session.
- Reporting of the same procedure using two different methods. One method should be chosen and reported.
- Reporting an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.

The charges associated with codes failing a CCI edit will not be considered for payment and cannot be billed to a covered member. Further information or instructions can be found by visiting CMS.gov and type "CCI edits" into the search box.

General Information

A National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services. Providers covered under the NPI mandate are required to use this identifier except when the claim guidance otherwise dictates. Medical Mutual will reject the

claim if a required NPI is missing, invalid, or does not match the name associated to it in the [NPI Registry](#).

Medical Mutual accepts claims submitted electronically (837P, 837I) from any clearinghouse of the provider's choosing or submitted directly from the provider. Medical Mutual also accepts claims submitted on a standard paper claim format (CMS-1500 and UB-04). Medical Mutual receives secondary claims directly from Medicare to facilitate payment to our providers and minimize impact to our Medicare Advantage members.

All claims submitted electronically will receive verification of receipt with the 999 Acknowledgement transaction. However, if the claim fails to pass pre-adjudication edits, it will be rejected with the 277 Claims Acknowledgement (277CA) transaction.

For providers enrolled with a clearinghouse to receive an electronic remittance, final adjudication will be reported in the 835 payment/advice transaction, otherwise you will receive a Notice of Payment (NOP).

Providers should allow 30 days from the date of the claim's submission before inquiring about the outcome of that claim. After 30 days without notice from the Company, providers may inquire about the claim's outcome via the 276-claim status request transaction, the Provider Portal, your clearinghouse, Medical Mutual VoiceConnect®, or your practice management system. A new claim should not be submitted.

Claims not submitted electronically should be mailed to the following address, or the address shown on the back of the member's ID card:

SuperMed
Claims Submission
Medical Mutual
PO Box 6018
Cleveland, OH 44101-1018

Network Access Services
Network Access Services
Medical Mutual
PO Box 94648
Cleveland, OH 44101-4648

Billing Agents

A provider may choose to use a billing agent to prepare and submit insurance claims for a fee. In some cases, the provider authorizes that payment be directed to the billing agent, who also performs various accounting and billing duties. Regardless of who prepares claims, the ultimate responsibility for accuracy and completeness of claim information remains with the provider of the service.

Conditions for Payment

Each payment is conditioned on the provider's satisfaction of the following: submitting the claim to the Company within the time frame specified and submitting a fully completed claim that conforms to the requirements as defined in the 837, NUCC, or NUBC. The Company has no obligation to process any claim until those conditions of payment have been satisfied.

Additionally, as per the Provider's Agreement with the Company, the provider waives any claim to payment, other relief, penalty, or interest if it has not fully met the cited conditions for payment, notwithstanding any law, rule, or regulation in force now or hereafter.

Time Limit for Submitting Claims

All claims, unless otherwise noted in the contract, must be filed within 12 months of the date of service.

This policy is consistent with your Provider Agreement, industry standards, and the Company's ongoing efforts to better manage healthcare costs.

Healthcare providers who contract with the Company may not hold Covered Persons responsible for claims submitted past the filing limit. Covered Persons who receive healthcare services from non-contracting providers also are required to submit claims within the 12-month period.

Recovery of Claim Overpayments

When an overpaid claim is identified, the Company initiates a process to correct the overpayment. When an overpayment adjustment is done by the Company, a refund request is issued to the provider as an invoice, unless the overpayment is a result of the submission of a replacement claim (frequency code 7).

The payment of the invoice is due within 35 calendar days of the invoice date. During this 35-day period, the provider has the option of paying the invoice by check, appealing the overpayment adjustment, or letting the invoice due date expire. The provider has 30 days to question or appeal the invoice. When the invoice due date expires without an appeal or payment, the Company will offset the invoice amount against future payments. If the provider disagrees with items on the invoice and would like to take more time to research the claim, the provider should telephone the Provider Inquiry unit at (800) 362-1279 to have the

overpayment adjustment, sometimes called a take-back, put on hold.

The appeal status is entered into the Company's online tracking and inquiry system, which triggers the invoicing system to hold the adjustment. The adjustment will be suspended until the appeal is researched and resolved, or the claim is adjusted.

When the 35-day period expires without an appeal or receipt of a refund, the Company's automatic deduction process will begin to deduct the overpayment amount for each overpaid claim. The resulting negative balance will be applied against a positive payment. You may find all recovery amounts on the provider remit on the top of the second page. The overpayment amount will continue to be displayed until the negative balance is recouped by the Company.

NOTE: When a provider's identification number is canceled or made inactive, the Company will apply the dollars to be recovered to an active provider number in the same provider group.

FOR EXAMPLE: If the provider's accounting records show a -\$100 balance for John Doe and a +\$500 payment for Jane Smith, the provider would receive a +\$400 payment for Jane Smith. The provider should then post a \$500 payment to Jane's account because \$100 was already paid by the Company on John's account. The overpayment for John Doe is cleared and Jane Smith's account is considered paid in full.

For replacement claims that result in a net overpayment, recoupment will occur at the time of payment. If the payment amount is inadequate to offset the amount owed an open receivable is created that will be recouped from future payments.

Tips for Handling Overpayment Adjustments

Identify the Covered Person by the patient account number and the Medical Mutual claim number associated with the adjustment, date of service, amount, and reason for the adjustment. Validate that the provider ID number used for the payment recovery is the same number used for the original payment.

Before allowing the automatic adjustment, make sure you have cashed the original payment check.

If you disagree with the adjustment but missed the 35-day time frame by which to contact the Company, you may appeal the decision by completing a Provider Action Request (PAR) Form and following the normal appeal process. PAR

forms can be submitted electronically through the Provider Portal or via paper and mailed to the address on the form.

The PAR Form is available on the Company's website by visiting MedMutual.com/Provider, Resources, Forms and selecting Provider Action Request Form.

Claims Filing Tips (Optical Character Recognition Related)

The Company uses Optical Character Recognition (OCR) technology to process paper claim forms more efficiently and accurately. To realize these benefits, providers must accurately complete the claim form as defined by the NUCC or NUBC. OCR technology is entirely automated. That is, it reads exactly what is on the claim form, based in part on the location of the information on the form.

To avoid unnecessary delays and otherwise help ensure that your claims are consistently processed accurately and in a timely fashion, please be certain that all claims are prepared and printed in accordance with the following:

- Use only standard UB-04 or CMS-1500 original forms. Otherwise, the claim will need to be manually entered which may delay claim payment.
- Print should be dark and legible.
- Decimal points and cents should ALWAYS be clearly indicated to avoid OCR or data entry errors that may possibly result in an incorrect reimbursement amount.
- Information on claims should be inside the borders of the appropriate field.
- Do not use red ink on the claim form.
- Providers may use either 10-point or 12-point Courier New; however, the type size (10 or 12) must be used throughout the claim for OCR to work effectively.
- The UB-04 claim form has a maximum number of 22 detail lines and the CMS-1500 claim form has a maximum of six detail lines. Only one service should be reported in each detail line. An additional claim form will need to be used when services exceed the form maximums.
- When reporting ICD-10 codes, decimals must be used in the correct location. If spaces are used the OCR will misread the data.
- Present on Admission value must be printed within the shaded portion of the diagnosis field.
- HCPCS/CPT procedure codes and modifiers must be reported as defined by NUCC and NUBC and contained in the box on the claim form.

- ICD-10-CM2 codes must be reported as defined by the NUBC and contained in the applicable box on the UB-04 claim form.
- Dates (e.g., birthdates, date of service) must be within the boxes on the form and in the correct format.
- Field information should not be highlighted.
- Special characters (e.g., *, &, %) should not be used.
- Do not use white out or other correction devices.
- All required data must be completed.
- Do not stamp information on the claim form.

Other Claims Filing Tips

Please make certain that:

- The patient's ID number is accurately included on the claim.
- The insured's ID number is accurately included on the claim.
- Only claims for Company-eligible patients are submitted to the Company.
- The patient's name is correct. (Do NOT use nicknames; verify the full name by referencing the ID card.)
- If Medical Mutual is the secondary payer to Medicare, the claim is submitted electronically on your behalf by the Medicare contractor. If you do submit the secondary claim to us, it will be denied as a duplicate.
- Providers allow the Company 30 days from the date of a claim's submission to inquire about the outcome of that claim. After 30 days without notice from the Company, providers may inquire about the claim's outcome via the 276 Claim Status Request transaction, Provider Portal, your clearinghouse, Medical Mutual VoiceConnect®, or your practice management system. Do not submit a new claim; that could delay payment.
- When filing claims electronically, it is critical to read the Detailed Claims Report immediately. That report provides detailed tracking and related information for an accepted claim or file, or a rejection code if the claim or file is rejected. Such a rejected claim or file means the claim or file has not been received by the Company. Those claims or files should be corrected and refiled immediately.

Electronic Claims Processing Program

Electronic claims may be submitted to a clearinghouse of the provider's choosing or may be submitted directly to the Company. The provider's practice management system

performs editing that allows for immediate correction of claims prior to transmission. Your clearinghouse may do additional editing on your behalf prior to transmitting the claim to the Company.

Once received by the Company's front-end systems, the claims are validated against the HIPAA standards using SNIP 1 – 7 compliance level edits, coding standards, billing rules, and other national standards that pertain to billing requirements. All of this is accomplished electronically, eliminating costly administrative intervention. Once the electronic claim has passed the Company edits, it is possible to have the claim processed within 24 hours.

The 837 contains data elements that are used in the reporting of all payers that may have processed a claim prior to Medical Mutual. The Company does not require a paper Explanation of Benefits to be sent as this information is included in the electronic claim submission.

Any Medicare secondary claim where RARC code MA18: *Alert: The claim information is also being forwarded to the patient's supplemental insurer*; does not appear on the Explanation of Medicare Benefits (EOMB), indicating that the claim was not automatically sent from Medicare contractor to the Company should be submitted electronically. The Company processes electronic secondary claims in compliance with the standards established in the ANSI X12N 005010 837I and 005010 837P HIPAA Implementation Guides.

Please contact your vendor/clearing house for information relating to services that they may perform on your behalf. Additional resources relating to electronic transactions are available at www.x12.org.

Electronic Claims Filing Tips

When filing claims electronically, providers should:

- Use Payer ID 29076 to identify the Company as the payer.
- Review all acknowledgement reports (999 and 277CA) to verify either acceptance or identification of errors that need to be corrected before refiled the claim.
- Use the Covered Person's ID number from his/her ID card.
- Use the provider's NPI number unless otherwise required.
- When services are rendered in the patient's home, use "Residence" in the service location name segment and the address of the patient.

Benefits of Electronic Claims Filing

Widespread use of HIPAA adopted transactions, where everyone uses the same language, format, and code sets, can lead to substantial savings across the health care industry. These include:

Enhanced Efficiency

- Claims for all Company lines of business may be transmitted together electronically.
- Processing time is reduced as claims that pass validation edits are generally processed within 24 hours.
- All Company electronic claims may be submitted together, eliminating the costs and burden relating to mailing to each PO Box used for the routing and processing of paper claims.

Enhanced Accuracy

- Audit Trail: Acknowledgement (999 and 277CA) reports establish an audit trail. The reports include pertinent information such as Payer Claim Control Number, NPI, and charges. Summary data is provided at the batch and claim levels.
- Prompt Notification/Correction of Errors: Providers are notified within 24-hours to three (3) business days of any claims that fail to pass Medical Mutual's pre-adjudication edits. This prompt notification allows the provider to make the necessary corrections. Corrected claims can then be resubmitted as a new claim electronically.

For questions related to the submission and/or rejection of claims contact EDISupport@MedMutual.com or call Voice Connect at (800) 362-1279.

To begin sending claims electronically to the Company, please notify your billing service, clearinghouse, or practice management software vendor.

Financial Investigation

The Financial Investigations department is a visible and aggressive component of the Company's cost containment efforts. The department's mission is to detect and investigate all allegations of unlawful activities aimed at corporate assets. When healthcare fraud is suspected, the unit seeks administrative, civil, and criminal remedies for the benefit of the Company's policyholders. The unit responds as follows:

- Administrative actions to recover monies lost and recommendations are made to ensure that fraudulent payments do not continue.

- Civil action is initiated to recover assets lost through fraudulent acts.
- When evidence dictates, cases are referred to the authorities for criminal prosecution.

In the past, most cases investigated have been generated by the Company's toll-free fraud hotline, (800) 553-1000. Although still a vital component for leads received by the department, the addition of sophisticated software and analytical tools has helped identify cases and corroborate tips. The addition of professionals with background in the areas of finance, technology, medicine, and law enforcement has placed the department in the forefront of combating fraud and abuse.

Since the inception of the department in 1983, Financial Investigations cases have led to the indictment of more than 600 individuals and/or corporations. The department has generated savings of more than \$157 million in fraudulent claims since 2003.

Risk Adjustment Data under Patient Protection and Affordable Care Act

As of January 1, 2014, the Patient Protection and Affordable Care Act of 2010 (ACA) requires insurers to complete and submit accurate risk adjustment data for members of risk adjustment covered plans. Medical Mutual, as an insurer that offers risk adjustment covered plans, is required to comply with this regulation.

Provider agrees to submit to Medical Mutual or its designee complete and accurate risk adjustment data, including medical records, data necessary to characterize the context and purpose of each encounter between a Covered Person and Provider, and all information reasonably necessary for Medical Mutual to meet its data reporting and submission requirements under 45 CFR 153.610 and other applicable State or Federal guidance or instructions ("Risk Adjustment Data").

Provider must submit requested material within 14 days of Medical Mutual's or its designee's written request, or as otherwise required pursuant to state or federal guidance.

Such Risk Adjustment Data shall be provided to Medical Mutual or its designee at no cost. If required by Federal or State regulations, guidance or instructions, Provider agrees to furnish a certification in writing that verifies to the accuracy, completeness and truthfulness of Provider's Risk Adjustment Data submitted to Medical Mutual.

ANSI ASC X12N 837I, 837P

Medical Mutual will reject claims that do not conform to the X12N 005010 837I/P requirements.

Completing the CMS-1500 Claim Form

Providers can view a copy of the CMS-1500 Claim Form, crosswalks, and instructions at NUCC.org.

- Instructions at <https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42>
- NUCC1500 Crosswalk at <https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/nucc-data-set-and-1500-837p-crosswalk-mainmenu-49>
- 1500 Claim Form at <https://www.nucc.org/index.php/1500-claim-form-mainmenu-35/08-05-1500-claim-form>

Please refer to the instructions for completion of the CMS-1500 Claim Form for specific requirements. The following information outlines the Company's expectations and items that will facilitate the prompt processing of the claim.

Patient Information (Items 1–13)

Item 1: Not required by the Company

Item 1A: Insured's Identification (ID) Number

ID number and contract number are found on the ID Card. The ID number identifies the Covered Person's enrollment and is one of the most important items on the claim form. If the correct Covered Person ID number does not appear in Item 1a, the Company is unable to process the claim and it will be returned.

Special Note:

- The Company has issued ID cards with computer-generated ID numbers that identify Covered Person(s).
- Always copy the ID number carefully and accurately from the ID card. It may be helpful to make a photocopy of the card for future reference before the Covered Person leaves the office. Be sure to take all information from the Covered Person's card on each visit because coverage may have

changed, and a new card may have been issued. Taking information from an obsolete card may cause a delay as well as errors in claims processing.

- Because the ID number is used to determine enrollment and coverage, it is essential that the correct number be listed on the claim form. If the number is incorrect, payment may be denied as the Covered Person does not appear to be enrolled with the Company.
- Do not include dashes, hyphens, spaces, or suffixes.

Item 2: Patient's name

- The name as it appears on the claim is compared by computer to the names registered as eligible subscribers and dependents to determine whether payment should be made for services rendered to the Covered Person.
- A nickname or different spelling from the Covered Person's registered name will delay claims processing and may result in the denial of payment for services rendered.

Item 3: Patient's Birth date and sex

- This information is important for several reasons, including verification of enrollment and detection of errors in procedure and/or diagnosis coding that may result in an incorrect payment for services rendered.
- If date of birth is missing or does not match our membership records, payment may be delayed.

Item 4: Insured's (Cardholder's) name

Use the name as it appears on the ID card; otherwise payment may be delayed.

Special Note:

The cardholder's name is used to verify the ID number.

Item 6: Patient's relationship to insured

The relationship, as given on the claim and the name are compared to the cardholder's registered dependents to determine whether the patient is a Covered Person. This information is also used, along with name and date of birth, to access claims history and to accumulate deductible or benefit limits.

Item 9A–9D and Item 11D: Other Health Insurance

- This information is necessary even if the billed services are not covered by the other insurance company. It is important that the Company be informed that other insurance coverage exists.

- If the service is billed first to the other insurance company, evidence that the claim has been processed and finalized by the other coverage must be provided.
- The Company accepts Coordination of Benefits (COB) Professional and Institutional claims electronically. The Company does not require a paper Explanation of Benefits (EOB) when COB claims are submitted electronically. For paper submissions, a copy of the prior payer(s) EOB must be attached. Up to ten(10) prior payer EOBs will be accepted.
- See Section 5 – Other Carrier Liability of this Manual for more information regarding claims submission when more than one insurance coverage is involved.

Special Note:

If the other insurance company was not able to make its final benefit determination due to missing, incomplete, or invalid information, neither will the Company.

Item 10A–10D: Is Patient’s Condition Related to: (A) Employment, (B) Auto Accident, (C) Other Accident (required), or (D) Claim Codes (designated by NUCC)

- The information in Item 10 is necessary to determine whether another person or insurance coverage may be liable for these expenses. This information will not delay claims processing but will allow the Company to recover any duplicate payments after the Company pays the claim.
- Certain benefits are available only for services resulting from an accident. If not identified as accident related, the full benefit may not be allowed.
- See Section 5 – Other Carrier Liability of this Manual for more information regarding workers’ compensation and subrogation.

Item 11: Insured’s Policy, Group or FECA Number

This is a five-digit or nine-digit number that is printed on the ID card. It identifies the account through which the Covered Person is enrolled.

Special Note:

- Group numbers for local accounts are usually nine numbers. National accounts may be represented by five numbers (e.g., 83200).
- The group number is not required by the Company.

Item 12: Patient’s or Authorized Person’s Signature

This item is provided for the signature of the Covered Person or other person authorized to consent to the release of medical information necessary for claims processing.

Item 13: Insured’s or Authorized Person’s Signature

This item is provided for the signature of the Covered Person or other person authorized to consent to payment of medical benefits to the provider.

Patient Physician/Supplier Information (Items 14-23)

Item 17: Qualifier/Name of Referring Physician or Other Source

This name must be on the claim form if services include a consultation.

Item 18: Hospitalization Dates Related to Current services

Benefits for inpatient services cannot be correctly administered if hospitalization dates are missing.

Item 19: Additional Claim Information (Designated by NUCC)

Reporting a Z-Code Identifier on a CMS-1500 Claim Form

The Company requires that Providers report Z-Codes, when applicable, in Item 19 using the appropriate qualifier. If Providers do not, reimbursement may be impacted.

Professional	Placement of Z-Code Identifier
Paper	
CMS-1500 Claim Form	In the comment field at the header level (Box 19)
Electronic	
837P	In the professional service line (SV101-7)

1500 Claim Form Z-Code Identifier location, Box 19:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Item 21: Diagnosis or Nature of Illness or Injury

- Diagnosis code(s) are required on all claims, regardless of the service rendered.
- ICD indicator “0” is required (indicating ICD-10-CM), unless a new rule or law allows the use of the ICD-11-CM or ICD-11-PCS code set.
- List the primary and secondary ICD-10-CM(s) in priority order.
- Do not provide narrative description in this field
- Be aware of numbering order (e.g. No third diagnosis if second diagnosis is blank).
- Do not duplicate diagnosis codes.

- Up to 12 diagnoses can be reported on one form. If additional diagnoses need to be reported, a separate form is required.

Item 22: Resubmission and/or Original Reference Number

The appropriate bill frequency code must be reported when submitting a replacement or void/cancel of a prior claim. In addition, the Payer Claim Control Number from the electronic payment/advice (835) or Notice of Payment is required to be reported. If the Payer Claim Control Number is missing, payment may be delayed.

Item 23: Prior Authorization Number

The authorization number, as assigned by the Company, in its response must be reported on the claim when the services that were authorized are reported on the claim. Otherwise, payment may be delayed if it is missing.

Service(s) Rendered (Items 24A-24J)

- Items 24A–24J are used to provide specific information about the services or expenses being claimed.
- Six (6) lines are available on each claim form.
- Only one service is to be billed per line item.
- In some cases, multiple services may be combined as a single line item.
- All related claims should be submitted at the same time if possible. (DO NOT staple multiple forms together.)
- Superbills will not be accepted

Item 24: Dates of Service

- In the case of interpretation or other services performed later, the date of service should be reported as the date of encounter with the Covered Person.
- In some cases, multiple dates of service may be combined as one line item. Refer to NUCC 1500-claim form instructions.
- When multiple dates of services span two different calendar years, the dates, units, and fees should be split and listed as a single line item. Separate claim forms must be submitted for services rendered in separate years.

Item 24B: Place of Service (POS)

- The Company follows the standard POS code guidelines, as standardized by CMS for professional claims. For more information visit <https://www.hhs.gov/guidance/document/cms-place-service-code-set>.

- An error in POS or use of a code other than a CMS code may result in denial of the service or an incorrect reimbursement amount.

Item 24D: Procedures, Services or Supplies (Explain Unusual Circumstances)

- CPT codes define medical procedures, services, and tests. HCPCS codes represent several other non-provider healthcare expenses not found in the CPT book, such as eyeglasses, supplies and equipment, prosthetics, and ambulance service.
- Because procedure codes affect the determination of benefits, those codes must be assigned carefully and accurately.
- For specific coding guidelines, refer to Coding Instruction in this Section, as well as the instructions included in the CPT/HCPCS manuals.
- Do not include CPT or HCPCS description.
- Use of the shaded “supplemental info” area should be kept to a minimum to report unusual circumstances and only be used to report anesthesia time and NDC numbers in the 5-4-2 format.

Reporting an NDC on a CMS-1500 Claim Form

Drug products are assigned a unique 10-digit, 3-segment number by the U.S. Food & Drug Administration (FDA). This number, known as the National Drug Code (NDC), identifies the labeler, product, and trade package size. The NDC will be in one of the following configurations: 4-4-2, 5-3-2, or 5-4-1.

Medical claims, however, require the NDC to be converted to an 11-digit number in a 5-4-2 format, without any hyphens.

Converting NDCs from 10-digits to 11-digits ([NDC 5-4-2 format](#)):

10-Digit Configuration	Actual 10-Digit Example	11-Digit Conversion Example (hyphens are for illustration purposes only)
4-4-2	0002-7597-01	<u>0</u> 0002-7597-01
5-3-2	50242-040-62	50242- <u>0</u> 040-62
5-4-1	60575-4112-1	60575-4112- <u>0</u> 1

Use Item 24 to report a National Drug Code (NDC) on a CMS-1500 Claim Form.

- NDC unit of measures must be reported.
- Use ME to report Milligrams.

- Valid CPT/HCPCS code(s) and NDC identifiers must be entered on the claim form. If the NDC does not have a specific CPT/HCPCS code, assign the appropriate miscellaneous code per Centers for Medicare and Medicaid correct Coding Guidelines.
- **You cannot bill more than one NDC per service line.**
- For electronic claims, the NDC qualifier (N4), NDC Code (5-4-2 format, no hyphens), NDC Quantity and Unit of Measure are submitted in the 2410 loop.

Procedure Code Modifiers

This is a two-digit code which further defines the service represented by the procedure code.

- Modifiers are required when the charge is for:
 - Distinct Procedural Service – use Modifier 59
- Non-E/M procedure or service that is distinct or independent from other non-E/M services performed on the same day by the same provider. The procedure or service must be medically necessary and appropriate under the circumstances and not be normally performed and reported on the same day by the same provider – Use Modifier 59. When using Modifier 59, medical record documentation should establish medical necessity for the:
 - Different session or patient encounter
 - Different procedure or surgery that is distinct and independent
 - Procedure or surgery on different site or organ system
 - Separate incision/excision
 - Separate lesion
 - Separate injury (or area of injury in presence of extensive injuries)

It is the policy of the Company that Modifier 59 must be also place on the add-on code if utilized on a primary code. Add-on codes include certain procedures that are commonly performed in addition to the primary procedure. These additional or supplemental procedures are designated as add-on codes with the symbol “+” and they are listed in Appendix D of the CPT Manual. Add-on codes should never be reported as stand-alone codes.

- Secondary multiple surgeries – use Modifier 51.
- Professional component – use Modifier 26.
- Durable Medical Equipment (DME) requires a rental/purchase modifier. The following modifiers are valid values and can be used when billed:
 - NR – New when rented (Use the ‘NR’ Modifier when DME which was new at the time of rental is subsequently purchased)
 - NU – New Equipment

- RR – Use when DME is to be rented
- UE – Used Durable Medical Equipment
- LL – Lease/Rental (Use the ‘LL’ Modifier when DME Equipment Rental is to be applied against the purchase
 - Significant separately identifiable Evaluation and Management (E&M) service performed by same provider on same date of service as another procedure or service, an E&M that resulted in a decision to perform a minor surgery – use Modifier 25.
 - Evaluation and Management (E&M) that resulted in a decision to perform a major surgical procedure on the day of or the day before the surgery – use Modifier 57.
- Foot surgery, surgery assistance, ambulance, anesthesia or foot x-rays — refer to Foot and Toe Modifiers in this section for a list of foot and toe codes.
 - Without these modifiers, the service cannot be correctly defined. An inaccurate description of a service (e.g., omitting a required modifier) may result in unnecessary delays in processing or an incorrect reimbursement amount.
 - Although not required by the Company, the use of other modifiers is encouraged. A complete list of CPT modifiers can be found in Appendix A of the CPT manual.

Note: Up to four Modifiers may be assigned to one CPT procedure code, e.g., 73630-26-ZF.

Item 24E: Diagnosis Pointer

For each service billed, the primary diagnosis and up to three associated diagnoses relating to the procedure must be reported in descending order as identified by the applicable pointer code.

Special Note:

- On claims with multiple line items, not all services will necessarily be related to the same primary diagnosis.
- The primary reason(s) for the encounter should be coded as the primary diagnosis.
- A point code of “All” is invalid and if used may result in a delay in payment.
- Diagnoses are required to be reported in Item 21.

Item 24F: \$ Charges

- Do not combine charges unless specifically instructed by the Company to do so.
- To ensure consideration of all services, charges should be itemized for each procedure and be represented by a separate procedure code. Do not itemize charges for services which are incidental,

included in the global allowance for another billed procedure, or for which there was no charge. Refer to Coding Instructions in this section.

- Decimal points and cents should always be clearly indicated to avoid data entry errors that may possibly result in an incorrect reimbursement amount.
- Do not place a space between dollars and cents; use a decimal.
- Do not use commas. Dollars should be reported without any other punctuation or symbols.

Item 24G: Days or Units

- A number must be provided when it is specifically required by the procedure code description (e.g., per hour, each test, or indicate number of tests).
- A number is also required when multiple services are combined into one line item on the claim form. (See Combining Multiple Services in this section.)
- Do not circle units' value.
- If only one service is provided, the numeral 1 must be entered.

Item 24J: Rendering Provider ID

The rendering provider's NPI must be submitted in this field.

Provider Information (Items 25-33)

Item 25: Federal Tax ID Number — TIN/EIN/SSN

This is the number assigned by the Internal Revenue Service or Social Security Administration that is used by the provider to report income that is paid by the Company. For hospital-based anesthesia, radiology, pathology and emergency room providers, the Group ID should be reported here and in Item 33. Dashes, hyphens or spaces should not be included in the number.

Item 26: Patient's Account Number

If a provider uses an account or case history number to identify Covered Persons, it may be included in this space. If included on the form, it will be recorded on the Notice of Payment or 835.

Item 27: Accept Assignment (For Medicare Related Claims)

The Company determines the direction of payment according to the provider's participation status and contract or group contract provisions. The provider assignment on the claim form is not used by the Company and will not alter the direction of payment, unless required by state law. However, for Medicare medical claims, payment direction is based on the provider's assignment as reported in this field.

Item 28: Total Charge

The total charge is used for balancing against the amount(s) charged for each service reported on the claim.

Special Note:

- Multiple page claims: The total on each claim form should be the sum of all charges on that specific form, not all forms.
- Do not place a space between dollars and cents; use a decimal.
- An accurate total is very important to prevent data entry errors and to clarify any question regarding itemized charges.

Item 31: Signature of Physician or supplier, including degrees or Credentials (I certify that the services were rendered by me or under my direct supervision.)

If a group practice, do NOT list the name of the group in this item; the signature of the provider who supplied the service is required in this item. This information is necessary to ensure accurate and timely claims processing/payment.

Special Note:

- Name of provider should also be typed in this field.
- Signature should not cover up typed name.

Item 32: Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

If services are rendered in the patient's home, the name must be reported with the word RESIDENCE and use the patient's address as the address in this item.

Item 33: Physician's/suppliers Billing name, Address (including any suite number), ZIP Code and Phone number

- The billing provider's NPI should be submitted in item 33A.
- If claims are being submitted for more than one provider from the same office location or for a group practice, be certain that the correct provider of service is identified on each claim.
- Services performed by one provider but reported on claims of an associate may delay payment due to differences in specialty or apparent duplicate billing when services have been performed by both providers.
- The full name of the city must be reported as abbreviations may cause the claim payment to go to the wrong provider.
- Include zip code + 4 when possible. However, using all zero's or 9's in the +4 is invalid.

Coding Instructions for Selected Services and Related Billing Policies and Procedures (Revised)

Ambulance

Ambulance service is transportation by a specially designed and equipped vehicle used for transporting the sick and injured, including sea and air transportation. The vehicle must have patient care equipment and supplies. Vans for transport of patients to and from clinics, provider's offices, or for other personal errands are not considered ambulance service.

Claims for an ambulance service should be submitted on the CMS-1500 Claim Form, completed as for any other service, with the following exceptions:

Item 10: Was Condition Related to Accident

Always be sure to indicate if the condition resulted from an accident rather than an illness. Otherwise, benefits may not be available.

Item 14: Date of Current Injury, Illness or Pregnancy

This date is needed to determine whether benefits are available based on the date ambulance transportation was necessary because of an accident or injury.

Item 24B: Place of Service (POS)

The POS for ambulance transportation must always be 41. Any other POS will delay processing because of an invalid relationship of a procedure to the POS.

Item 24D: Procedure Code

Assign the appropriate HCPCS code for ambulance services.

Item 24D: Modifier

Origin and destination modifiers must be used when reporting ambulance services. The modifiers are created by combining two alpha characters. The first letter must describe the origin of the transport (pick-up) and the second letter must describe the destination (drop-off).

Item 24F: Charges

Submit itemized services with a separate procedure code with origin and destination modifiers for each service billed.

Anesthesia

Anesthesia Modifiers Revision

Medical Mutual follows the American Society of Anesthesiology (ASA) guidelines for submitting modifiers. Anesthesia claims received without the appropriate modifiers to accurately reflect the services provided will not be processed for payment. Prior to the effective date of Medical Mutual's Anesthesia Reimbursement Policy, the following will apply: Unless otherwise negotiated, reimbursement amounts will follow CMS guidelines for modifier reimbursement. Beginning on the effective date of Medical Mutual's Anesthesia Reimbursement Policy, the terms of Medical Mutual's Anesthesia Reimbursement Policy will apply.

If you are billing two separate claims or claim lines, one for CRNA and one for the Anesthesiologist, you must bill with all appropriate CRNA and Anesthesiologist modifiers on the appropriate lines.

Anesthesia Billing Requirements

Anesthesia services can be billed using either the appropriate CPT procedure code or American Society of Anesthesiology (ASA) code. Anesthesia services are defined as monitored anesthesia care.

The use of invasive monitoring techniques, such as arterial lines, central venous catheters, and Swan-Ganz, must continue to be billed using the appropriate CPT code for the procedure. Pain Management providers, likewise, must bill using the appropriate CPT code for the services rendered.

Anesthesia Paper Claims Submission

Base Units

Do not indicate base unit values in Item 24, Box G.

Base units are determined as defined by the American Society of Anesthesiologists Relative Value Guide. The base units assigned to a procedure are intended to demonstrate the relative complexity of a specific procedure and include the value of all anesthesia services, except the value of the actual time spent administering the anesthesia. The Company will calculate the anesthesia payment of the base units according to the information provided on the claim.

Reporting of Anesthesia Time

Anesthesia time begins when the anesthesiologist starts to prepare the Covered Person for the induction of anesthesia in the operating room or in an equivalent area. Anesthesia time ends when the anesthesiologist is no longer in personal attendance, which is when the Covered Person may be safely placed under postoperative supervision. Time units are calculated by allowing 1 unit for each 15 minute interval

or remaining fraction thereof. Providers are to show time as total number of minutes in Item 24, Box G.

Maximum Billable Time Allowed for Delivery (Maternity)

Maximum billable time allowed for a normal delivery is 300 minutes (20 units); maximum time allowed for a C-section is 360 minutes (24 units). If delivery is started as a vaginal delivery but becomes a C-section delivery, the maximum time is 360 minutes (24 units).

Physical Status Modifiers

Any request for reimbursement of Physical Status Modifiers (P1-P6) must be included in Item 24, Box D, with the CPT procedure code being billed. If the Physical Status Modifier is P3-P6, provide additional diagnosis/ comorbidity to support additional reimbursement of the modifying unit or supporting documentation in the anesthesia record. Failure to provide this information will result in the claim being processed without consideration for the modifier. Charges for the Physical Status Modifier are to be included with the charges for anesthesia services, in Item 24; Box F. Physical Status Modifiers are used to distinguish among various levels of complexity of the anesthesia service provided.

DO NOT enter additional minutes in Item 24, Box G (days or units) for Physical Status Modifiers. If eligible for reimbursement based on additional diagnosis/comorbidity or supporting documentation in the anesthesia record, reimbursement will be made in accordance with the Covered Person's benefit plan.

The Covered Person cannot be billed for Physical Status Modifiers not allowed by the Company.

Qualifying Circumstances Revision

Prior to the effective date of Medical Mutual's Anesthesia Reimbursement Policy, the following will apply: CPT codes 99100, 99116, 99135, and 99140 represent various Covered Person conditions that may impact the anesthesia service provided. Such codes may be billed in addition to the anesthesia being billed. Charges for these codes are to be shown on the same line as the CPT Qualifying Circumstances code in Item 24, Box F. The Covered Person cannot be billed for qualifying circumstances not allowed by the Company. Beginning on the effective date of Medical Mutual's Anesthesia Reimbursement Policy, the terms of Medical Mutual's Anesthesia Reimbursement Policy will apply.

Patient Controlled Analgesia

The initial set up/visit and any subsequent daily maintenance associated with Patient Controlled Analgesia (PCA) must be reported under ASA code 01996. The initial set up/visit and up to three occurrences of daily maintenance of PCA will be considered eligible for reimbursement.

Continuous Epidural Infusion

If Continuous Epidural Infusion is used as the primary method of anesthesia for a surgical procedure, insertion of the catheter is included in the base units for the procedure and is not reimbursed separately. Claims for the service must be submitted using the CPT code for the surgical procedure, not CPT code 62319. For example, a claim for Continuous Epidural Infusion for anesthesia during routine labor and delivery should be submitted using CPT code 59400 and the appropriate number of time and/or modifying units. If Continuous Epidural Infusion is used for postoperative analgesia, the insertion of the epidural catheter should be billed using ASA code 01996, as well as the CPT code for the surgical procedure. Any subsequent days of analgesia should also be billed using ASA code 01996.

Conscious Sedation

Sedation with or without analgesia (conscious sedation), intravenous, intramuscular or inhalation is considered eligible for reimbursement when billed by:

- An anesthesiologist, pain management, or certified registered nurse anesthetist or
- The same provider performing the procedure and the patient is 16 years of age or younger

Swan-Ganz, A-line, and Placement of Central Venous Catheter (CVC)

These services are not subject to the multiple surgery cutback. Each service will be considered eligible for reimbursement at 100 percent of the allowed amount. The procedures should be billed in addition to the anesthesia services.

Dental Anesthesia

General anesthesia is a benefit when administered for a covered dental service when the anesthesia is rendered by an individual licensed to administer general anesthesia, including the operating surgeon, providing the procedure could not be reasonably and customarily performed under local anesthesia. The service is payable under the Dental Subscriber Certificate.

General anesthesia is a benefit under the Medical Subscriber Certificate when administered for a non-covered dental service, if the procedure requires general anesthesia due to complexity or length, or the Covered Person's condition is such that general anesthesia is required. The anesthesia may be rendered by any individual licensed to administer general anesthesia, including the operating surgeon. Anesthesia or Certified Registered Nurse Anesthetist (CRNA) services are reported at a group level.

Durable Medical Equipment (DME) Billing Guidelines

DME providers should bill in accordance with CMS guidelines. Proof of delivery is required. At such time Medical Mutual determines an item should be purchased rather than continuing to rent, all accumulated rental reimbursement shall be applied toward and capped at the purchase price of the item under the fee schedule in the Provider Agreement.

Endoscopic Billing Procedures

When submitting a claim for screening endoscopic services, please list the appropriate ICD-10-CM diagnosis code for screening (Z12.10 - Z12.13, Z80.0, Z83.71).

The screening Z code should be listed first on the claim even if a medical condition(s) (e.g., polyp, adenocarcinoma) is discovered during the procedure.

In addition to the screening code, list the appropriate diagnoses codes to indicate all medical conditions that were detected during the screening endoscopic procedure.

The screening Z code should also be listed first on the claim for a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography).

Global Surgery Rules

Surgical procedures are subject to global pricing reimbursement. All visits or services performed by any provider during the global surgical period for a diagnosis related to the surgical procedure are subject to the following global guidelines:

Major Procedures

Visits or services one day prior to and up to 90 days after a major procedure are included in the global reimbursement for the major surgical procedure. The following are considered major procedures:

- Major surgery
- Fracture/dislocation care
- Podiatry procedures
- Obstetrical procedures
- Anesthesia

Minor Procedures

Visits or services on the same day as a minor procedure are included in the global reimbursement for the minor surgical procedure.

Medical Drug Management

National Drug Codes

Medical Mutual requires that National Drug Code (NDC) identifiers be submitted on all professional and outpatient claims when billing for all medications and diabetic supplies. This will allow us to process medical drug claims and avoid delays in provider reimbursement more efficiently.

Affected claims must have a valid Healthcare Common Procedure Coding System (HCPCS) code and NDC identifiers, which include the 11-digit drug code (5-4-2 format), quantity of medication dispensed and unit of measure.

Billing for Discarded Drugs

Medical Mutual requires the modifier JW on claims submission 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 authorization process.

The modifier JW ensures the patient received the dosage approved during the prior authorization 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 Healthcare Common 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 a 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 3 mg 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.

Medical Mutual expects that, in addition to the amount of drug or biological administered to the patient, provider's document in the patient's medical record:

- The date the drug is discarded
- The time the drug is discarded
- The amount of drug discarded
- The reason for the drug being discarded

A provider cannot bill for discarded drugs if not administered to a patient (for example, in the case of a missed appointment). In addition, the amount billed as discarded cannot be administered to another patient.

The Company expects providers to use the most cost-effective vial of drug when procuring and preparing a dose for administration and reimburses accordingly. 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.

Billing for Single-Dose Vial Drugs

Medical Mutual requires the JZ modifier on claims submission for drugs and biologicals supplied in single-dose containers (including single-use vials) and there are no discarded amounts. The JZ modifier is a HCPCS Level II modifier reported on a claim to attest that no amount of drug was discarded and eligible for payment. The modifier should only be used for claims that bill for single-dose container (including single-use vial) drugs. The modifier is necessary for processing claims for single-dose containers of drugs subject to Medical Mutual's prior authorization process.

When a billing provider or supplier administers a drug from a single-dose container/vial and there are no discarded amounts, the provider or supplier must file a claim with one line for the drug. For the administered amount, the claim line should include the billing and payment code (such as HCPCS code) describing the given drug, the JZ modifier (attesting that there were no discarded amounts), and the number of units administered in the units' field.

The JZ modifier is to be reported on UB-04 and CMS-1500 claims. The JZ modifier does not apply for drugs that are not separately payable, such as packaged OPPS or ASC drugs. The JZ modifier is not required for vaccines.

Effective October 1, 2023, Medical Mutual will deny claims not submitted as requested above.

Molecular Diagnostic Tests

Mandatory Z-Code Identifiers

The lack of specificity of molecular diagnostic CPT codes can make it difficult for payers to manage the cost of care and make informed coverage decisions. To better identify and evaluate what molecular diagnostic tests are being ordered and why, Medical Mutual works with the Palmetto GBA, LLC DEX™ Diagnostics Exchange to provide laboratories with unique Z-Code Identifiers.

Payment for molecular diagnostic tests will be rejected without Z-Code Identifiers.

Laboratories must provide information on the molecular diagnostic tests they perform, including any future changes or additions, to the DEX™ Diagnostics Exchange.

Z-Code Identifiers should appear on a claim as follows.

Claim Type	Placement of Z-Code Identifier
Paper	
UB-04	In the comment field at the header level (Box 80)
CMS 1500	In the comment field at the header level (Box 19)
Electronic	
837P	In the professional service line (SV101-7)
837I	In the institutional service line (SV202-7)

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.

Surgical Procedure Modifiers

A surgeon may perform part of the global surgical package, identified by certain modifiers.

Modifier 54 identifies surgical care only and payment to the provider will be based on the CMS Physician Relative Value File intra-op percent. Reduction in payment only applies to codes with an intra-op percent assigned to such codes in the CMS Physician Relative Value File.

Modifier 55 identifies post op care only and payment to the provider will be based on the CMS Physician Relative Value File post-op percent. Reduction in payment only applies to

codes with a post-op percent assigned to such codes in the CMS Physician Relative Value File.

Modifier 56 identifies pre op care only and payment to the provider will be based on the CMS Physician Relative Value File pre-op percent. Reduction in payment only applies to codes with a pre-op percent assigned to such codes in the CMS Physician Relative Value File.

Modifier 78 identifies an unplanned return to the operating room and payment to the provider will be based on the CMS Physician Relative Value File intra-op percent. Reduction in payment only applies to codes with an intra-op percent assigned to such codes in the CMS Physician Relative Value File.

Modifier 52 indicates reduced services were performed and the provider will be paid for such services at 50% of the allowed fee schedule.

Modifier 53 identifies discontinued services. Services billed with this modifier will be clinically reviewed to determine the percent of services that were completed. The provider will be paid for such services at the determined percentage of the allowed fee schedule.

CMS Multiple Procedure Payment Processing Revision

Medical Mutual uses the CMS Relative Value file and values 3, 4, and 5 on the CMS Physician Relative Value file for multiple procedure payment reduction.

Multiple Surgeries and Services

Value 2 and 3: Multiple Surgeries

When multiple surgeries are performed on the same date of service, the primary procedure is reimbursed at 100 percent of the allowed fee schedule, and subsequent procedures are reimbursed at 50 percent of the allowed fee schedule. When multiple surgical procedures are required, the claim for the services should be submitted using the following steps:

- A separate, itemized charge should be submitted for each procedure.
- Claims should identify, by single line item, each surgical procedure with a proper CPT code.
- The primary procedure should be listed first, followed on subsequent lines of the claim by secondary procedures.
- Secondary procedures may be identified by including Modifier 51
- No charge should be made for incidental procedures or for procedures included in the global reimbursement for another procedure.
- No charge should be made for the amount in excess of the reduced allowed reimbursement amount for the secondary procedures

Some services that are classified as surgical procedures may be performed by anesthesiologists. The procedures most performed by anesthesiologists are insertion of Swan-Ganz catheters, central venous lines, and arterial lines.

The Company prices multiple minor surgical procedures performed on the same day at the following rate: 100 percent for the procedure with the highest customary and 50 percent of the customary for each successive surgical procedure.

Value 3: Endoscopic reductions

For services that share a base endoscopic procedure, Medical Mutual will reimburse the endoscopy with the highest fee schedule (if the base is shared). For subsequent codes, Medical Mutual will reimburse the difference of the next highest fee schedule and the base endoscopy.

Value 4: Diagnostic imaging

Primary procedure is allowed at 100 percent of the fee schedule amount and subsequent procedures will be reduced by 50 percent of the technical component portion of the fee schedule.

Value 6: Diagnostic cardiovascular services

Primary procedure is allowed at 100 percent of the fee schedule amount and subsequent procedures will be reduced by 25 percent of the technical component portion of the fee schedule.

Value 7: Diagnostic ophthalmology services

Primary procedure is allowed at 100 percent of the fee schedule amount and subsequent procedures will be reduced by 25 percent of the technical component portion of the fee schedule.

Bilateral Surgical Procedures

Bilateral surgical procedures are considered multiple surgical procedures. The claim should be submitted with the Modifier 50 assigned to the appropriate CPT code.

The number entered in Item 24G (days or units) on the CMS-1500 should be 001. The procedures will be reimbursed at 150 percent of the allowed fee schedule.

Combining Multiple Services

Services may be combined only when the procedure code and POS are the same for each service, except during the last quarter of the year (i.e., October, November, and December). Many policies include a Deductible Carryover provision, which allows deductibles taken during the last quarter of the year to carry-over in the next year to help satisfy the deductible requirement for the following year. For

this reason, last quarter deductibles must be accumulated separately.

Two or More Surgeons During One Operative Session

If each of **two surgeons with different specialties or skills** work on a different surgical problem involving **separate body systems** during the same operative session, Modifier 62 should be assigned to the CPT procedure code on each provider's claim to identify separate services.

If **two surgeons with similar skills** work on a specific surgical problem involving the same major body system during the same operative session, each provider should submit a separate claim with Modifier 62 assigned to the CPT procedure code to indicate co-surgery.

If more than two surgeons work together on a specific surgical problem involving **multiple major organ systems** during the same operative session, charges should be identified with Modifier 66 assigned to the CPT procedure code to identify **team surgery**.

If services are not identified with Modifier 62 to indicate co-surgery or Modifier 66 to indicate team surgery, the second and subsequent claims received will be denied as duplicates.

Only services identified as allowable for co-surgery or team surgery as allowable by Centers for Medicare Services (CMS) will be eligible for reimbursement. Although not required by the Company, the use of CPT code modifiers is encouraged. An additional list of modifiers can be found in Appendix A of the CPT manual.

Combining Services on Multiple Dates

Processing requirements of certain benefits and pricing provisions dictate the following rules for combining services on multiple dates.

Services in different calendar years cannot be combined on one line item of a claim.

When services in different calendar years are unrelated, they should be submitted on separate claim forms.

Emergency Room (ER) Care

If ER care is performed by the same provider on the same date of service for any of the procedures listed below, the ER care will be approved, and the following services will be denied:

Professional component for

- Any diagnostic radiology
- Any diagnostic medical service
- Any diagnostic laboratory

Fracture care

Consultation

Office visit

If ER care is performed by the same provider on the same date of service for any of the procedures listed below, the ER care will be denied, and the following services will be approved:

- Inpatient hospital visit
- Hemodialysis
- Inpatient critical care
- Dislocation
- Observation room care

If the ER care is performed by the same provider on the same date of service for any of the procedures listed below, the ER care will be **approved** in addition to the following:

- Major surgery
- Minor surgery

Global ER Procedures

Payment for non-surgical ER treatment classified as minimal, brief, limited, intermediate, and extended (CPT 99281– 99288) is based on definitions published by the AMA and American College of Emergency Physicians in the Procedural Terminology for Emergency Medicine, 4th Edition. Allowances for those services include reimbursement for history and physical examination, initiation of diagnostic tests and treatment, and preparation of patient care records. No separate additional charge may be made for any of those services.

No separate charges may be made for pelvic or rectal exams, which are part of the physical exam.

No separate ER provider charges may be made for supervision of procedures performed by hospital personnel (e.g., splint applied by physical therapist, peripheral IV or bladder catheter inserted by an RN).

No separate ER physician charges may be made for services performed by another provider specialist (e.g., reduction of closed fracture by an orthopedic surgeon).

Separate ER provider fees for interpretation are not billable or payable when a radiologist, pathologist, or a cardiologist is ultimately responsible for the interpretation and reporting of diagnostic test results.

Foot and Toe Modifiers

The Company uses HCPCS foot and toe modifiers for claims listing foot and toe procedures (including foot x-rays). Foot and toe modifiers are not required for claims submitted by anesthesiologists or radiologists.

Without these modifiers, the service cannot be correctly defined. Inaccurate description of service(s) by omitting a required modifier will result in unnecessary delays in claims processing or an incorrect reimbursement amount.

HCPCS Modifier	Description
TA	Left Great Toe
T1	Left Second Toe
T2	Left Third Toe
T3	Left Fourth Toe
T4	Left Fifth Toe
LT	Left Side
T5	Right Great Toe
T6	Right Second Toe
T7	Right Third Toe
T8	Right Fourth Toe
T9	Right Fifth Toe
RT	Right Side

Hospital Visits by the Surgeon

No charge should be made for a history and physical on the same date as surgery or hospital visit by the surgeon for which consideration is included in the surgical allowance. Separate charges for such services will be denied and are not billable to the Covered Person. However, hospital visits for which an additional charge is made because complications or other circumstances prolonged the length of stay beyond the usual should be billed with the appropriate prolonged CPT codes.

Obstetrical Care

Physicians should use the global CPT codes for a vaginal (59400), and C-section (59510) delivery codes for maternity care and delivery services. The claim should be submitted after the delivery, and E&M codes should not be used to reflect routine pre-natal and post-natal services associated with the delivery.

Special Note:

For the most current information visit - MedMutual.com/Provider, Policies and Standards, Reimbursement Policies, Obstetrical Care Reimbursement Policy.

Prenatal Care Visit

The Company reimburses separately for the first prenatal care visit, which should be performed within the first 12 weeks of pregnancy. This payment is in addition to the routine global obstetrical allowance for maternity care.

Use code H1000 Prenatal Care at Risk Assessment to report the initial prenatal care visit, if the visit is performed **within the first 12 weeks of pregnancy**. (NOTE: This code can be used when the pregnancy is confirmed.) The H1000 code is allowable when the Covered Person is being seen for a

maternal risk assessment and/or physical examination. Only one prenatal risk assessment visit is allowable per provider, nurse midwife or group practice.

HCPCS Coding and Billing of Preventive Medicine Services

Billing practices for Healthcare Common Procedure Coding System (HCPCS) codes billed in conjunction with Preventive Medicine Services should be checked as follows:

- HCPCS Codes for preventive examinations or screenings (G0101, G0102, Q0091, S0610, S0612 and/or S0613) are not separately payable when billed with Preventive Medicine Service CPT codes (99381- 99397)
- Pap smear (Q0091) is not separately payable when billed with annual gynecological exam HCPCS codes (S0610 or S0612)
- Annual GYN exam that includes a breast exam without pelvic exam (S0613) is not separately payable when billed with annual gynecological exam HCPCS codes (S0610 or S0612)

These services should not have been billed separately in the past, and they will not be reimbursed separately in the future.

Maternity Care and Delivery by Certified Nurse Midwives

The Company reimburses Certified Nurse Midwives (CNM) for providing care and management during antepartum, intrapartum and postpartum periods to women with normal obstetric development. CNMs may contract with the Company and must use their own provider number when billing for services. A CNM must perform care and management under the direction and supervision of a licensed provider.

The provider consultant should remain within a moderate distance to allow access to the Covered Person within a reasonable amount of time. Services not considered part of the CNM practice include:

- Amnioscopy
- Amniocentesis
- Fetal oxytocin test
- Management of acute obstetric emergency
- Instrumental vaginal delivery
 - Breach version
 - Fourth degree perineal lacerations, extensions* (*Service may be considered in case of an emergency)

Two CPT Category II Codes for the Initial Prenatal Care visit and Postpartum Care visit are now recognized to permit reimbursement for both in addition to the global obstetrical payment. Using these Category II Codes allows for greater

reimbursement for you and notifies us that timely prenatal and postpartum care visits have occurred.

CPT Code 0500F: Initial Prenatal Care Visit (Category II Code)

Use CPT Code 0500F to report performance of the Initial Prenatal Care Visit within the first 12 weeks of pregnancy.

This visit should include the following:

- History
- Blood work
- Physical examination
- Pregnancy risk assessment
- Pelvic exam

CPT Code 0500F may be used only after pregnancy has been confirmed. CPT Code 0500F also is eligible for reimbursement past the first trimester if a member transfers from one provider to another.

CPT Code 0503F: Postpartum Care Visit (Category II Code)

Please use CPT Code 0503F to report performance of the Postpartum Care Visit between 3 to 8 weeks after delivery.

The postpartum visit should include the date of the visit and documentation of at least one or more of the following:

- Pelvic exam or
- Evaluation of weight, blood pressure, breasts and abdomen

Circumcision and Newborn Exam

The Company allows both the newborn exam and circumcision (54150 or 54160, newborn only) to be performed on the same day, with the same or different provider.

Preventive Services Coding

The Affordable Care Act designates the preventive services that health plans must cover with no cost-sharing for members of non-grandfathered groups, when recommended by an in-network provider.

Medical Mutual follows guidelines recommended by the U.S. Preventive Services Task Force (A and B), the American Academy of Pediatrics (Bright Futures), and the U.S. Department of Health and Human Services. When billing for the annual wellness visits the following Current Procedural Terminology (CPT)1 codes should be used:

Well Child Examination: Birth to Age 21

The following CPT codes pay at 100 percent (limited to 31 visits from birth to age 21): G0438, G0439, 99381-99385, 99391-99395, 99420 and 99429.

Routine Physical Examination: Age 21 and Older

The following CPT codes pay at 100 percent (limited to one per benefit period): G0101-G0102, G0402, G0438, G0439, 99384-99387, 99394-99397 and 99429.

If the service is for preventive care, the appropriate preventive care diagnosis code also needs to appear on the claim. However, preventive care procedure codes are not covered when billed with a medical diagnosis as the primary diagnosis.

Services billed outside the established diagnosis, age or other criteria are eligible for reimbursement based on medical necessity and according to the member's regular, non-preventive benefits.

Physician Assistants, Advanced Practice Registered Nurses and other Non-Physician Providers (Revised)

The Company directly contracts with Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs).

Physician Assistants wishing to directly contract with the Company will need to furnish an application through CAQH. Physician Assistants must provide a copy of the Physician Assistants Certificate to Practice and a copy of the Physician Assistants Supervision Agreement when submitting their required paperwork to the Company.

It will be necessary to contact your Provider Contract manager to contract with the Company. See Section 1 – Introduction of this manual for regional Provider Contracting offices and phone numbers.

The Company contracts directly with advanced practice registered nurses ("APRNs"), which include certified nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified nurse anesthetists. All APRNs must register with the Company to allow their claims to process, using their own provider number. APRN services rendered can no longer be billed by a supervising provider.

APRNs and PAs are eligible to sign the Company Provider Agreement as well as make application to the Company's various networks (e.g., HMO, PPO). Failure to do so may result in a reduction in benefit. Persons covered under the Company's POS or HMO products are not allowed to choose an APRN as their primary care physician (PCP).

If you need to register or wish to contract with the Company as a provider, please contact your regional Provider Contracting office.

Medical Mutual considers the following provider types to be non-physician providers. As such, the non-physician provider will be reimbursed by Medical Mutual or its Accounts for Covered Services the lesser of the Provider's Charge or the percentage indicated below of the then-current Physician Fee as described in the Provider's agreement minus the sum of the Covered Person's Obligations

Non-Physician Provider Type	% of Physician Fee
Advanced Practice Registered Nurse	85%
Behavioral Health (Non-MD/DO)	85%
Convenience Clinic	85%
Diabetes Management	85%
Genetic Counselor	85%
Occupational Therapy	100%
Physical Therapy	100%
Physician Assistant	85%

Outpatient Services

A Covered Person is considered an outpatient until an inpatient admission is made to a healthcare facility. Charges for pre-admission testing (PAT) submitted using inpatient CPT codes 99221 through 99239 in an outpatient place of service (POS) will be denied. The outpatient POS is correct for PAT services, but CPT codes 99221 through 99239 are clearly reserved for services rendered in an inpatient setting. Use of such conflicting procedure and POS codes is inappropriate and will not be reimbursed by the Company.

The Company reimbursement to the attending provider includes history and physical, and pre- and post-operative office and/or hospital visits rendered in conjunction with any major or minor surgical procedure(s). Consequently, claims for history and physical rendered in conjunction with PAT should not be separately submitted to the Company, nor should the Covered Persons be billed for those services.

HCPSC Codes Required for Revenue Codes 0634, 0635 and 0636

Health Care Procedure Coding System (HCPSC) codes are required on outpatient claims submitted with revenue codes 0634, 0635 and 0636. Any claims submitted to Medical Mutual with revenue codes 0634, 0635 and 0636 without a

HCPSC code will result in claims being returned to the provider and payment delays.

Home Healthcare Billing Must Reflect Visits

When home healthcare providers bill with revenue code 551, the units must reflect the number of home health visits and should not be recorded as amount of time spent for the visit. The billing unit is a visit measurement, not a time measurement.

Using the appropriate billing unit reference ensures home healthcare visits are correctly applied against the number of authorized visits. Avoid using time measurements in home healthcare billing, which can result in claims being denied for exceeding the maximum number of visits allowed.

Vision Services Reimbursement

Vision care providers should note that the Company's payment for a vision examination is payment in full for that service and the Covered Persons must not be balanced billed. Providers may bill the Covered Persons for amounts exceeding the standard amounts that the Company reimburses for lenses, frames, and contacts.

Physical Medicine Services (Chiropractic/Physical/Occupational) and Speech Therapy

Therapy visits are subject to benefit limitations which are determined by the Covered Person's individual contract.

Providers need to verify a Covered Person benefits by calling Provider Inquiry at 1-800- 362-1279 to determine the benefit structure, if any physical medicine or speech therapy visits have been used and, consequently, whether the Covered Person's benefits require that a Request for Additional Visits be made prior to providing services. Therapy provided in an inpatient hospital setting is not subject to the prior authorization review.

Providers are required to submit claims for services provided to the Covered Persons and may bill them for any non-covered items identified in the Covered Person liability column in the Notice of Payment.

Treatments denied as not medically necessary will not be reimbursed and cannot be billed to the Covered Person.

Routine or Screening Tests

ICD-9-CM diagnosis codes that begin with a "V" are defined as supplementary classification of factors influencing health status and contact with health services.

Codes V70-V82.9 are reserved for persons without reported diagnosis encountered during examination and investigation of individuals and populations. Those V codes should always

be assigned to identify routine or screening tests performed in the absence of specific symptoms. Do not use diagnosis code 780 (General Symptoms). If tests are related to an illness or injury, assign the appropriate diagnosis defining the specific condition.

Pass-Through Billing

Medical Mutual reserves the right to deny pass-through billing when identified. Providers should only be billing for the components of the lab service they perform: technical, professional or both.

Services Included in Intensive Medical Care

The Company considers certain services to be included in the allowance for intensive medical care visits. Separate charges should not be billed for services such as:

- Arterial blood gases
- Blood pressures
- Cardiac output
- Dressing changes
- EKG interpretation
- Gastric intubation
- Hematologic data review
- IV push medication
- Temporary transcutaneous pacing
- Vascular access procedures
- Ventricular management
- X-ray interpretation

X-rays

When x-rays are bilateral but there is no CPT code which specifies bilateral, assign the appropriate unilateral CPT code and enter number 002 in Item 24G on the CMS-1500 Claim Form.

Additional itemized charges should not be made, and the Covered Person should not be billed for extra views when the CPT code states complete or specifies a minimum number of views.

Extra allowance will be considered for additional views only when the CPT code specifically limits the number of views, and no CPT code is available for a greater number. The necessity of extra views must be documented in Item 24C by assigning Modifier 22 to the appropriate CPT code. Modifier 22 will refer the claim to the Company's Clinical Quality and Health Services department for individual consideration. Comparison views are not reimbursed.

Professional Component for Diagnostic X-ray Testing

When submitting a claim for interpretation of radiologic procedures, use Modifier 26. The POS indicated on the claim form should be the POS where the technical

component of the procedure was performed, even if the radiologic interpretation is done in a different location from where the technical component was performed. When submitting a claim for the technical portion of the radiologic procedure, use the Modifier TC.

CMS-1500 Claims Involving Medicare

Crossover and Medicare Supplemental Claims

When the Company is the secondary payer, it receives an electronic crossover file that is transmitted from Medicare intermediaries for both Part A and Part B claims (institutional and professional). The crossover file is promptly loaded to the Company's claim systems and has all the information necessary for processing the secondary payment.

If you experience problems with payment for crossover claims, contact your Provider Contract manager to make certain the correct Medicare Number/NPI is in the Company's system. If the Company does not have the correct number, claims pay to the Covered Person or pay incorrectly.

Due to the nature of the coverage and the involvement of other insurance companies, providers should pay special attention to requirements when submitting claims for Covered Persons with Medicare coverage.

Note: Claims must be filed first with Medicare Part B, except for Medicare eligible Covered Persons who are still actively employed. When the former occurs, please include the EOMB for consideration by the Company.

Due to the automatic crossover, there is no need to submit a supplemental paper claim to the Company. The Medicare Notice of Payment will contain the remark code of MA18, which indicates that the claim has crossed over electronically to the Company.

Claims should be submitted to the Company by the provider only when the remark code MA18 is NOT reported on the EOMB from the Medicare intermediary.

Before filing a CMS-1500 Claim Form with the Company, look for remark MA18 on the EOMB. Remark MA18 means that the claim has been automatically sent from Medicare to the Company. A second claim filed by the provider or Covered Person will be denied as a duplicate.

Completing the CMS-1500 Claim Form for Crossover and Supplemental Medicare Coverage

To facilitate claim filing, Medical Mutual registered to receive crossover claims directly from the Medicare contractor. However, if remark code MA18 is not listed on either the electronic remittance advice or EOMB, you will need to file the claim directly to Medical Mutual.

Special attention should be paid to the following items on the CMS-1500 Claim Form when completing claims for Covered Persons with Medicare coverage:

Item 4: Insured's Name

All Medicare and most Medicare complementary policies are single, meaning that only the cardholder is a Covered Person. Each Covered Person will usually have his or her own policy.

Look carefully at the name on the ID card. If the name on the card is not that of the Covered Person, ask whether he/ she has a card with his/her own name. That is important because the ID number will also be different on the cards for a husband and wife. Claims processing will be delayed when the CMS-1500 Claim Form is completed using information from the wrong ID card.

If the Covered Person is certain the card is correct, complete the claim accordingly. (A few groups do provide complementary coverage for both husband and wife under the same ID number, but that is rare).

Item 1A: Insured's ID Number

Be sure the ID number is obtained from the correct ID card. As previously noted, both husband and wife who are enrolled in Medicare usually have their own policies with different ID numbers.

Item 9A–9D: Other Health Insurance

Be sure to indicate Medicare and the name of the Covered Person's Part B carrier, nationwide or otherwise.

Always attach a copy of the EOMB to the claim form in the instances when a paper claim needs to be filed.

It is not enough to indicate only the amount paid by Medicare on the CMS-1500 Claim Form. Much more information is needed from the EOMB than just Medicare's allowance, deductible and payment. An EOMB must be submitted with each paper claim.

Be certain that the Medicare information is included for every service on the claim. Claims are often returned to the provider because the attached EOMBs are for different services and dates than those listed in Item 24A of the CMS-1500 Claim Form. If multiple claim forms are submitted for the same patient but for non-related services, be sure to

submit each with its associated EOMB. Do not submit multiple non-related claim forms with just one EOMB.

Item 24A–24J: Service(s):

Be sure that the services, dates, and charges on the CMS-1500 Claim Form are itemized in the same way that they were processed by Medicare. The individual charges on the EOMB must match those on the claim so that the Company can accurately identify Medicare's allowance for each service.

Note: It usually is unnecessary to submit a separate claim for supplemental professional coverage.

Tips for Filing Medicare Crossover Claims

Do NOT file claims with Medical Mutual until Medicare has made its final benefit determination and has indicated that you need to file the claim, otherwise, it will be considered a duplicate claim.

If EOMB Remark Code MA18 appears on your Medicare voucher, the Medicare intermediary has electronically filed the claim to the Company or the appropriate secondary carrier.

If a provider has not received the Company secondary payment and it has been 15 days since receiving the Medicare primary payment, a secondary claim should be submitted to the Company with the Medicare EOMB attached.

UB-04 Overview and Instructions

Recommended Format of the UB-04 if More Than One Page

If the number of revenue code lines exceeds 22, another page is required to complete the UB-04. On each page, except for the last page, print the information required in Items 1, 3, 4, 5, 6, 8, 12, 38, 50, 51 and 60, and the revenue information in Items 42 through 48. When going to other pages, be sure to complete the "Page of" on line 23.

Reporting Hospital Acquired Conditions and Present on Admission

Hospital Acquired Conditions (HAC) and Present on Admission (POA) Indicator Reporting is required to be reported for accurate reimbursement determination based on the Medicare Severity Diagnosis Related Group (MS-DRG) assignment.

A valid POA indicator needs to be recorded for ICD-10-CM diagnosis or external cause of injury (other diagnosis) code

transmitted on an inpatient claim unless the diagnosis code is exempt from POA reporting, per the ICD-10-CM Official Guidelines for Coding and Reporting.

Commercial claims will be rejected if submitted with invalid POA data. Hospitals exempt from CMS required POA reporting will not be impacted. Our Company will continue to evaluate its approach to POA coding and will notify providers of any potential changes prior to their implementation.

Completing the UB-04 Claim Form

SUBMIT ONLY THE TOP PAYER COPY OF THE UB-04. ITEMIZED STATEMENTS ARE NOT REQUIRED. (Note: If needed, an itemized statement may be requested.)

Special Note:

Please refer to the NUBC Official UB-04 Data Specifications Manual for billing requirements, Code Source 132 National Uniform Billing Committee (NUBC) Codes, and the UB-04 to 837I Crosswalk. Go to NUBC.org for any additional information that may be needed.

The following provides further information to ensure that there are no delays in payment.

Form Locator 4: Type of Bill

This is a code indicating the type of facility, bill classification and frequency. The type of bill must match the provider type and the services being provided. If the type of bill is incorrect, the claim will be denied and sent back for correction and resubmission. Please refer to the NUBC Official UB-04 Data Specifications Manual for the descriptions of each code.

Special Note:

The Company does not accept interim claims, except in certain circumstances, and they are subject to Prior Authorization terms and requirements, and reimbursement methodology.

Form Locator 5: Federal Tax Number

- Must be a valid Federal Tax ID Number
- Must match the provider's Federal Tax ID number on Medical Mutual records/files

Form Locator 6: Statement Covers Period

- Must be numeric
- When all services are rendered on the same day, use the same date for "From" and "Through"
- Should not be confused with Admission Date (Form Locator 12)

- Accepted format: MMDDYY

Form Locator 8: Patient Name/Identifier

Last name, first name and middle initial of the patient and the Company member ID as it appears on the ID card.

Form Locator 10: Patient Birth Date

Accepted format: MMDDCCYY

Form Locator 11: Patient Sex

Must be M or F

Form Locator 12: Admission/Start of Care Date

This is the date the patient was admitted to the provider for inpatient care, outpatient service or start of care.

Special Note:

- Must be less than or equal to Statement Covers Period reported in Form Locator 6
- Must be greater than or equal to Patient Birth Date reported in Form Locator 10
- Must be less than or equal to the date that the claim was received

Form Locator 13: Admission Hour

- Refer to the NUBC Official UB-04 Data Specifications Manual for when it is not required to be reported on inpatient claims.
- Valid characters: 00 through 23

Form Locator 16: Discharge Hour

This is the hour that the patient was discharged from inpatient care. Refer to the NUBC Official UB-04 Data Specifications Manual for when it is not required to be reported on inpatient claims.

This data element is not necessary for outpatient visits.

Valid characters: 00 through 23

Form Locator 18–28: Condition Codes

If failed to be reported when required, it may impact the processing of the claim or delay payment.

Form Locator 29: Accident State

Required when the services provided are related to an auto accident.

Form Locator 31–34: Occurrence Codes and Dates

If failed to be reported when required, it may impact the processing of the claim or delay payment.

- Accepted format: MMDDYY

Form Locator 35–36: Occurrence Span Codes and Dates

If failed to be reported when required, it may impact the processing of the claim or delay payment.

- Accepted format: MMDDYY

Form Locator 38: Responsible Party Name and Address

If a nine-digit ZIP code is used, use format XXXXX-XXXX

Form Locator 39–41: Value Codes and Amounts (Required if applicable)

Codes used to relate amounts or values to identify data elements necessary to process this claim.

Form Locator 42: Revenue Code

- Always use the specific code that reflects the service provided.
- On a multiple page UB-04, all the claim level detail is repeated on page with only the line items in the revenue code section varying.
- Line 23 contains an incrementing page number and total number of pages for the claim on each page.
- Revenue code 0001 – Total Charge – should be used on paper claims only and is reported on line 23 of the last page of the claim.

Form Locator 43: Revenue Description/ID Number/Medicaid Drug Rebate

- The descriptions should correspond with the Revenue Codes as defined by the NUBC.
- Required on paper claims only when applicable.

Form Locator 44: HCPCS/Accommodation Rates/HIPPS Rate Codes

This is the accommodation rate for inpatient bills and the CPT or HCPCS Codes applicable to ancillary services and outpatient bills or the Health Insurance Prospective Payment System (HIPPS) code.

Special Note:

- Inpatient Bills: Accommodations must be entered in Revenue Code sequence. Dollar values reported in this field must include whole dollars, the decimal, and the cents.
- When multiple rates exist for the same accommodation Revenue Code, e.g., semi-private room at \$300.00 and \$310.00, a separate revenue line should be used to report each rate and the same Revenue Code should be reported on each line.
- HCPCS Modifiers should be reported if they clarify or improve the reporting accuracy of the associated procedure code. The field accommodates a 5-

character HCPCS/CPT code and four 2-character modifiers per revenue line.

Form Locator 45: Service/Assessment Date

- Service date is required on outpatient claims.
- Creation date is required on all claims.
- Accepted Format: MMDDYY

Form Locator 46: Service Units

Required to be reported to identify the quantitative measure of services rendered by revenue category. If not numeric, ancillary units of service will be defaulted to one unit on each line item.

Special Note:

- Inpatient Room and Board: enter the number of days.
- Outpatient: enter the units of service.

Form Locator 47: Total Charges

Total charges pertaining to the codes reported in Form Locators 42 and/or 44.

- Indicate actual total charges
- Do not prorate the charges to reflect the percent of charges you estimate as payable
- Revenue Code 0001 must be listed on line 23 of Form

Form Locator 48: Non-covered Charges

- If present when required, it must be numeric.
- Must be less than or equal to Total Charges reported in Form Locator 47.

Form Locator 50: Payer Name

Primary payer should be listed first, followed by secondary payer. If Medicare is primary, it must be listed as primary payer on the first line, A.

Form Locator 51: Payer ID

There is no longer an adopted standard to identify health plans. Therefore, it is not required to be reported.

Form Locator 52: Release of Information Certification Indicator

The response is limited to information contained in this claim, no other information may be released.

Form Locator 53: Assignment of Benefits Certification Indicator

The Company does not accept assignment, except where required by law.

Form Locator 54: Prior Payments — Payer

- When required, it must be numeric.
- Must be less than or equal to Total Charges reported in Form Locator 47.

Form Locator 55: Estimated Amount Due — Payer

- If the provider chooses to report, it must be numeric.
- Must be less than or equal to Total Charges reported in Form Locator 47.

Form Locator 58: Insured's Name

- The Covered Person's name must appear exactly as shown on the patient's ID card.
- This must be alpha only.

Form Locator 60: Insured's Unique Identifier

- This is the unique ID number assigned to the Covered Person by the Company.
- Covered Person certificate numbers are usually 7, 9 or 12 characters in length.
- They can be all numeric or a combination of alpha and numeric.
- Extraneous data, such as service codes, that are not part of the certificate number MUST NOT be reported in this field, otherwise it may impact processing of the claim and delay payment.
- Required when for all payers that are reported in Form Locator 50.

Form Locator 61: Insured's Group Name

When applicable, the insured's group name must be reported for all payers that may have a responsibility to pay for this claim.

Form Locator 62: Insured's Group Number

List the group numbers of all payers that have a responsibility to pay for this claim exactly as they appear on the patient's ID card.

Form Locator 63: Authorization Code/Referral Number

This is the certification number issued by the Company when the admission was preauthorized.

Form Locator 64: Document Control Number (DCN)

This is the Payer Claim Control Number reported on the electronic remittance advice or Notice of Payment. It is required to be reported when submitting a replacement or voided/canceled claim.

Item 67: Principal Diagnosis Code and Present on Admission Indicator

Principle diagnosis code must be reported to avoid delays in payment.

Form Locator 67A-Q: Other Diagnosis Codes and Present on Admission Indicator

Do not report diagnoses that relate to an earlier episode and have no effect on the current episode of care.

Form Locator 69: Admitting Diagnosis Code

- Required on all inpatient admissions.
- Report only one admitting diagnosis.

Form Locator 70A–C: Patients Reason for Visit

Required for all "unscheduled" outpatient visits or upon the patient's admission to the hospital.

Form Locator 71: Prospective Payment System (PPS) Code

- The PPS code is used to accurately calculate the DRG reimbursement rate.
- Required when the provider is under contract with the payer to provide this information.

Form Locator 74: Principal Procedure Code and Date

This is the inpatient principal procedure performed and must be reported when applicable.

- Required on Home IV therapies.
- Must be a valid ICD-10-CM procedure code.
- Use of CPT/HCPCS codes may delay claim payment.
- Accepted format: MMDDYY.

Form Locator 74A–E: Other Procedure Codes and Dates

- Required on claim for an inpatient stay if other procedures were performed.
- Required on Home IV therapies.
- Date format: MMDDYY.
- Must be a valid ICD-10-CM procedure code.
- Use of HCPCS/CPT procedure codes may delay claim payment.

Form Locator 76: Attending Provider Name and Identifiers

- Name is required on all inpatient claims or encounters.
- Provider's NPI is required to be reported.

Form Locator 77: Operating Physician Name and Identifiers

- Name is required on all inpatient claims or encounters where a surgical procedure was performed.
- Provider's NPI is required to be reported.

Form Locator 78–79: Other Provider Names and Identifiers

- Name is required on all inpatient claims or encounters when another provider was involved.
- Provider's NPI is required to be reported.

Form Locator 80: Remarks Field

- Usage is in the judgment of the provider if it is believed additional information is necessary.
- Required for reporting any applicable Z-codes

Reporting a Z-Code Identifier on a UB-04 Claim Form

Z-Code Identifiers should appear on a claim as follows.

Claim Type	Placement of Z-Code Identifier
Paper	
UB-04	In the comment field at the header level (Box 80)
Electronic	
837I	In the institutional service line (SV202-7)

UB-04 Z-Code Identifier location, Box 80:

80 REMARKS

UB-04 Claims Involving Medicare

Medicare Claims Submission

Due to the nature of the coverage and the involvement of other insurance companies, providers should pay special attention to requirements when submitting claims for patients with Medicare coverage.

Medicare Supplementary — Electronic Claims

The Company accepts Medicare supplementary Crossover claims directly from several Medicare intermediaries.

By participating in the automatic Crossover program, hospitals receive faster supplementary claim payments and

eliminate the need to file paper Medicare supplemental claims with the Company.

Claims

Both Medicare inpatient and outpatient claims are eligible for the crossover process. To be transferred successfully, claims must meet basic edit requirements which generally can be satisfied by meeting Medicare's EMC billing requirements.

How the Crossover Process Works

Medicare identifies the Company's claims based on an eligibility file that the Company sends to the Medicare intermediary. The eligibility file is sent to the Medicare intermediary on a monthly basis. The Medicare intermediary cross-references their paid claims file with the eligibility file, and then automatically forwards properly identified claims to the Company once a week. That occurs at approximately the same time that hospitals receive their weekly Medicare remittance. As the Company feeds the claims into the claims system, providers will receive a listing on their normal Electronic Claims Detail Received Report of the claims that crossed over.

Providers should reconcile crossover reports received from the Company against Medicare's pay list. A paper claim does not have to be submitted to the Company if that claim appears on the Electronic Claims Detail Claims Received Report. If any claim listed in the electronic remittance advice does not appear on a Crossover report for seven days after receiving the remittance, providers may send the claim electronically directly to the Company by adhering to the instructions detailed under the next heading.

How to Submit a Claim Electronically When It Does Not Cross Over Properly

Claims that do not crossover electronically from Medicare should be included in the provider's regular electronic claims submission to the Company. Simply retrieve the claim on your system and complete the Medicare information exactly as it appears on the Medicare Remittance. The Other Insurance loops and segments must be completed as applicable and Medicare's payment disposition must be reported at either the claim level or service level.

Note: Make sure the billing vendor is aware that claims which did not crossover electronically are being sent to the Company.

How to Reconcile Crossover Claims

As stated earlier, the Company provides providers with reports listing Crossover claims received from Medicare. Those claims are reported as they are released for adjudication. It is possible that if a provider's claims volume

is very large, it could receive its reported Medicare claims over two successive days.

Providers submitting electronic claims to the Company will recognize that the Crossover claim reports are comparable in appearance to the electronic claims reports currently being distributed to them. If a provider is currently submitting electronic claims to the Company, the Medicare Crossover reports are included with its regular reports.

Reports

If a provider does not currently submit electronic claims to the Company, the following claims reports will be unfamiliar.

Hospitals should receive three types of reports:

- The first report is a detailed list of Crossover claims received from Medicare on behalf of the provider. To use this report, simply check off the claims appearing on the report against the Medicare pay list. These claims do not have to be submitted to the Company.
- The second report supplies claim counts and total dollar amount.
- The third report is an error frequency and routing report by batch. It shows an error ranking for regular (non-Crossover) electronic claims as well as the following totals:
 - Claims Submitted by Provider: This is a count of electronic claims submitted by the provider. If the provider is not submitting electronic claims to the Company, the count is zero.
 - Claims Accepted: This is the number of claims submitted by the provider that are accepted. The number does not include Crossover claims.
 - Claims Rejected: This is the number of claims submitted by the provider that are rejected in the paperless claim edits. The number does not include Crossover claims.
 - Total Claims Crossed Over: This is the number of Medicare claims successfully crossed over to the Company.
 - Total All Claims Submitted: This is the total number of claims submitted by the provider and Medicare. A page with totals covering all of the batches also is supplied.

If the provider submits claims electronically to the Company, it should receive its regular electronic Detail Claims Received Reports and its Crossover reports together in one package.

Questions or problems related to the electronic submission of claims to Medicare should be directed to the Ohio Medicare Federal Intermediary.

Specific claims processing or payment questions or problems should be directed to the Provider Inquiry unit and handled according to normal established procedures.

Medicare Supplementary Hard Copy Claims

Filing instructions

The following is an explanation of those items on the UB-04 which are crucial to the prompt and efficient processing of a Medicare supplementary claim payment when a UB-04 is used.

UB-04 Requirements	
UB-04 Form Locator	Requirements
50B Payer	To properly identify the patient's primary, secondary and, if applicable, tertiary payers. If there are more than three (3) prior payers, report up to ten (10) prior payers on subsequent claim forms.
39 – 41 Deductible, Coinsurance, Co-payment, and Estimated Responsibility	Report all applicable cost-share amounts reported in the Medicare remittance advice and estimated responsibility using the appropriate code and leading alpha character for each payer. The amounts reported must align with the alpha characters reported in Form Locator 50.
55 Amount Due	The estimated amount due should be the total of Medicare's deductible plus coinsurance amounts.

Medicare Secondary Payer Rules Applicable to the Working Aged

The term Working Aged refers to those Medicare-eligible employees age 65 or over, and people age 65 or over with employed spouses of any age, who have group health plan coverage because of their own or their spouse's current employment.

The Working Aged rules apply to employers that employ 20 or more employees. Such employers are required to offer their employees age 65 or over the same group health coverage offered to younger employees.

Those employers are also required to offer their employees with Medicare eligible spouses age 65 or over the same spousal group healthcare coverage the employer offers to spouses who are not Medicare eligible. Employees and their spouses have the option of choosing to participate in the

Crossover Electronic Processing System, which is in place with Medicare.

If a provider does not belong to or is ineligible for the Crossover system through Medicare, a paper claim must be submitted for supplementary payment if the provider does not regularly submit electronically.

The processing of institutional Medicare paper claims is very simple. Due to the lack of Medicare information supplied when supplementary claims are submitted, manual intervention often is required.

This intervention causes delays in payments, incorrect payments, or even the rejection of claims. To ensure the prompt processing of the paper claim, the information transferred from the Medicare voucher to the UB-04 claim form should be complete and exactly as it appears on the Medicare Provider Remittance Advice. It is imperative that all required information is accurate when submitting claims (paper or electronic) to the Company, employer group health plan or Medicare as primary.

If the employee or employee's spouse elects the employer group health plan as primary, Medicare will pay secondary. If the employee or employee's spouse declines coverage under the employer's group health plan, then Medicare is the primary payer. The employer may not offer the employee or his/her spouse coverage that complements Medicare.

This law creates the possibility that a provider will encounter an individual who is over age 65 for whom Medicare is not the primary payer. The provider should determine the existence of all applicable coverages and submit the claim to the proper payers.

- Complete the claim form carefully, following the instructions in this Manual. Missing or incorrect information delays processing and may result in underpayments or denials.
- Submit single CMS-1500 Claim Forms. Do not include superbills, statements of account, copies of ID cards or other unnecessary attachments to the claim. Such attachments delay processing and may result in errors when transcribing information from the attachment to the claim form, where the information must be for processing.
- Do not include more than 6 line items on each CMS-1500 Claim Form. Additional charges should be submitted as a separate claim. Do not staple two claims together.
- The only items that should be attached to a claim are explanation of benefits from Medicare or other insurance, operative notes, ER notes, or other documentation required by the Company.

- Allow 30 days from the date of submitting a claim to the Company before contacting the Provider Inquiry department about processing status.
- Please tell Covered Persons that their claim will be filed through their provider and that they should not submit one as well. Do not submit a second claim for the same service(s) unless instructed to do so by the Company. When processing has been delayed, follow the inquiries procedure provided in Section 6 – Adjustments and Inquiries, of this Manual. Submission of duplicate claims will further delay processing.
- Claims for services that are unusual or complicated due to extraordinary circumstances or that are potentially cosmetic in nature may be reviewed by the Clinical Quality and Health Services department. Operative reports, ER notes and/or pre- and post-operative photographs are often requested for such a review. If the provider wants a claim reviewed, assign CPT Modifier 22 and attach all pertinent documentation when submitting the claim.
- All claims, unless otherwise noted in the contract, must be filed within 12 months of the date of service.
- Healthcare providers who contract with the Company may not hold Covered Persons responsible for claims submitted past the filing limit. The Covered Persons who receive healthcare services from non-contracting providers also are required to submit claims within the 12-month period.

Section 3 — Clinical Quality and Health Services Overview (Revised)

The Clinical Quality and Health Services (CQHS) team strives to facilitate the delivery of medically necessary, high-quality, cost-effective healthcare services in the most appropriate setting. The CQHS care team supports this effort through an innovative care model and clinical services designed to improve health outcomes and create value for our customers and the populations we serve.

Ensuring Medically Necessary and Appropriate Services

Our goal is to ensure that all covered persons have access to quality and medically appropriate care, provided in a cost-effective manner, and rendered so that maximum benefits are available under the covered person's plan. The Company understands that covered persons cannot make decisions without adequate information. Therefore, the Company encourages and expects its network providers to communicate freely with every covered person on all treatment options available to them, regardless of the covered person's benefits or coverage limitations.

To ensure access to high-quality healthcare, the Company uses physicians and other healthcare professionals to review medical services for appropriateness.

The Company affirms that:

- Utilization management decisions are based solely on the appropriate use of care and services provided to covered persons and the existence of coverage.
- The Company does not directly or indirectly reward physicians or any other individuals participating in utilization management decisions for denying or limiting coverage or service, or for decisions that result in the underutilization of services.

- Decisions regarding hiring, compensation, termination, promotion or other related matters with respect to any individual are not made based on the probability that the individual will support a denial of coverage.
- The Utilization Management and Behavioral Health departments are accessible Monday through Friday between 8:15 a.m. and 4:15 p.m., ET. The number to call is listed on each covered person's identification (ID) card. Questions or requests for written information should be directed to:

Medical Mutual
Pharmacy & Clinical Quality and Health Services
Department, MZ: 02-3P-7501
100 American Road, Cleveland, OH 44144-2322

Behavioral Health	1-800- 258-3186
Prior Authorizations and Acute and Post-acute Authorizations	1-800-338-4114
Case Management	1-800-258-3175, option 3
Clinical Drug Management	1-800-424-7698
Clinical Quality Improvement	1-800-586-4523
Chronic Condition Management and Maternity Programs	1-800-590-2583

Clinical Quality and Health Services Program Components

The Clinical Quality and Health Services program includes Utilization Review, Case Management, Chronic Condition Management and Quality Improvement activities.

Utilization Review includes prior authorization of medical, surgical and behavioral health inpatient admissions and home health services. It also includes concurrent review, discharge planning and retrospective review. It also includes a prior authorization process to establish the medical necessity of a procedure, therapy, device or supply.

Case Management includes management of members:

- With complex medical and/or surgical conditions
- With mental health/substance abuse conditions
- Requiring transplants
- At or near the end of life
- With complex neonatal care
- With high-risk pregnancy
- With kidney disease

- Requiring assistance with care transitions and discharge planning (e.g., acute hospital to skilled nursing facility to home)

Chronic Condition and Maternity Management includes educational programs for chronic conditions, including asthma, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), diabetes, and hypertension, and pregnancy.

Prior Authorization (Revised)

General Guidelines

The Company conducts prior authorization review of certain services. Prior authorization is the process of establishing medical necessity of a service, procedure, therapy, device or supply in advance of the actual date of service. The results of the prior authorization review are shared with the provider and covered person and explain whether the medical necessity guidelines have been met for the requested service. This review facilitates the coordination of healthcare for the covered persons.

For the most current list of services requiring prior authorization or services that are investigational or not medically necessary, we recommend providers routinely check MedMutual.com/Provider, Policies and Standards, and Prior Approval and Investigational Services. This listing provides a reference on how to submit a request, as well as relevant contact information.

Please note that Medical Mutual requires prior authorization for the following drugs under the medical benefit:

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

The Company requires all contracting facilities and professional providers to obtain prior authorization for designated services. Failure to comply with the requirements will result in rejection of the claim. The facilities and professional providers are required to provide the following information:

- Provider name
- Member demographics
- Diagnosis
- Procedure or service
- Procedure to be performed
- Clinical treatment plan
- Relevant clinical history

If a prior authorization request is not received by the Company before the service is performed, Medical Mutual, at its sole discretion, may perform a retrospective review for medical necessity if the provider can demonstrate that an exception to the plan rules prevented the authorization from being requested timely. Such exceptions to the plan rules are limited to the following:

- Circumstances in which the provider was unable to obtain member eligibility information at the time of registration. Examples include, but are not limited to: member incapacitation due to illness/injury; member traveling out of area; incorrect insurance card provided; etc.
- A retrospective enrollment where the member's eligibility was terminated, and subsequently reinstated, but the eligibility was not loaded timely.
- A provider or facility system outage that prevented prior authorization from being obtained timely. The provider will need to supply evidence of the outage including dates of impact.
- Natural disaster/catastrophic events that prevent the provider or facility from obtaining prior authorization in a timely manner.
- Any other extenuating circumstances that Medical Mutual determines, at its sole discretion, prevents provider from timely submitting a prior authorization request.

Otherwise, claims received for services in which no prior authorization was approved prior to services being rendered will not be paid.

The provider must submit a summary of the service including information supporting the medical necessity for each day of inpatient confinement, outpatient procedure or service.

Prior authorization requests for services that require prior authorization must be submitted in advance of rendering the service and need to allow for the below response times for the review determination.

Service Is	Requesting Time	Company Response Time
Non-Urgent	Prior to Service	Within 15 calendar days from receipt of request, unless a shorter timeframe is required by applicable law
Urgent	Prior to Service	Within 72 hours from receipt of request, unless a shorter timeframe is required by applicable law
Urgent	Concurrent	Within 72 hours from receipt of request, unless a shorter timeframe is required by applicable law

Urgent/Expedited Care Requests

For a prior authorization request to be considered urgently needed care, the treating provider must stipulate that adherence to the time frame for conducting a standard initial prior authorization decision, in their professional judgment, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function or would subject the covered person to severe pain that cannot be adequately managed without the care or treatment being requested; and that, for this reason, the prior authorization request for this covered person's initial prior authorization review should be processed on an expedited basis. Additionally, a prior authorization request will be considered a request for urgently needed care if Medical Mutual determines that adherence to the time frame for conducting a standard initial prior authorization decision would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function or would subject the covered person to severe pain that cannot be adequately managed without the care or treatment being requested.

Authorization for services already rendered is not a prior authorization and cannot be requested as an urgent/expedited review.

Submitting Prior Authorization Requests

Cohere Health

Cohere Health is a web solution that must be used by providers to submit certain outpatient prior authorization requests and that provides bidirectional communication with providers around the submission of prior authorization requests and the final determinations. It is available 24 hours-per-day 7 days-per-week. Registered users of Cohere Health submit requests and electronically communicate information regarding a variety of services such as, but not limited to, surgical procedures, durable medical equipment, diagnostic services, and home health care services. Providers can upload supporting documentation and receive real time case status information. Cohere Health can send messaging to providers regarding missing documentation or can potentially provide a real time approval if the request meets Medical Mutual criteria. Prior authorization requests may be submitted via web at <https://login.coherehealth.com>

eviCore

eviCore supports prior authorization for outpatient radiology services. Providers may access the eviCore web portal at <https://www.evicore.com/Pages/ProviderLogin.aspx>. Prior authorizations are accepted 24 hours a day, seven days a

week, excluding planned down time for system maintenance through the eviCore website, or by phone at (888) 693-3211 or fax to (888) 693-3210. eviCore will provide a voice message service for telephone requests received outside the normal operating hours of 8 a.m. to 9 p.m. E.T., Monday through Friday. We recommend ordering providers secure prior authorization and pass the authorization numbers to the service facility at the time of scheduling. Authorization records will contain prior authorization numbers and one or more CPT codes specific to the services ordered.

Prime Therapeutics Management LLC

Medical Mutual uses Prime Therapeutics LLC to provide prior authorization services for specialty drugs when they are administered by professional and outpatient institutional providers to Medical Mutual members under their medical benefit.

For select specialty drugs, prior authorization requests must be submitted one of the following ways:

- Online at [GatewayPA.com](https://www.gatewaypa.com) (24 hours a day, seven days a week)
- By phone at 1-800-424-7698 (Monday through Friday, 8 a.m. to 7 p.m. Eastern)
- By fax to 1-888-656-1948 (24 hours a day, seven days a week).

eviCore Landmark

eviCore Landmark provides prior authorization for certain services. Not all plans require prior authorization for services (e.g., Mutual Health Services). Please contact the For Providers number on the back of the Covered Person's ID card for specific information.

- Prior Authorization Requests may be submitted via web at <https://www.evicore.com/provider>.
- Prior Authorization Requests may be submitted via phone at 1-877-531-9139
- Prior Authorization Requests may be submitted via fax at 1-855-774-1319.

MedCommunity

MedCommunity is a flexible, web-based solution that automates the prior authorization process by allowing healthcare providers to easily submit clinical requests for consideration.

This collaborative tool gives providers a simplified method to submit clinical service authorization requests and receive responses for inpatient acute and behavioral health hospital stays, acute physical rehabilitation, skilled nursing, and long-

term acute care stays. MedCommunity links directly with the authorization system to support a simplified request process.

For additional information about becoming a MedCommunity user, please contact your Provider Contract manager.

Fax Forms

For services that require prior authorization, and the provider is non-contracting with Medical Mutual (servicing or requesting), the Company publishes fax forms to facilitate the review process.

Medical Drug Management Forms

Certain medical drugs require prior authorization. Providers should use the Prior Authorization Form to request prior authorization. The form is available at [MedMutual.com/Provider, Resources, Forms](https://www.medmutual.com/Provider/Resources/Forms). Providers may also use Prime Therapeutics Management LLC to submit medical drug prior authorization requests.

Therapy Authorization Forms

Therapy Authorization Forms for chiropractic, occupational, physical or speech therapy can be found on [MedMutual.com/Provider, Resources, Forms, Therapy Authorization Forms](https://www.medmutual.com/Provider/Resources/Forms/Therapy%20Authorization%20Forms). Please complete and fax the form to the number specified on the forms.

Medical Necessity Guidelines

The Company uses nationally recognized and accepted utilization management criteria, as well as internally developed policies, guidelines and protocols for medical necessity determination.

Criteria are supplied to covered persons or providers upon written request to the following address:

MZ: 02-3P-7501
Clinical Quality and Health Services Department
Medical Mutual
100 American Road, Cleveland, OH 44144-2322

MCG Health Medical Necessity Guidelines

MCG Health is Medical Mutual's vendor for medical necessity guidelines for inpatient, observation, surgical, ambulatory care, home care, behavioral health care, and private duty nursing. Medical Mutual also uses MCG length of stay benchmarks and discharge planning guides.

MCG guidelines are available to providers through an online tool. Links to MCG Guidelines are available as follows:

[MedMutual.com/Provider, Policies and Procedures, Medical Necessity Criteria and Clinical Review Guidelines](https://www.medmutual.com/Provider/Policies%20and%20Procedures/Medical%20Necessity%20Criteria%20and%20Clinical%20Review%20Guidelines), then choose the MCG Guidelines link.

Corporate Medical Policies

Corporate Medical Policies are internally developed guidelines used for determining coverage for specific procedures, therapies, devices, equipment and services. The policies are accessible at [MedMutual.com/Provider, Policies and Standards and Corporate Medical Policies](https://www.medmutual.com/Provider/Policies%20and%20Standards/Corporate%20Medical%20Policies).

Providers are required to review the Company Corporate Medical Policies disclaimer, and upon acceptance, access to the site is granted. The Medical Policies section lists Corporate Medical Policies in alphabetical order. If the exact policy title is unknown, the list can be searched by keyword, Current Procedural Terminology (CPT) Codes or Healthcare Procedure Coding System (HCPCS) Codes.

Clinical Review Process (Revised)

The clinical review process is used to confirm the medical necessity of treatment and appropriateness of setting. Following provider submission of clinical information, the nurse reviewer compares this information against established criteria. When criteria are met, coverage is authorized for the requested service. When criteria are not met, the case is referred to a physician reviewer for final determination. Physician reviewers make medical necessity approval or denial decisions based on all information submitted by the treating provider or facility at the time the review is requested. Only physician reviewers render medical necessity decisions for denial determinations.

The requesting provider(s) and covered person are notified in writing when a request is denied. The denial letter explains the reason(s), the specific criteria used and how to reach a physician reviewer to discuss the denial decision.

In addition, information on appeal rights and the appeal process are provided.

Discussing a Denial with Reviewer

If a review results in a medical necessity denial, a discussion with a physician reviewer is available prior to the initiation of an appeal. The conversation with a physician reviewer regarding the denial may circumvent the need for a formal appeal. Providers may use the contact numbers below for scheduling a physician discussion:

- Medical/Surgical: (800) 338-4114
- Behavioral Health: (800) 258-3186
- Medical Drug Management: (800) 424-7698

Inpatient Review Guidelines

Admission Review Revision

The provider is required to notify Medical Mutual within 24 hours or next business day of a patient's admission for inpatient services, or the next business day if such admission occurs on the weekend/holiday, to initiate a medical necessity review. **Clinical information must be supplied timely following admission but is not required to be submitted with the notification of admission.** Such notification is not required for routine obstetrical admissions which are limited to the following:

- Vaginal delivery - discharged within two days of delivery and the total length of stay does not exceed four days.
- Cesarean delivery - discharged within four days of delivery and the total length of stay does not exceed six days.

If the provider fails to provide notification of admission **within 24 hours or the next business day of a patient's admission**, Medical Mutual may, at its sole discretion, perform a retrospective medical necessity review. Payment for inpatient services will be subject to a one hundred percent (100%) payment reduction penalty if the required notification to the Company is not made within 24 hours or the next business day of a patient's admission. Providers can only dispute the one hundred percent (100%) payment reduction penalty by submitting a written appeal further described in the Provider Appeals – Clinical Appeals section to demonstrate that an exception, as specifically delineated below, to plan rules prevented the provider from providing timely notice to Company of the admission.

Such exceptions to the plan rules are limited to the following five exceptions:

- Circumstances in which the provider was unable to obtain member eligibility information at the time of registration. Examples include, but are not limited to: member incapacitation due to illness/injury; member traveling out of area; incorrect insurance card provided; etc.
- A retrospective enrollment where the member's eligibility was terminated and subsequently reinstated, but the eligibility was not loaded timely.
- A provider or facility system outage that prevented timely notice of admission. The provider will supply evidence of the outage including dates of impact.
- Natural disaster/catastrophic events that prevent the provider or facility from submitting timely notification.
- Any other extenuating circumstances that Medical Mutual determines, at its sole discretion, prevents provider from timely submitting notification of admission.

Otherwise, claims received for inpatient services without timely notification, as described above, will be subject to the one hundred percent (100%) payment reduction penalty. will be denied and not paid.

Concurrent Review

Concurrent review is conducted following the inpatient admission review. Concurrent review activities are performed on services delivered in settings such as acute inpatient hospitals, skilled nursing facilities, and acute rehabilitation facilities and performed by home health providers.

For cases reimbursed as percent of charges or per diem, concurrent review is an ongoing clinical review to support the medical necessity and appropriateness of location of service. Clinical information should include a current or an updated treatment plan, diagnostic testing results and current clinical picture of the covered person. The frequency of concurrent review varies depending on the clinical condition of the covered person.

For cases reimbursed as a DRG payment, the concurrent review should address ongoing clinical treatment plans, discharge plans, alternate level of care needs and any medical complication factors with each concurrent review.

Providers may also receive a request for additional clinical detail when a patient has been hospitalized for an extended length of time; the length of time may vary by setting. All covered services must continue to be medically necessary. A designated nurse reviewer may contact the provider to collaborate on the discharge plans for the covered person.

Discharge Planning

Discharge planning facilitates coordination of ongoing care, whether transitioning to home or the next level of care. It begins upon admission and continues throughout the hospitalization. Discharge planning is conducted collaboratively between the facility and the Utilization Management nurse reviewer to ensure the efficient use of resources while providing continuity and coordination of care for covered persons.

This process incorporates collaboration and decision-making with the covered person and significant other, as well as all healthcare providers involved in the covered person's care. The Company requires network hospitals to provide discharge planning information as well as notification of discharge dates and disposition. Providers may receive a request for additional clinical detail when a patient has been hospitalized for an extended length of time; the length of time may vary by setting. A designated nurse reviewer will contact the provider to collaborate on the discharge plans for the covered person.

Clinical Claim Edits

Clinical claim edit system is the application of industry standards to evaluate provider claims for accuracy, completeness, medical necessity and appropriate utilization of services and procedures. The sources used for clinical edits include:

- National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
- Centers for Medicare and Medicaid Services (CMS), including 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), and Medicare Code Editor (MCE)
- Covered person's Summary Plan/Certificate of Coverage
- Corporate Medical Policy/Medical Necessity Criteria/Laboratory Management
- American Medical Association Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS) coding guidelines
- U.S. Food and Drug Administration (FDA) approved drug labels

Examples of clinical edits include:

- CPT/HCPCS code validation for age, sex, frequency, place of service, diagnosis, procedure, provider specialty, duplicate claim/line, etc.
- Coding validation related to unbundling, rebundling, and add on procedure billed as primary
- Anesthesia edits, including anesthesia crosswalk, anesthesia secondary procedure, and performed by non-anesthesia provider
- Correct coding for components of comprehensive procedures and mutually exclusive services
- Global surgical services
- Multiple procedure pricing
- Bilateral procedure pricing
- Team/Co-surgeon pricing
- Not medically necessary
- Experimental/Investigational services

Member Programs

Technology Assessment Program

The Technology Assessment Program includes reviews of pharmaceuticals, biologicals, medical devices, diagnostic and therapeutic procedures, evaluation/management services, durable medical equipment and other products or issues related to clinical care.

Assessment of new applications for existing technologies must demonstrate medical efficacy, improved outcomes, or

the presence of a prevailing standard of practice within the medical community.

Each technology assessment results in a recommendation on whether to include coverage of services in the Company's basic benefit packages. If a new technology is considered to be either experimental or investigative, it will be excluded from benefit packages offered and administered by the Company.

Case Management

The Case Management Program addresses member needs by applying core components of the case management process across the continuum of care. Case managers assess, plan, implement, coordinate, educate, monitor and evaluate all aspects of healthcare involving members identified as appropriate for case management intervention. The program identifies members at risk for complex, high cost and/or long-term needs through short term, complex and continued care case management. The purpose is to empower members to take control of their health care needs across the continuum. This is achieved by assisting with coordination of care so that the right members receive the right interventions that are effective, efficient and focused, at the right time resulting in quality outcomes, safety and satisfaction that contribute to the goal of improved health and wellness.

Eligibility

Providers often are the best referral source to identify covered persons that can benefit from case management. Examples of members that may benefit from case management support include members with:

- High emergency room usage
- Multiple hospital admissions within six months
- Selected diagnoses, including:
 - High-risk pregnancy
 - High-risk neonates
 - Severe stroke/cerebrovascular accident (CVA)
 - Major trauma
 - Respiratory dependence
 - Severe burns
 - Multiple fractures
 - Amputations
 - Advanced neurological disorders
 - Pain management
 - Terminal cancer
 - Solid organ and blood component transplants
 - Other terminal conditions and other rare catastrophic diseases
 - Depressive, anxiety, eating or psychotic disorders
 - Hemophilia
 - Dialysis
 - Chronic kidney disease

Referrals

The Company will accept referrals from any source, including any provider or covered person. To initiate a referral, contact the Case Management department or the Behavioral Health department. (See contact phone numbers in the Ensuring Medically Necessary and Appropriate Services sub-section of this section.)

Please have the following information available when calling the Case Management department:

- Name of covered person
- Name of cardholder
- Certificate number
- Current healthcare situation
- Provider's name
- Anticipated ongoing needs

Chronic Condition Management Program

To assist individuals diagnosed with chronic diseases, Medical Mutual offers the Chronic Condition Management Program. This program helps members with chronic conditions to better manage their care. Specially-trained nurses and health coaches offer structured education and support to increase a member's knowledge about their disease, the potential complications and the importance of complying with their prescribed treatment plan. Conditions currently covered by the Chronic Condition Management Program include:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Coronary Artery Disease
- Asthma
- Hypertension

Additionally, please note that Marketplace members are only eligible for Diabetes.

Maternity Program

Medical Mutual offers the Maternity Program for our members who are pregnant to ensure their pregnancy is as happy and healthy as possible.

A trained health coach can help members learn more about prenatal care, labor and delivery with self-care strategies that supplement the treatment they receive from their physician.

General Information about Chronic Condition Management and Maternity Programs

If your patient is not currently enrolled in the Chronic Condition Management or Maternity Programs and would like to enroll, please advise that they call us at (800) 590-

2583 or visit MedMutual.com/Provider, Resources, Disease Management and Maternity Programs.

Program brochures are available and may be ordered through MedMutual.com/Provider by selecting "Resources," then "Clinical Supply Materials". Request form number Z5340-CMT.

Covered persons can be referred to the program by telephone, by faxing the enrollment form included in the brochure or via the internet. In order to properly identify a covered person when making a referral, the following information must be provided:

- Cardholder ID
- Covered person's telephone number
- Covered person's ID number
- Provider name
- Group number
- Provider tax ID
- Date of birth
- Provider address
- Covered person's address
- Provider telephone number

For greater continuity of care, the program is administered in a comorbid model, and all eligible persons diagnosed with a condition or conditions covered by the program are managed for each of these conditions, based on a hierarchy of clinical severity.

Quality Improvement Program

The Quality Improvement (QI) Program is a dynamic approach to achieve the following population health goals:

- Improve the quality and service provided to members
- Ensure that clinical initiatives address the needs of special populations related to diversity and complex health needs
- Support evidence-based practice and patient access to safe, timely and appropriate care
- Adopt a systematic approach to continuous quality improvement and act upon identified opportunities

Scope of the Program

The QI Program applies to all aspects of clinical care and services provided to covered persons and is continually evolving to respond to the changing healthcare environment. Providers who are contracted to deliver medical care to covered persons, including all professional and institutional providers, are required to participate in the QI Program to improve the quality of care and services the members experience. Medical Mutual may gather provider performance data from multiple sources and provider agrees that such data may be used by Medical Mutual for Quality Improvement activities.

Monitoring and Evaluation

The QI Program's monitoring and evaluation functions are performed through the assessment of information obtained from a variety of sources, including:

- Medical and prescription claims data
- Covered person and provider satisfaction surveys
- Inquiry and investigation of covered person complaints
- Ongoing tracking and trending of potential quality of care and service issues identified in the course of daily care management and administrative activities
- Inquiry and investigation of all Serious Reportable Events
- Identification of potential covered person safety issues through monitoring established tracking indicators
- Ongoing review of geographic and accessibility standards, medical record reviews, utilization studies and HEDIS® measures

Visit MedMutual.com, About Medical Mutual, Corporate Profile, Quality Improvement Program to access the current [Quality Improvement Program](#).

Serious Reportable Events (SREs)

The CQI department investigates all quality of care or service issues including SREs and Hospital-Acquired Conditions (HACs). Medical Mutual follows the National Quality Forum (NQF) list of SREs, commonly referred to as "Never Events" and labeled "Sentinel Events" by the Joint Commission. As defined by the NQF, SREs are clearly identifiable, measurable and usually preventable events that result in an adverse patient outcome, such as significant harm (i.e., loss of body part, disability) and/or death. The list of SREs published by the NQF is reviewed on a quarterly basis for any changes or additions. Medical Mutual identifies HACs using the [CMS list](#) that identifies these conditions.

The CQI department requests records and performs a focused review on all cases where a potential or confirmed quality of care issue was identified when the occurrence threshold exceeds established thresholds.

Corrective Action Plan (CAP)

The Company has policies and procedures for appropriate corrective action to be taken when there is an apparent occurrence of undelivered, inappropriate or substandard healthcare services.

Collaborative steps in the QI action plan include:

- Clinical indicators identified in the Clinical Quality and Health Services department are tracked and investigated by the Clinical Quality Improvement department.
- Member complaints against network providers are assigned and investigated by the Clinical Quality Improvement Department.

- The Clinical Quality Improvement Department utilizes Medical Directors to help determine whether a case should be forwarded to the Chief Medical Officer for further investigation or action.
- The Chief Medical Officer may recommend a number of additional actions including contact with the cardholder or provider or presenting the case to the CQI committee.

If a case is presented to the CQI Committee, the provider is notified of:

- Inclusion in the process
- The issues that must be addressed and the specific actions required
- The time frame in which the issues are to be addressed
- The need for the CAP agreement to be signed and returned within 30 days of receipt

A provider who fails to execute the CAP agreement within 30 days of the CAP notification is referred to the Credentialing Committee for a recommendation.

The Clinical Quality Improvement department monitors and assesses a provider's compliance with the outlined corrective steps required by the CAP.

A provider's compliance to the required CAP is presented to the Clinical Quality Improvement Committee for recommendation.

The Clinical Quality Improvement Committee and Credentialing Committees comply with all state and federal reporting requirements relating to quality-of-care issues.

For a copy of the QI Program description, contact the Clinical Quality Improvement department at:

MZ: 02-3P-7501
Clinical Quality Improvement Department
Medical Mutual
100 American Road, Cleveland, OH 44144-2322
(800) 586-4523
Clinicalquality@MedMutual.com

Visit the Provider section of MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Mission section to access the current QI program.

Pharmacy Management Programs

Medical Mutual and its pharmacy benefit management (PBM) partner, Express Scripts, Inc., manage all prescription drug formularies, Coverage Management programs, RationalMed® drug safety program and other drug-related programs (e.g., specialty) to help ensure patients' prescription drug benefits are provided at a reasonable cost.

Providers can help patients have access to affordable prescription drug benefits by prescribing with coverage, safety and costs in mind.

Formulary

Medical Mutual offers multiple formulary options depending on the member's drug coverage. An independent Pharmacy and Therapeutics Committee of physicians and pharmacists assists with creating the formularies based on safety and efficacy information and Coverage Management programs' coverage criteria based on a comprehensive review of the evidence-based literature.

To access the information detailing all formularies Medical Mutual offers, visit MedMutual.com/Provider and select Policies and Standards from the "Providers" drop-down. Click on Prescription Drug Information and scroll down to Prescription Drug Formularies.

For general questions, providers may contact our PBM at (800) 211-1456 Monday through Friday between 8 a.m. and 8 p.m., ET.

Getting Started with Mail-order Prescriptions

If patients take long-term prescription medications, such as those used to treat high blood pressure, high cholesterol or diabetes, their prescription drug benefits may allow them to conveniently order prescriptions for home delivery from the Express Scripts Pharmacy. Some patients may be required to use mail order based on their plan benefits.

To get patients started using home delivery, write a prescription for up to a 90-day supply (or the patient's prescription drug benefit mail-order limit) plus refills for up to one year (as appropriate), and choose one of these options:

- Send an electronic prescription to Express Scripts pharmacy.
- Call (888) 327-9791 for instructions regarding how to fax the prescription. The patient's ID number (which is on the Medical Mutual ID card) is required on faxed prescriptions.
- Patients may mail the prescription(s) directly to the Express Scripts mail order

Note: Express Scripts will call all providers directly when prescription refills are requested by patients in situations where no valid refill exists.

Coverage Management

Our Coverage Management programs determine whether certain drugs qualify for coverage based on the patient's prescription drug benefit. Coverage Management programs, administered by Express Scripts, include three categories:

- Prior Authorization
- Step Therapy

- Quantity Limit

A comprehensive list of the drugs affected by Coverage Management, the coverage criteria and associated fax forms used to initiate a coverage review with Express Scripts can be found online. To access the information, visit MedMutual.com/Provider, select Policies and Standards from the "Providers" drop-down and click on Prescription Drug Information, then scroll down to the Prior Authorization and Step Therapy sections for the most current information. Criteria is regularly updated, and drugs are added periodically to these programs.

Please note that Medical Mutual requires prior authorization for the following drugs filled under the pharmacy benefit:

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

Providers should contact Express Scripts to initiate the Coverage Management review process, which is described below:

1. Submit the request through the existing electronic prior authorization (ePA) platform. More information about the ePA and electronic prescribing is available from the Provider's EHR vendor or from Superscripts® at SuperScripts.com. If the provider does not have access to ePA, Medical Mutual also supports electronic submissions through either ExpressPath™ or CoverMyMeds®. More information on these free, time-saving options is available at Express-PAth.com or CoverMyMeds.com, respectively. Alternatively, to request a fax form or submit the request over the phone, call Express Scripts at (800) 753-2851 Monday through Friday between 8 a.m. and 9 p.m., ET. (If the prescription was submitted to the mail-order service or a specialty pharmacy, the pharmacy will typically contact the provider to initiate the review process.)
2. Express Scripts will send the provider and patient a notification confirming whether coverage has been approved (usually within two business days of receiving all the necessary information).
3. If coverage is approved, patients will simply pay their normal cost share for the drug. If coverage is not approved, patients will be responsible for the full cost of the drug. Providers or patients have the right to appeal the decision, and information regarding the appeal process will be included in the notification.

Note: A coverage review is not available for additional quantities on drugs to treat erectile dysfunction such as Caverject, Cialis, Edex, Levitra, MUSE and Viagra. Patients

must pay the full cost of additional quantities prescribed beyond the prescription drug benefit allowed amount.

Note: Compound drugs, kits and patches that contain certain ingredients, including bulk powders, as well as over-the-counter and non-FDA-approved products, are typically excluded from coverage, and reimbursement is not available under the applicable benefit plan. High-cost drug products with clinically equivalent, lower cost alternatives may also be excluded from coverage. Providers should consult the patient's formulary to find covered alternatives. For questions about excluded products, please contact Express Scripts toll free at (877) 281-6342.

RationalMed

The RationalMed program (available for select covered persons) helps providers protect their patients' health and prevents unnecessary hospitalizations caused by the improper use of prescription drugs based on laboratory, medical and pharmacy information. Providers are alerted to potential problems related to medical therapies, such as potential gaps in care, over/under utilization, multiple prescribers, drug-disease interactions and drug interactions based on a sophisticated, outcome-driven system. In addition, pharmacists are also typically notified of these potential problems in real time, at the point of dispensing. Providers are asked to carefully review these alerts and determine the appropriate treatment course for their patients.

Medication Sourcing Requirements for Select Specialty Medications Infused in a Hospital Outpatient Department

Effective January 1, 2025, Medical Mutual will require contracted hospitals to obtain select specialty medications infused in a hospital outpatient department from an in-network specialty pharmacy. These medication sourcing requirements will apply to Medical Mutual's commercial and Affordable Care Act (ACA) plans, including plans that utilize the SuperMed HMO, SuperMed PPO, SuperMed Preferred, MedFlex, CLE-Care HMO, CLE-Care HMO Individual, and MedMutual Individual HMO networks. These medication sourcing requirements do not apply to Medicare Advantage plans.

These medication sourcing requirements only apply to select specialty medications infused in a hospital outpatient department that are billed on a UB-04 claim form. These medication sourcing requirements do not apply to such medications when billed on a CMS-1500 claim form.

When the select specialty medications are obtained from one of Medical Mutual's in-network specialty pharmacies, the in-network specialty pharmacy will bill Medical Mutual directly for the specialty medication under the member's medical benefit. Hospitals will continue to receive reimbursement from Medical Mutual for the administration of specialty medications infused in a hospital outpatient department that are supplied by an in-

network specialty pharmacy, if all other conditions required for reimbursement of the administration have been met. Hospitals may not bill Medical Mutual or members for the select specialty medications that are supplied by an in-network specialty pharmacy.

If a hospital does not obtain the select specialty medications for infusion in a hospital outpatient department from one of Medical Mutual's in-network specialty pharmacies, and instead acquires such medications from a different source and bills for the medication directly to Medical Mutual, payment for the medication will be denied, and the hospital may not bill or otherwise seek payment from Medical Mutual or the member for any cost of the medication.

For specialty medications that are NOT subject to the medication sourcing requirements, hospitals may continue to acquire such specialty medications from a source other than Medical Mutual's in-network specialty pharmacies, and hospitals may bill for the medication directly to Medical Mutual.

All specialty medications identified as subject to the medication sourcing requirements require prior authorization. Prior authorizations that are valid as of January 1, 2025, will be honored through the approved number of doses/validity period indicated on the prior authorization determination letter without being subject to the new medication sourcing requirements. All new prior authorization requests, including renewals of a previously approved medication, on or after January 1, 2025, will be subject to the new medication sourcing requirements.

The specialty medications that are subject to these medication sourcing requirements are identified on Medical Mutual's Commercial and Exchange Prior Authorization List for Medical Drugs, which is available at [MedMutual.com/Provider](https://www.MedMutual.com/Provider) under Prior Approval Resources.

Other Education

Express Scripts or Medical Mutual may reach out to providers with opportunities regarding care coordination, generics, cost savings, and other pharmaceutical care opportunities.

Clinical Practice Guidelines (Revised)

The Company has adopted a number of preventive and clinical practice guidelines for specific age groups and conditions. Many covered persons, especially those considered to be high risk for specific diseases, may require additional screening or diagnostic tests than are reflected in the guidelines. The Company's guidelines should not deter the

provider from providing additional medically necessary services.

Clinical practice guidelines are made available as they are adopted and can be viewed or downloaded at [MedMutual.com/Provider, Policies and Standards, and Clinical Practice Guidelines](https://www.medmutual.com/Provider/Policies-and-Standards-and-Clinical-Practice-Guidelines). Guidelines may include:

- Alcohol and Substance Use Disorder
- Depression
- Diabetes
- Hypertension
- Opioid Prescribing

The company has also provided a link to SAMHSA, a behavioral health shared decision-making tool. The link is found at [MedMutual.com/Provider, Resources, and Behavioral Health Shared Decision-Making Tools](https://www.medmutual.com/Provider/Resources-and-Behavioral-Health-Shared-Decision-Making-Tools).

Continuity of Care Guidelines

Responsibilities of the Referring Provider when Requesting Consultation

Prior to the patient's evaluation, the referring provider should supply the consulting provider with all necessary information, including:

- Reason for the consultation
- Pertinent clinical information
- Desired method(s) of communication from the consultant (e.g., fax, phone, mail, email)

Responsibilities of the Consulting Provider when Reporting Results to the Referring Provider

Medical/Surgical

A written summary of the consultation and findings should be sent to the referring provider as expeditiously as the condition warrants after the initial visit.

Note: Any preliminary report should be followed with a final

report.

Behavioral Health

The behavioral health consultant is responsible for obtaining a signed consent from the covered person permitting the communication of important clinical information to the referring provider.

If the covered person consents to communication, the behavioral health consultant is responsible for exchanging information regarding the covered person's evaluation and care plan to the referring provider. The communication should be completed as expeditiously as the condition warrants after the initial evaluation.

Communication Components

The communication should contain the following components when applicable:

- Clinical Evaluation – Pertinent information from your evaluation
- Diagnostic Tests – Results of completed tests and recommendations for additional testing
- Clinical Impression – Patient's diagnosis and/or differential diagnosis
- Medication Therapy – Current medication list with new medications added and any medication adherence issues
- Treatment Plan – Therapy rendered and ongoing recommendations
- Follow-up – Recommendations concerning who should provide follow-up care and when those services should be performed

Summary Communication Form

Continuity of Care Patient Summary Forms can be found at [MedMutual.com/Providers > Resources > Continuity and Coordination of Care](https://www.medmutual.com/Providers/Resource/Continuity-and-Coordination-of-Care). The Behavioral Health Summary Form includes a section for patient consent to release medical information. The company maintains strict privacy and confidentiality policies aimed at ensuring that covered persons are treated in a manner that respects their rights and protects the confidentiality of personal health information and records

Availability Goals and Accessibility Standards

Provider Accessibility Standards

Provider accessibility represents an important element of healthcare quality. Please strive for compliance with these accessibility standards so that our members have access to needed healthcare services in a timely manner. We recognize that the provider may not be able to accommodate these time frames when unpredictable circumstances and emergencies occur.

These standards do not apply for behavioral health providers. Please refer to the Behavioral Health Accessibility Standards in the following section.

Primary Care Provider Accessibility Standards

All care should be given as expeditiously as condition warrants

Type of Service	Description	Performance Goal
Emergency Care	Examples: Major trauma injury, chest pain, severe abdominal pain, new onset shortness of breath.	Directed to the nearest emergency room or call 911.
Urgent Care	Examples: Minor trauma injury, unrelieved fever, signs/symptoms of urinary tract infection, children with ear pain and fever.	Appointment is available within 24-48 hours of initial request. As appropriate, members may be directed by the provider or the Company's 24/7 NurseLine to seek care at an Urgent Care Center for onset of symptom(s) or health problems requiring prompt but not immediate medical attention.
Preventative, Regular and Routine Care	Examples: Well child visit, routine physical, visit for recurring/chronic problem(s) and follow-up of non-acute symptoms.	Appointment is available within 30 business days.
Office Wait Time	Office wait time	Wait time should be less than 30 minutes from the time of the scheduled appointment.
After Hours Care	Accessibility to healthcare provider outside of normal business hours.	24-hour, 7 day-a-week (after business hours) on-call coverage system is in place where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours. - Covering provider is expected to be a participating network provider. - Respondent or after-hour answering machine must include: - Urgent/Emergent instructions as first point of instruction. - Information on contacting a covering provider. - Telephone number for after-hours provider access. - After-hours phone response for Urgent problems should be addressed within 60 minutes.
Patient No-Show	Patient no-show	No-shows for scheduled appointments need to be documented in the patient medical record.

High Volume Specialty Care OB/GYN Accessibility Standards

All care should be given as expeditiously as condition warrants

Type of Service	Description	Performance Goal
Emergent/Immediate	Emergent/Immediate	Directed to the nearest emergency room or call 911.
Urgent Care	Urgent/Non-Emergent	Urgent Care: Appointment is available within 24-48 hours of initial request. As appropriate, members may be directed by the provider or the Company's 24/7 NurseLine to seek care at an Urgent Care Center for onset of symptom(s) or health problems requiring prompt but not immediate medical attention. Urgent Obstetrical Care: Appointment is available within 24 hours of initial request. Patient may be directed to a facility Obstetrical Department or Emergency Department if an urgent appointment is not available within 24 hours or as requested by the physician.
Routine Care	Routine care	Routine GYN Care: Appointment is available within 60 business days of initial request. Routine Obstetrical Care: Appointment is available within 30 business days of initial request.
Newly Pregnant Care	Newly pregnant care	Appointment is available within 10 business days or generally in the second month of pregnancy around 8 weeks after last menstrual period.
Office Wait Time	Office wait time	Wait time should be less than 30 minutes from the time of the scheduled appointment.
After Hours Care	Accessibility to healthcare provider outside of normal business hours.	24-hour, 7 day-a-week (after business hours) on-call coverage system is in place where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours. - Covering provider is expected to be a participating network provider. - Respondent or after-hour answering machine must include: - Urgent/Emergent instructions as first point of instruction. - Information on contacting a covering provider. - Telephone number for after-hours provider access. - After-hours phone response for Urgent problems should be addressed within 60 minutes.
Patient No-show	Patient no-show	No-shows for scheduled appointments need to be documented in the patient medical record.

High Impact Specialty Care Oncology Accessibility Standards

All care should be given as expeditiously as condition warrants

Type of Service	Description	Performance Goal
Emergency Care	Emergency care	Directed to the nearest emergency room or call 911.
Urgent Care	Urgent care	Appointment is available within 24-48 hours of initial request. As appropriate, members may be directed by the provider or the Company's 24/7 Nurse Line to seek care at an Urgent Care Center for onset of symptom(s) or health problems requiring prompt but not immediate medical attention.
Regular and Routine Care	Regular and routine care	Appointment available within 30 business days for follow-up of non-acute symptoms.
Office Wait Time	Office wait time	Wait time should be less than 30 minutes from the time of the scheduled appointment.
After Hours Care	Accessibility to healthcare provider outside of normal business hours.	24-hours, 7 day-a-week (after business hours) on-call coverage system is in place where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours. - Covering provider is expected to be a participating network provider - Respondent or after-hour answering machine must include: - Urgent/Emergent instructions as first point of instruction - Information on contacting a covering provider - Telephone number for after-hours provider access - After-hours phone response for Urgent problems should be addressed within 60 minutes
Patient No-Show	Patient no-show	No-shows for scheduled appointments need to be documented in the patient medical record.

All Other Specialists Accessibility Standards

All care should be given as expeditiously as condition warrants

Type of Service	Description	Performance Goal
Emergency Care	Emergency care	Directed to the nearest emergency room or call 911.
Urgent Care	Urgent care	Appointment available within 24-48 hours of initial request. As appropriate, members may be directed by the provider or the Company's 24/7 Nurse Line to seek care at an Urgent Care Center for onset of symptom(s) or health problems requiring prompt but not immediate medical attention.

Regular and Routine Care	Regular and routine care	Appointment is available within 30 business days for follow-up of non-acute symptoms.
Office Wait Time	Office wait time	Wait time should be less than 30 minutes from the time of the scheduled appointment.
After Hours Care	Accessibility to healthcare provider outside of normal business hours.	24-hour, 7 day-a-week (after business hours) on-call coverage system is in place where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours. - Covering provider is expected to be a participating network provider. - Respondent or after-hour answering machine must include: - Urgent/Emergent instructions as first point of instruction. - Information on contacting a covering provider. - Telephone number for after-hours provider access. - After-hours phone response for Urgent problems should be addressed within 60 minutes.
Patient No-Show	Patient no-show	No-shows for scheduled appointments need to be documented in the patient medical record.

Coverage and eligibility depend upon the terms and conditions of the applicable benefit plan. These recommendations are not intended to serve as an exclusive course of treatment. Decisions regarding care are subject to individual consideration and should be made by the patient in concert with treating medical personnel.

Behavioral Health Accessibility Standards (Prescribing and non-Prescribing)

All care should be given as expeditiously as condition warrants

Type of Service	Definition	Performance Goal
Emergency Care	Emergency care	Directed to the nearest emergency room or call 911.
Care for Non-Life-Threatening Emergencies	Services provided for the onset of symptoms of behavioral health problems that require prompt attention but are not considered emergency care. Example: Suicidal/homicidal ideation without a definitive plan.	Members are scheduled to be seen within 6 hours of contacting the provider. As appropriate, members may be directed by the provider or the Company's 24/7 NurseLine to seek care at an Emergency Department.
Urgent Care Services	Services provided for the onset of symptoms of behavioral health problems that require prompt attention but are not considered emergency care. Example: Symptoms severely affecting daily functioning in such a way that eventual detriment to the member or others will occur.	Members are scheduled to be seen within 48 hours of contacting the provider. As appropriate, members may be directed by the provider or the Company's 24/7 NurseLine to seek care at an Urgent Care Center.
Initial Visit for Routine Care	Initial visit for routine care	Members are scheduled to be seen within 10 business days of request. Excludes follow-up care for an existing problem.

Follow-up Routine Care	Includes visits at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit.	Within 30 days or as agreed upon by the member and the practitioner.
Office Wait Time	Office wait time	Wait time should be less than 30 minutes from the time of the scheduled appointment.
After Hours Care	Accessibility to healthcare provider outside of normal business hours.	24-hour, 7 day-a-week (after business hours) on-call coverage system is in place where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours. - Covering provider is expected to be a participating network provider. - Respondent or after-hour answering machine must include: - Urgent/Emergent instructions as first point of instruction. - Instructions may include: Contact numbers for National and/or Local Suicide Hotline, Mobile Crisis Units - Information on contacting a covering provider. - Telephone number for after-hours provider access. After-hours phone response for Urgent problems should be addressed within 60 minutes.
Patient No-Show	Patient no-show	No-shows for scheduled appointments need to be documented in the patient medical record.

*All covered persons should have access to their provider or covering network provider when the office is closed. After hours phone calls should be returned within 30 minutes.

Medical Record Documentation Standards

The Clinical Quality Improvement department:

- Educates the provider community regarding nationally recognized standards for confidentiality, medical record documentation, organization and accessibility, and availability of patient appointments through displays on the Company website and articles in Company newsletters.
- Performs random medical record keeping reviews to assess provider compliance to these standards.

These medical record keeping reviews use criteria that are consistent with widely accepted national quality and regulatory standards. The Company uses two different sets

of documentation standards, with one set directed toward medical/surgical providers, while the other set is designed for behavioral health specialists.

These standards as well as sample intake sheets are available at [MedMutual.com/Provider, Resources, Continuity and Coordination of Care](https://www.medmutual.com/Provider/Resources/Continuity%20and%20Coordination%20of%20Care).

Medical Record Guidelines and Considerations

A highlight of medical record guidelines and considerations is listed below:

Medical Record Documentation

- Medication allergies and adverse reactions are prominently noted in the medical record. The absence of any known allergies must be likewise prominently noted in the medical record.

- Past medical history is easily identified and includes serious accidents, operations and illnesses. Past medical history for children should relate prenatal care, birth information, operations and childhood illnesses.
- Assessment for the presence of depression or alcohol abuse/dependence is performed and the nationally recognized tool used in this assessment is documented.
- There is a documented patient height and weight and Body Mass Index taken annually as a screening measure.
- Personal/biographical data includes: date of birth, address, employer, home and work telephone numbers, emergency notification name and number, and marital status.
- Family medical history is easily identified and includes any illnesses in family members.
- Notation concerning use of tobacco, alcohol and substances is present for patients who are age 11 and older. Thereafter, an annual query for tobacco usage is documented.
- Current medications and dosages are prominently displayed.
- Consultation, lab and imaging reports are contained within the patient record.
- Significant illnesses and medical conditions are indicated on a problem list.
- Each and every page in a medical record contains the patient's name or identification number.
- The medical record is legible to someone other than the writer.

Plan of Care

- A patient's history and physical exam documents appropriate subjective and objective information for presenting complaints.
- Working diagnoses are consistent with findings.
- Treatment plans documented are consistent with diagnoses.
- Provide and document appropriate child and/or adult preventive services and risk screenings.

Advance Directives

- Beginning at age 18, prominently document the existence of a patient's advance directive.
- Store the advance directive in a consistent and prominent location in the patient's medical record.

Medical record standard (Paper)

- Medical record is organized to facilitate easy retrieval of patient information.
- Medical record is stored to permit easy retrieval.
- Medical record is secured out of public access.
- Historical medical records are stored to permit easy retrieval during normal business hours.

Medical record standard (electronic)

- Patient health information and data are readily available to the practitioner.
- Security of the patient's health information and data is maintained.
- Test ordering and results are organized and managed in the system.
- Reminders, prompts and alerts are used to support decision-making activity.

Confidentiality

- A confidentiality statement is signed by all staff.
- Office staff receives periodic training in the confidentiality of patient information.

Patient Rights and Responsibilities

- The office has a written policy that demonstrates they do not discriminate in the delivery of healthcare services.

Appointment Accessibility

- See the Availability Goals and Accessibility Standards sub-section of this section for the list of Provider Accessibility Standards.

Office Site Standards

A highlight of the office site standards is listed below.

- Rooms and floors are clean and uncluttered.
- Corridors leading to exits are clear.
- Storage areas are separate from exam rooms.
- One exam room is present for each provider.
- Adequate waiting areas are present with adequate seating.
- Waiting room is well lit.
- Office hours are posted.
- Handicap parking is available, or a written alternative plan is present.
- Wheelchair access/ramp to the office is present or a written alternative plan is present.
- Minimal or no-hands access entry to the building is available or a written alternative plan is present.
- All office doors are wide enough for wheelchair access or a written alternative plan is present.
- Handrail assist is present in patient restrooms or a written alternative plan is present.

Behavioral Health Treatment Record Documentation Standards

The Clinical Quality Improvement department:

- Educates the provider community regarding nationally recognized standards for confidentiality, medical record documentation, organization and accessibility, and availability of patient appointment

accessibility through displays on the Company website and articles in Company newsletters.

- Performs random medical record keeping reviews to assess provider compliance of these standards.

These medical record keeping reviews use criteria that are consistent with widely accepted national quality and regulatory standards. The Company uses two different sets of documentation standards, with one set directed toward medical/surgical providers, while the other set is designed for behavioral health specialists.

These standards as well as sample intake sheets are available at MedMutual.com/Provider, Resources, Continuity and Coordination of Care.

Treatment Record Guidelines and Considerations

A highlight of the Behavioral Health Treatment Record Standards is listed below:

Treatment Record Documentation

- Medication allergies and adverse reactions are prominently noted in the medical record. The absence of any known allergies must be likewise prominently noted in the medical record.
- Each and every page in a medical record contains the patient's name or identification number.
- The medical record is legible to someone other than the writer.
- Personal/biographical data includes: date of birth, address, employer, home and work telephone numbers, emergency notification name and number, and marital status.
- Current medications and dosages are prominently displayed.
- Patient's past mental health history is documented.
- Patient's past medical history is easily identified.
- Assessment for the presence of depression or alcohol abuse/dependence is performed and the standardized tool used in this assessment is documented.
- Notation concerning current and past use of tobacco, alcohol and substances is present for patients who are age 11 and older. Thereafter, an annual query for tobacco usage is documented.
- Patient's legal history is documented.
- Family mental health history is easily identified and includes any illnesses in family members.

Treatment Plan

- A patient's history and mental status exam documents information for presenting complaints.
- Working diagnoses addresses the five axes of DSM-IV and are consistent with findings.

- Treatment plans documented are consistent with diagnoses.
- Documented goals are measurable and behaviorally oriented with an estimated time frame for attainment.
- Interventions are consistent with the diagnosis.
- Appropriate consent form for communication is used.
- Detail evidence of continuity/coordination of care.

Treatment Record Standard (Paper)

- Treatment record is organized to facilitate easy retrieval of patient information.
- Treatment record is stored to permit easy retrieval.
- Treatment record is secured out of public access.
- Historical treatment records are stored to permit easy retrieval during normal business hours.

Treatment Record Standard (Electronic)

- Client health information and data are readily available to the practitioner.
- Security of the client's health information and data is maintained.
- Test ordering and results are organized and managed in the system.
- Reminders, prompts and alerts are used to support decision-making activity.

Confidentiality

- A confidentiality statement is signed by all staff.
- Office staff receives periodic training in the confidentiality of patient information.

Patient Rights and Responsibilities

- The office has a written policy that demonstrates they do not discriminate in the delivery of healthcare services.

Appointment Accessibility

See the list of Behavioral Health Accessibility Standards from the previous section. See the Availability Goals and Accessibility Standards sub-section of this section for the list of Provider Accessibility Standards.

Provider Office Site Standards

A highlight of the office site standards follows.

- Rooms and floors are clean and uncluttered.
- Corridors leading to exits are clear.
- Storage areas are separate from exam rooms.
- One exam room is present for each provider.
- Adequate waiting areas are present with adequate seating.
- Waiting room is well lit.
- Office hours are posted.

- Handicap parking is available, or a written alternative plan is present.
- Wheelchair access/ramp to the office is present or a written alternative plan is present.
- Minimal or no-hands access entry to the building is available or a written alternative plan is present.
- All office doors are wide enough for wheelchair access or a written alternative plan is present.
- Handrail assist is present in patient restrooms or a written alternative plan is present.

Practitioner Corrective Action Plan

The Company has policies and procedures that may require a network practitioner's participation in a CAP when so directed by the Credentialing Committee.

A CAP is a collaborative approach taken between the Company and the network practitioner to resolve issues related to credentialing.

If a CAP is recommended by the Committee, the practitioner is notified of:

- Inclusion in the CAP process
- The issue(s) that must be addressed and the specific actions required
- The time frame in which the issue(s) are to be addressed
- The need for the CAP agreement to be signed and returned within 10 business days of the date of the letter.

A practitioner who fails to execute the CAP agreement within 10 business days of the CAP notification is referred to the Credentialing Committee for a recommendation.

The Clinical Quality Improvement department further monitors and assesses a practitioner's compliance with the outlined corrective action steps required by the CAP.

Available Documentation and Compliance Sample Forms and Policies

To help ensure efficient medical record documentation and appropriate compliance with other national and regulatory standards, sample forms and policies, including our Privacy Policy and Member Rights and Responsibilities, are available at MedMutual.com

Standard Benefit Exclusions (Revised)

Covered services are specifically defined by the benefit descriptions and exclusions contained in the covered person's policy. The

following benefit exclusions are typically found in most Company policies but are not all inclusive.

The Company does not provide benefits for services, supplies or charges:

- That are not prescribed by, performed by, or under the direction of a provider
- That are not performed within the scope of the provider's license
- That are not medically necessary or do not meet the Company's policy, clinical coverage guidelines or benefit policy guidelines
- That are investigational/ experimental, as determined by the Company
- To the extent governmental units or their agencies provide benefits
- For injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war
- For which the covered person has no legal obligation to pay in the absence of this or like coverage
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group
- Received from a member of the covered person's immediate family
- Incurred before the plan's effective date
- Incurred after the covered person stops being a covered person under the plan, except as specified under the Benefits after Termination of Coverage section of the certificate/benefit book/policy
- For which benefits would have been payable under Part B of Medicare if a covered person had enrolled in Part B coverage. For the purposes of the calculation of benefits if the covered person is eligible for, but has not enrolled in, Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law.
- Primarily for outpatient educational, vocational or training purposes
- For standby charges of a physician
- For non-custom-made foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace
- For treatment by methods, such as dietary supplements, vitamins and any care that is primarily dieting or exercise for weight loss or obesity (The only exception to this exclusion would be if surgery is medically necessary because of the covered person's weight and coverage is available for bariatric surgery.)

NOTE: Because such a wide variety of group and non-group policies are offered, it is emphasized that NOT all policies include the same coverage provisions and exclusions.

Section 4 — Appeals Overview

General Guidelines

The Company follows appeal guidelines based on federal and state regulations and accreditation standards of the National Committee for Quality Assurance (NCQA).

- The Company has processes in place to reconsider claims and resolve disputes with providers. These include processes for clinical appeals, prescription drug appeals and review of claim payment inquiries.
- If a provider has authorized a representative (individual agent, revenue recovery organization, etc.) to act on behalf of the provider in an appeal, the provider is responsible to ensure that the appropriate business associate agreement is in place to ensure protection of personal health information.
- A provider may request an appeal on behalf of a covered person
- In the event that a covered person has authorized the provider to appeal a clinical or benefit coverage decision on his or her behalf, a copy of the covered person's written authorization is required and must be submitted with the appeal.
- A provider may request an expedited appeal on behalf of a covered person for covered services involving urgent care. Written authorization of the covered person is not required when filing an expedited appeal on behalf of a covered person.
- Expedited appeals for urgent care are those where waiting for a standard appeal decision could:
 - Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or
 - In the opinion of the provider, subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- An appeal made by a provider on behalf of a covered person for denied urgent, pre-service or post-service requests or claims will expend one of the appeals available to the covered person under his or her coverage policy with the Company. Such an appeal will follow the process governing member appeals as outlined in the covered person's benefit book or coverage certificate.

- Covered persons may also have external review rights through an independent review organization, as described in the covered person's benefit book or coverage certificate. If an independent review organization has made a binding determination on a denied request or claim in conjunction with an appeal, no further appeals may be filed.

Medical Coverage and Claim Decision Redeterminations

Pre-service appeal rights under Medicare are granted to the member. As the member's healthcare provider, you may request an appeal on the member's behalf by following the member appeal process. If you disagree with a decision Medical Mutual made regarding a coverage decision, you, after providing notice to the member, may request a redetermination (appeal) without submitting written authorization from the member. Appeal requests must be submitted within 60 calendar days of the date of the original denial notice.

If the member's health condition would be jeopardized by waiting for a decision under our standard time frame (30 days), you or the member may request an expedited decision. Responses for expedited appeals will be provided within 72 hours.

Responses for a pre-service standard appeal will be provided within 30 days. Responses for a member's post-service standard appeal will be provided within 60 days. Responses for a provider's post-service standard appeal will be provided within 30 days. Post-service provider appeals follow the guidelines described in Section 4 – Appeals: Provider Appeals—Clinical Appeals.

If it is determined that the appealed services were medically necessary, the denial will be overturned. All members' post-service appeal decisions that remain unfavorable will be forwarded to an Independent Review Entity (IRE) for an additional review. No IRE is involved for providers' post-service appeal decisions that remain unfavorable.

See Section 4 – Appeals, for additional information regarding Non-clinical Claim Payment Inquiries.

Provider Appeals — Clinical Appeals

A provider may appeal the Company's decision of the following:

- Claims denied for failure to obtain prior authorization, but only to demonstrate an exception to plan rules, as outlined in the Prior Authorization section, applies.
 - Claims denied for failure to timely notify the company of an inpatient admission, but only to demonstrate an exception to the plan rules, as outlined in the Inpatient Review Guidelines section, applies.
 - Appeals relating to the medical necessity, or investigational or experimental nature of a claim will be reviewed by a physician reviewer who did not participate in any prior decisions about this service or claim, nor a subordinate of the reviewers who made the prior decisions. There are two appeals available to the provider.
- A written request to formally appeal the decision which outlines the reason(s) for the request; and
 - Information and supporting documentation or justification substantiating the medical necessity of the service for the covered person, including any materials that the provider wishes to have considered in the appeal review such as clinical records, treatment plans, etc.
 - The written request must also include the following information:
 - Provider's name;
 - Provider's NPI;
 - Cardholder's name;
 - Cardholder's ID number;
 - Covered person's (patient) name;
 - Covered person's (patient) relationship to the cardholder;
 - Date of service of the request or claim being appealed;
 - Total charge (as applicable); and
 - Claim number or case reference number.

Provider Appeal 1

- The provider must submit a written appeal within 180 days from the date the provider receives written notification of the original denial decision
- The Company will issue a decision within 30 days after receiving all required information from the provider.

Provider Appeal 2

If a provider disagrees with the Provider Appeal 1 decision, he or she may submit a second appeal.

- The provider must submit a written appeal within 60 days from the date the provider receives written notification of the Provider Appeal 1 decision.
- The Company will issue a decision within 30 days after receiving all required information from the provider.

Expedited Appeals

- Expedited appeals do not follow the Provider Appeal—Clinical Appeals process.
- Expedited appeals will follow the process governing member appeals as outlined in the covered person's benefit book or coverage certificate.
- The Company shall render a decision within 72 hours after receiving all required information from the provider.
- Expedited appeals are not available if services have already been rendered.

Filing a Clinical Appeal

To initiate a clinical appeal, the provider must submit to the Company:

The denial notice/explanation of payment (EOP) sent to the provider will provide instructions on where to submit the appeal. Clinical appeals can also be filed through the Provider Portal. Appeals filed via the Provider Portal must contain all the above required information in order to be processed. Documents can be attached when filing via this method. Expedited appeals may not be submitted through the Provider Portal.

Expedited appeals may be submitted via telephone or fax at the numbers listed on the denial notice sent to the provider.

Non-clinical Claim Payment Inquiries

If reimbursement is denied, wholly or in part, for reasons other than those addressed through clinical appeals, as described above, call Customer Care at (800) 362-1279 and speak with a Customer Care Specialist for assistance. If the claim remains denied after this initial contact, or you still disagree with our reimbursement, submit your request on a completed Provider Action Request (PAR) Form, along with any additional records as described in the PAR instructions, to:

Provider Inquiry Unit
Medical Mutual
P.O. Box 94917
Cleveland, Ohio 44101-4917

The PAR Form is available:

Online through the Availity Provider Portal, which can be accessed at [MedMutual.com/Provider](https://www.availity.com/Provider). Log into the Availity Provider Portal, access the Medical Mutual Payer Space, then click the Resources tab.

- A printable, fillable PDF version of the PAR Form is located at [MedMutual.com/Provider, Resources, Forms](http://MedMutual.com/Provider/Resources/Forms). The PDF version should be used to submit paper inquiries by mail with supporting medical documentation.

All requests for adjustments must be received at the Company within 12 months from the original notice of denial. The Company will respond to your request within 30 days.

Prescription Drug Appeals

When a covered person's prescription drug coverage is administered by Express Scripts and issued through the Company, prescription drug appeals follow an appeal process consistent with the applicable benefit plan appeal rights. Appeals are processed in accordance with all state and federal rules and regulations.

To expedite processing, ensure all required information and documentation is included in the appeal request.

To appeal a prescription drug claim or request, appeals must be submitted in writing to:

Express Scripts
Attn: Appeals Department
P.O. Box 66588
St. Louis, Missouri 63166-6588
Phone: (800) 935-6103
Fax: (877) 852-4070

Section 5 — Other Carrier Liability

Coordination of Benefits

The Company coordinates benefits when a patient is covered by more than one healthcare coverage plan. A common example is when a working husband and wife each have family healthcare coverage through an employer plan, and each plan covers the couple's dependent child(ren). Benefits are coordinated to avoid double payment and to make sure that the combined payments of all healthcare plans are not more than the actual bills.

All bills should be submitted to the primary plan first. The primary plan must pay its benefits as if there were no other coverage. If the primary plan denies the claim or does not pay the full bill, the balance may be submitted to the secondary plan.

When the Company is the secondary carrier, the Company will pay the balance remaining after the primary carrier makes payment, as long as the amount does not exceed the Company's normal payment (what the Company would have paid in the absence of other insurance), less applicable copayments and deductibles.

Exceptions to this method are Medicare primary and a small number of specialty groups that require non-standard coordination of benefits processing. For more information on these types of specialty groups, contact your Provider Contract manager.

The Company currently accepts commercial coordination of benefits (COB) for professional and institutional claims electronically. The Company does not require a paper explanation of benefits (EOB) when commercial COB claims are submitted electronically. The Company does not currently support electronic dental COB at this time. For additional information contact your clearing house vendor or the Provider Inquiry unit at (800) 362-1279.

Determining the Primary and Secondary Carriers

The Company coordinates benefits according to the applicable COB rules established by law.

To determine which plan is primary, the COB provision of each plan, as well as the patient's status with each plan, must be considered. The primary plan will be determined by the first applicable rule:

- **Non-Coordination Plan:**
If the patient is covered under a plan that does not coordinate benefits, that plan will always be primary.
- **Employee:**
The plan that covers the patient as an employee, regardless of whether they are actively working, laid off, or retired, is always primary.
- **Children (Parents Divorced or Separated):**
If the court decree makes one parent responsible for healthcare expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention healthcare, the Company will follow the birthday rule. (See Children and the Birthday Rule [Parents not Divorced or Separated].)

If none of those rules apply, the following order will be used to determine which plan is primary:
 - The plan of the parent with custody of the child
 - The plan of the spouse of the parent with custody of the child
 - The plan of the parent not having custody of the child
 - The plan of the spouse of the parent not having custody of the child
- **Children and the Birthday Rule (Parents not Divorced or Separated):**
When dependent children's healthcare expenses are involved, the Company will follow the birthday rule. The plan of the parent with the first birthday in a calendar year is always primary for the children. However, if one parent's plan has some other coordination rule (for example, a gender rule which says the father's plan is always primary), the Company will follow the rules of that plan.
 - The benefit plan covering the patient as the card holder, as opposed to a dependent, is always primary.
 - When more than one plan covers the same dependent child, whose parents are not divorced or separated, the following order applies:
 - The benefit plan of the parent whose birthday occurs earliest in the calendar year will be primary.
 - If both parents have the same birthday, the benefit plan that has covered the parent longer will be primary.

Coverage under a Right of Continuation

If a person's coverage is provided under a right of continuation pursuant to Federal or State law, the following rules will be used.

- The benefit plan covering the person as an employee (including dependents) will be primary.
- The benefit plan provided under continuation coverage will be secondary.

Other Situations

- In the event that none of the preceding rules apply, the benefit plan that has covered the person longer will be primary.
- For all other situations not described above, the order of benefits will be determined in accordance with your state's insurance rule on COB.

Providers with questions regarding COB should contact their Provider Contract manager.

Billing Procedures

Completing the claim items on the CMS-1500 or UB-04 correctly is essential for the accurate and timely processing of COB-related claims.

Items 9a–9d and 11d on the CMS-1500 or items 50 and 51 on the UB-04 are the most critical items for COB. List all payers: private, governmental and/or individual healthcare plans.

Plans That Do Not Coordinate Benefits

The Company will determine benefits, without regard to benefits paid, by the following coverage plans:

- Medicaid
- Group hospital indemnity plans
- Several supplemental sickness and accident policies

COB with Medicare

Medicare payment is excluded for employees entitled to

Medicare based on age (the working aged), disability (a disabled active individual), and end stage renal disease (ESRD) to the extent that benefits have been paid or may be expected to be paid under an employer group health plan (EGHP). The Company coordinates benefits with Medicare in those cases, using the Medicare secondary payer (MSP) rules.

Medicare Secondary Payer Rules Applicable to the Working Aged

The term Working Aged refers to those Medicare-eligible employees age 65 or over, and people age 65 or over with employed spouses of any age, who have group health plan coverage because of their own or their spouse's current employment. The working aged rules apply to employers that employ 20 or more employees.

Such employers are required to offer their employees age 65 or over the same group health coverage offered to younger employees. Those employers are also required to offer their employees with Medicare-eligible spouses, age 65 or over, the same spousal group healthcare coverage the employer offers to spouses who are not Medicare-eligible.

If the employee or employee's spouse elects the employer group health plan as primary, Medicare will pay secondary. If the employee or employee's spouse declines coverage under the employer's group health plan, Medicare is the primary payer. The employer may not offer the employee or his spouse coverage that complements Medicare.

This law creates the possibility that a provider will encounter an individual who is over age 65 for whom Medicare is not the primary payer. The provider should determine the existence of all applicable coverages and submit the claim to the proper payer(s).

Disabled Active Individuals

Medicare disability eligibility as well as the time when Medicare becomes the primary payer is based on Medicare's rules relating to the length of time the patient has been receiving Social Security benefits. Until such time, the large group health plan (LGHP) is considered the primary payer, assuming the patient is still working (i.e. many work and are disabled), and group size is greater than 100.

End Stage Renal Disease (ESRD)

Medicare benefits are secondary for a limited period of time (up to 30 months) in the case of individuals who are entitled to Medicare solely on the basis of ESRD and who are entitled to healthcare coverage under an LGHP.

To determine the primary/secondary status in an ESRD case, examine the type of treatment involved: dialysis, transplant, or self-dialysis.

If the treatment is dialysis: A person is entitled to Part A benefits after a three-month waiting period has expired. The waiting period and the 30-month period during which Medicare may be secondary begins with the date the person first begins a regular course of dialysis. During the three-month waiting period, the EGHP is primary and there is no Medicare coverage. After the three-month waiting period, the

EGHP remains primary for 30 months, and Medicare is secondary during the 30-month period. After the three-month waiting period and the 30-month coordination period, Medicare becomes the primary payer.

If the patient participates in a self-dialysis training program during the three-month waiting period, entitlement to Medicare begins with the first month of the course of dialysis if the individual is expected to complete the training program and self-dialyze thereafter. The three-month waiting period is then waived and the 30-month coordination period, during which time Medicare is the secondary payer, begins.

If the treatment is a transplant: Medicare entitlement starts with the month of the transplant. The three-month waiting period is waived. Medicare will be primary after a 30-month coordination period.

If a transplant is successful, ESRD entitlement for Medicare will end after 36 months.

FCA US, LLC, AND GENERAL MOTORS

FCA US, LLC (formerly Chrysler Group) and General Motors use the birthday rule to determine the plan that has primary liability for dependents. Claims for a child covered by both parents' healthcare plans should be submitted under the contract number of the parent whose birthday occurs first in the calendar year.

Workers' Compensation

Federal law states that all employers must provide workers' compensation insurance for all their employees. Workers' compensation covers injuries or illnesses incurred on the job.

The Company does not coordinate workers' compensation cases. If a patient's illness or injury is determined to be work related, claims must be filed with the Bureau of Workers' Compensation in the respective state.

Billing Procedures

- Bill the Bureau of Workers' Compensation, or the
- Employer's Managed Care Organization (MCO).
- Complete items 10a, 14 and 16 of the CMS-1500 or items 18-28 and items 31-34 of the UB-04 claim form.

Subrogation

Subrogation is aimed at recovering claims dollars paid by the Company that are the legal responsibility of another party. The subrogation clauses in the Company healthcare contracts permit the Company to recover its claims payment in the event that a covered person sustains an injury or illness that is the responsibility of a third party.

Under the terms of the Company benefit contracts, if a subrogation situation arises, the Company will pay all related claims in accordance with its contractual obligations. However, all payments made in a subrogation situation are conditional. That means that when the covered person's case against the responsible party is settled, sometimes months or years after the incident, the Company has the right to recover its claims payment if such claims are determined to have been the responsibility of another party.

It is often the case that another insurance company or an attorney will send payment directly to the treating provider. If you receive a duplicate payment in a subrogation case, please send a written memorandum to:

MZ: 02-4T-1900
Subrogation Department
Medical Mutual of Ohio
100 American Road, Cleveland, OH 44144-2322

Even though a third party is responsible for covered services, all claims must be submitted to the Company for payment. If you are unsure as to whether a subrogation situation exists, please feel free to call:

The Rawlings Company
(800) 861-4826

Billing Procedures

- You can assist in our subrogation efforts by indicating an accident, the accident date, and the diagnosis on the claim form.
- Complete items 10b, 10c and 21 of the CMS-1500 or items 18-28 and 29 of the UB-04 claim form.

Section 6 — Adjustment and Provider Inquiries Overview (Revised)

Provider Inquiries (Revised)

Medical Mutual's Customer Care department is set up to give providers information on matters which need an immediate response. They respond to a wide variety of inquiries, including the status of claims, billing procedures, verification of covered person eligibility/benefits, and general provider information.

Customer Care does not handle inquiries related to the provider agreement. These questions should be directed to your Provider Contract manager.

Any of the Company's coverage information is subject to change and limited to the provisions of the applicable covered person's contract or group contract. This information is not intended to dictate a provider's treatment decisions, nor create any commitment for the payment of benefits.

Customer Care/Medical Mutual VoiceConnect®

Customer Care is set up to respond to questions from Professional and Institutional providers. Additionally, Medical Mutual VoiceConnect®, the Company's automated 24-hour service line, provides patient information about benefits, eligibility and claim status through voice recognition technology. Refer covered persons who have their own inquiries to the Customer Service number located on their ID card.

Contact Customer Care/Medical Mutual VoiceConnect® for questions involving:

- Benefits and/or covered person eligibility
- Status of the covered person's claim
- Status of a prior authorization
- Claims payment
- Claims denial issues or questions
- Be sure to have the following information available when calling:
 - Provider identification number (NPI or TIN)
 - Patient's identification number
 - Patient's date of birth

- Date(s) of service
- CPT/HCPC codes and diagnosis codes (for prior authorization inquiries and benefit quotes)

Resource	Number	Hours of Operation (EST)
Customer Care	(800) 362-1279	M - F 8:00a – 5:00p
Medical Mutual VoiceConnect®	(800) 362-1279	24-hour voice response system
Network Access Customers Customer Service	(800) 601-9208	M – F 8:00a – 5:00p

Provider Website Resources

Providers can check member eligibility and benefits directly through the Availity Provider Portal (login required). With this feature, you can verify patient enrollment and view coverage details, including copays, coinsurance and deductibles, in accordance with the member's benefit plan.

Providers can also access claim information through the Availity Provider Portal. Claims status is available through a variety of search options. You can view individual claims, as well as full remittance details. Electronic Remittance advices (ERA) offer immediate e-mail notifications with each electronic deposit.

For additional information and features of the Provider Portal, see Section 1 – Overview.

Provider Directories Available Online

Current provider directories are available online by visiting ProviderSearch.MedMutual.com. The Company's online directories give the most current information for each network provider.

The online directories offer providers a quick, easy way to locate network specialists when referring covered persons within network to enable the covered person to maintain the highest level of benefit.

Provider Action Request (PAR) Form

The PAR Form is available:

- Online through the Availity Provider Portal, which can be accessed at MedMutual.com/Provider. Log into the Availity Provider Portal, access the Medical Mutual Payer Space, then click the Resources tab.
- A printable, fillable PDF version of the PAR form is located at MedMutual.com/Provider, Resources, Forms. The PDF version should be used to submit paper inquiries by mail with supporting medical documentation.

Please submit the PAR form as instructed online. Providers can avoid delays in processing by reading and following the PAR Form Instructions. In addition to giving detail as to how to fill out the PAR form, the instructions also explain what to do when a claim is returned unprocessed.

Section 7 — Forms and Publications

Forms

The following forms mentioned in this Manual can be found online by visiting [MedMutual.com/Provider](https://www.MedMutual.com/Provider), Resources—unless otherwise specified.

Provider Information Form

Use the Provider Information Form (PIF) to change, add or modify demographic information on your provider record. Use additional forms for each TIN.

Provider Action Request Form

Use the Provider Action Request (PAR) Form for all provider inquiries and provider appeals related to reimbursement. Use one form per inquiry or patient. The Company has no obligation to make any adjustment after 12 months from the date the initial claim was processed.

PAR Form Instructions are available to help determine the supporting documentation required for each type of request and what to do when a claim is returned unprocessed.

Medical Drug Management Forms

Providers should use the Prior Authorization Form for medical drugs requiring prior authorization. The form is available at [MedMutual.com/Provider](https://www.MedMutual.com/Provider), Resources, Forms. Providers may also use Prime Therapeutics Management LLC online at [GatewayPA.com](https://www.GatewayPA.com)

Clinical Quality Supply Requisition Form

Use the Clinical Quality Supply Requisition Form to order the following forms or brochures mentioned in this Manual:

Continuity of Care Guidelines (Medical/Surgical)

The Continuity of Care Guidelines (Medical/Surgical) Z5417-CMT parameters for timely written communication between the primary care provider and the (non-behavioral health) specialist when referring patients.

Continuity of Care Summary Communication Form

The Patient Summary Provider Communication Form Z5417-CMT may be used by referring providers to document necessary clinical information when requesting a

consultation. This form is found on the back of the Continuity of Care Guidelines for Medical/Surgical.

Continuity of Care Guidelines (Behavioral Health)

The Continuity of Care Guidelines for Behavioral Health Z5443-CMT contains a one-page summary of Medical Mutual's guidelines for communication between the behavioral health specialist and the primary care provider.

Behavior Health Summary Communication Form

The Patient Summary Behavioral Health Communication Form Z5443-CMT is used to send referring providers a written summary of behavioral health consultations, including the patient's signed consent to release information. This form is found on the back of the Continuity of Care Guidelines for Behavioral Health.

Sample CMS-1500 Claim Form

Professional providers submitting paper claims must use the standard red ink version of the CMS-1500 Claim Form. A sample of this form is available for viewing from [CMS.gov](https://www.CMS.gov).

Sample UB-04 Claim Form

Institutional providers submitting paper claims must use the standard red ink version of the UB-04 Form (CMS-1450). A sample of this form is available for viewing from [CMS.gov](https://www.CMS.gov).

Provider Communications Publications

The Company publications listed in this section are designed to give providers the information necessary to work effectively with us. They are available by visiting [MedMutual.com/Provider](https://www.MedMutual.com/Provider), In the News. The current year plus two prior years of archived publications are maintained online. These publications are used to update this Manual and are considered part of it.

If you have not received one or more of these publications, please contact your Provider Contract manager. The following are the major Company publications relevant to professional and institutional providers. The Company also produces brochures, fact sheets and other communications of use to providers as needed.

Mutual News

Mutual News is a quarterly newsletter published to keep providers updated about Company products, policies, procedures, and quality improvement (QI) initiatives and

practice standards. It is also used to address issues and concerns identified through our conversations with providers.

Mutual News Bulletin

Mutual News Bulletin is published as needed to inform providers about topics that, due to their importance and/or timeliness, need to be distributed quickly.

Section 8 — Professional Reimbursement Overview

Pricing

All benefit payments are subject to the provider's contractual agreement with the Company and the provisions of the Covered Person's contract.

As with benefits, the covered amount or pricing method may vary for different Covered Persons, as defined in the applicable provider agreement. Pricing provisions are designated by the provider's contract.

In some instances, a deductible must be satisfied before the pricing method is applied.

The Covered Person's liability for covered services will be different depending on the pricing method defined by provider agreement. The pricing method and billable balance will be specified on the Notice of Payment (NOP). See Section 10 – Institutional Remittance Schedule and Summary for more information about the NOP.

Allowed Amount Revision

Allowed Amount is a fee-for-service method of payment and is characterized by maximum allowances for specific covered services.

Additional payment may be allowed if the Company Clinical Quality and Health Services department determines that the circumstances of a case are unusual in complexity. Clinical Quality and Health Services considers a case when a provider requests a review -

Coinsurance

Coinsurance is the percentage of the Allowed Amount that the Covered Person is responsible to pay.

Deductible

Deductibles may be either a specified dollar amount or the value of a specified service (such as one provider visit). Deductibles are usually tied to some reference period during which they must be satisfied, e.g., \$100 per calendar year, benefit period, or duration of illness.

After a deductible has been met or satisfied, contract benefits will be calculated. The Covered Person is responsible for paying to the provider any amount applied to a deductible for covered services.

After receiving the NOP from the Company, a Participating Provider may bill the Covered Person for the deductible amount up to the allowed reimbursement amount. Deductibles are indicated on the NOP.

The Participating Provider may bill the Covered Person for the coinsurance amount and the amount applied to the deductible. The Participating Provider may not bill the Covered Person for the amount that exceeds the Allowed Amount.

Copayment

A copayment is a dollar amount that must be paid per visit.

Coverage Secondary to Medicare

Medifil

Most Covered Persons who have coverage both under a group health plan and under Medicare Part B have coverage known as Medifil. This coverage fills in the gaps or amounts for services not paid by Medicare. The Medicare annual deductible and Covered Person coinsurance are paid by this supplemental coverage.

Two levels of Medifil benefits are offered. By adding an endorsement, the coverage is extended to include the difference between the amount approved by Medicare and the allowed reimbursement amount, if the provider has not accepted assignment with Medicare. Medifil without the endorsement covers only the balance up to the amount approved by Medicare.

Medifil benefits cover only services allowed by Medicare. The determination of covered services, medical necessity, and benefit limits lies solely with Medicare. Services allowed by Medicare will be covered by the Company. Those disallowed by Medicare will also be denied under Medifil.

Medifil Covered Persons may have additional coverage with the Company that includes benefits beyond those provided by Medicare. Some services not covered by Medicare and Medifil may be eligible under Supplemental Major Medical. Major Medical expenses are subject to an annual deductible, which must be satisfied before any benefit is available, and that payment is usually subject to a coinsurance.

Medicare Carve-out

Some groups offer complementary coverage which carves out Medicare reimbursements from the same scope of benefits offered to active employees. Under this type of coverage, Medicare's decision regarding benefits is irrelevant to the Company determination of covered services. Some services allowed by Medicare, such as office visits, may not be covered by the carve-out benefits, while others denied by Medicare may be paid by the carve-out.

In addition to Medifil and Major Medical benefits, some contracts offer prescription drugs, dental, vision and/or hearing care coverage.

Direction of Payment

Medical Mutual is authorized to make payments directly to providers who have performed a covered service for its members. Medical Mutual also reserves the right to make payment directly to its Covered Persons. When this occurs, the Covered Person must pay the provider and Medical Mutual is not legally obligated to pay any additional amounts. The Covered Person cannot assign his/ her right to receive payment to anyone else, nor can he/ she authorize someone else to receive payments on his/her behalf, including his/her provider.

Reimbursements for Medifil benefits will be directed according to the provider's acceptance of the Medicare assignment. If the provider has accepted assignment for the services rendered, agreeing to bill only the amount approved by Medicare, the Company will pay the provider directly.

For Medicare carve-out contracts, payment will be issued to the Covered Person, regardless of the provider's contracted status with the Company.

Payment for services covered under the Traditional Dental™ program will be directed according to the Covered Person's assignment of benefits on the dental claim form. If the Covered Person signs the form, the benefit check will be sent directly to the dentist. Otherwise, payment will be issued to the Covered Person.

For services provided to those covered under the SuperDental® program, payment will be directed to the provider regardless of the assignment on the claim form.

Note: Some dental plans have deductibles that must be satisfied prior to payments being made.

Indemnity Schedule

Some Covered Persons are covered by indemnity schedule contracts, sometimes referred to as schedule contracts. Indemnity benefits provide payment based on fixed, pre-established maximum allowances. However, benefits do provide the Covered Person with some assistance towards meeting the cost of needed healthcare.

A defined allowance for each covered service is established at the time the contract is written. Representative allowances are listed in the contract. These amounts remain the same as long as the contract is in effect.

Many Covered Persons with indemnity contracts also have Supplemental Major Medical Coverage. The balance between the indemnity schedule payment and the allowed reimbursement amount may be an eligible major medical expense.

If a Covered Person does not have Major Medical Coverage, the balance between the indemnity payment and the allowed reimbursement amount is the Covered Person's out-of-pocket liability. However, if the charge is covered by Major Medical, a Participating Provider may not bill for the balance in excess of the allowed reimbursement amount.

The provider can determine from the NOP whether the method of payment was based on the allowed reimbursement amount or the indemnity schedule, and whether the charge is covered under Major Medical. The Covered Person's liability will be indicated on the NOP.

Corporate Reimbursement Policies

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. The policies are accessible at MedMutual.com/Provider, Policies and Standards, Corporate Reimbursement Policies. The provider is responsible for submission of accurate claims.

Providers are required to review the Company Corporate Reimbursement Policies disclaimer, and upon acceptance, access to the site is granted. The Corporate Reimbursement Policies section lists Corporate Reimbursement Policies in alphabetical order.

Section 9 — Institutional Reimbursement Overview (Revised)

Payment Categories and Methodologies

The following section can be used to establish the payment methodology that is used to determine reimbursement for Institutional Providers.

To use the section, look first at the Payment Category of the healthcare service. Second, review the provider's current agreement with the Company to determine the payment methodology being used and refer to that payment methodology in this section.

Interim Claims

Medical Mutual does not accept and will deny interim claims, except in certain circumstances, and the services are subject to Prior Authorization terms and requirements and reimbursement methodology. (See also Completing the UB-04 Claim Form section in Section 2 – Claims Overview.)

Medical Mutual does not accept and will deny interim claims if the provider's reimbursement is based on DRG or Per Case payment methodology or in circumstances where the total charges from the admit date through discharge date impact the contracted reimbursement amount. Claims will be processed once claims coding shows that all services have been rendered and the complete admit through discharge claim is received.

In addition, Medical Mutual does not accept and will deny interim skilled nursing claims submitted for services provided to Covered Persons under Medicare Advantage policies.

If the provider's reimbursement is based on other payment methodologies, Medical Mutual will accept and process interim claims as long as the interim claims are received in chronological date order, and, more specifically, in the same sequence in which services were rendered. If an interim claim is received out of sequential order from the prior interim claim, the claim will be denied. Interim claims must also have appropriate coding per UB-04 guidelines.

Payment Categories

These are healthcare services categories for payment used by the Company:

- Medical/Surgical Services (MS-DRGs all others not listed)
- Maternity Services (MS-DRGs 768, 783-788, 796-798 and 805-807)
- Newborn Services (MS-DRGs 794, 795)
- Psychiatric (MS-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887)
- Substance Abuse (MS-DRGs 894, 895, 896, 897)
- Neonatal (MS-DRGs 789, 790, 791, 792, 793)
- Physician Rehabilitation services (including, without limitation, MS-DRGs 945, 946)
- Transplant Cases — the Company payment will be made according to the negotiated contract.
 - Heart Transplant (MS-DRG 001, 002)
 - Liver Transplant MS-DRG 005, 006)
 - Lung Transplant (MS-DRG 007)
 - Simultaneous Pancreas/Kidney Transplant (MS-DRG 008, 019)
 - Bone Marrow Transplant (MS-DRG 014, 016, 017)
 - Pancreas Transplant (MS-DRG 010)
 - Kidney Transplant (MS-DRG 650-652)
 - Chimeric Antigen Receptor (CAR) T-Cell (MS-DRG 018)
- Burn Cases — the Company payment will be made according to the negotiated contract. The hospital will transfer all burn cases, as soon as medically possible; to a burn unit that is an Approved Program.
 - Extensive burns or full thickness burns with MV 96+ hrs. with skin graft (MS-DRG 927)
 - Full thickness burn with skin graft or inhal inj with CC/MCC (MS-DRG 928)
 - Full thickness burn with skin graft or inhal inj without CC/MCC (MS-DRG 929)
 - Extensive burns or full thickness burns with MV 96+ hours without skin graft (MS-DRG 933)
 - Full thickness burn without skin graft or inhal inj. (MS-DRG 934)
 - Non-extensive burns (MS-DRG 935)

Please Note: Hospitals lacking an approved program must transfer Covered Persons with such specialty diagnosis to a hospital with an approved program within one day from the time of admission.

Regular MS-DRG Payment Methodology

A Medical Severity Diagnosis Related Group (MS-DRG) is a system to classify cases into groups, expected to have similar resource use. MS-DRGs were developed for Medicare as part of the prospective payment system. The formula for calculating an MS-DRG payment is:

$$\text{MS-DRG Payment} = \text{Contracted Rate} \times \text{CMS MS-DRG Weight}$$

Please Note: When a provider's primary payment method is MS-DRG, inpatient claims cap reimbursement at charges.

Transfer Payment

All payments for transfers will be made in accordance with the transfer methodology used by the Centers for Medicare and Medicaid Services (CMS) in effect at the time of the transfer. The appropriate Patient Discharge Status should be included on the claim to indicate transfers.

Reimbursement Methodology — Per Diem

The provider agrees that it will provide covered services to any Covered Person subject to the terms and conditions contained in the Provider Agreement and in the applicable policy.

The Company shall pay the provider for covered services according to the applicable Per Diem in the Agreement. The reimbursement amount will be calculated using the formula:

$$\text{Applicable Per Diem} \times \text{Approved Days}$$

Please Note: When a provider's primary payment method is MS-DRG, all inpatient claims cap reimbursement at charges, including those reimbursed per diem.

Outpatient Ambulatory Payment Classifications (APC)

Medical Mutual's APC Based Outpatient Prospective Payment System (OPPS) is based upon the OPPS developed by the Center for Medicare and Medicaid Services (CMS) and is used to classify and pay hospitals for outpatient services. In most cases, the unit of payment is the Ambulatory Payment Classification (APC), which is assigned by the Outpatient Code Editor (OCE), a program based on the Healthcare Common Procedure Coding System (HCPCS). Covered services are assigned to an APC based on similar clinical characteristics and costs. The payment calculated for an APC applies to each covered service within the APC.

Outpatient Code Editor (OCE)

All outpatient Claims will be run through the OCE, which will perform the following functions:

- Edits a Claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated Status Indicators
- Computes discounts, if applicable
- Outpatient Ambulatory Payment Classifications (APC) (continued)

- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable

Medical Mutual's APC Based OPPS is intended to use all structures, values and mechanisms of CMS' OPPS, with certain exceptions as noted in the Provider Agreement and this Provider Manual.

See [PCAT-3108 Reference Table 1 OCE Disposition of Errors](#) for Medical Mutual's disposition of each of the APC errors returned from the OCE.

The OCE is subject to all the terms and conditions of the Provider Agreement and this Provider Manual.

Payment Provisions

Reimbursement methodology for a covered service is determined by the Status Indicator returned by the OCE. The reimbursement methodologies are set forth in the Provider Agreement and are subject to all terms and conditions set forth in the Provider Agreement.

Outpatient Ambulatory Surgery Classification (ASC) Groups

Medical Mutual shall assign covered services to Ambulatory Surgery Classification (ASC) groups pursuant to the Medical Mutual ASC group methodology. The Medical Mutual ASC group methodology is available online at [MedMutual.com/Provider, Resources, and Outpatient Ambulatory Surgery Classification Groups](http://MedMutual.com/Provider_Resources_and_Outpatient_Ambulatory_Surgery_Classification_Groups).

For any code that falls within an ASC group, as maintained by Medical Mutual, reimbursement will be based on the applicable ASC group and the corresponding reimbursement rate. If a code does not fall within an ASC group, it will be reimbursed under the applicable reimbursement methodology specified in the Provider Agreement, if any. The percentage of charge rate set forth in the Provider Agreement will be used only if no other reimbursement rate applies.

Reimbursement — Percentage of Charge

Percentage of Charge Payment Methodology

The Company shall pay the covered service according to the applicable Percentage of Charge Rate in the Agreement, subject to and adjusted in accordance with the Provider Agreement. The reimbursement amount will be calculated by taking Charges for covered services times the applicable Percentage of Charge Rate less any Covered Person's obligation.

Repeat Admissions/Leave of Absence

Prior to September 18, 2024, the following repeat admissions/leave of absence provisions apply:

A Covered Person who requires follow-up care or surgery may be:

- Discharged and readmitted or
- Placed on a leave of absence (LOA).

A discharge/readmission may not result in two payments. The Company may review an acute care hospital admission occurring after discharge from an acute care hospital if it appears that the two confinements could be clinically related and if the readmission could have been avoided or prevented. Two separate payments would be made for these cases unless the readmission and preceding admission are found, by application of criteria set forth in Medical Mutual's Hospital Readmissions Reimbursement Policy, to be clinically related and the readmission is found to have been avoidable or preventable, in which case the readmission may be denied.

Upon the request of the Company, providers must submit medical records pertaining to the initial admission and the readmission, including, but not limited to, complete documentation of discharge planning, clinical status at discharge, and discharge instructions on each case.

NOTE: The Company will review and may deny a second admission to provider or any of its affiliated providers if the second admission occurs within 30 days of discharge from the provider if it appears the two confinements are clinically related and that the readmission is found to have been avoidable or preventable. The readmission review and second admission payment denial applies for those acute care hospitals and hospital systems reimbursed using a DRG or Case Rate methodology. When the readmission occurs at a different acute care hospital within the same hospital system, the readmission review and second admission payment denial will apply when the first admission was at an acute care hospital reimbursed using a DRG or Case Rate methodology.

LOA: Placing a patient on a leave of absence will not generate two payments. The provider may place a Covered Person on LOA when readmission is expected and the Covered Person does not require a hospital level of care during the interim period. Examples include, without limitation, a situation where surgery cannot be scheduled immediately, a surgical team was not available, bilateral surgery was planned, or further treatment is indicated following diagnostic tests but cannot begin immediately.

Upon the request of the Company, providers must submit medical record documentation to support the rationale for the expected readmission and why the member does not require a hospital level of care during the interim period.

LOA Billing: The provider shall bill only for Approved Days. Non-covered Charges for LOA days (i.e., holding a bed) must be omitted from the claim. The claim must have only one corresponding authorization record from the Company. The claim must include leave of absence dates with occurrence span code 74 to report the dates the leave began and ended.

The Company and the Covered Person may not be billed for LOA days.

The provider may submit a claim if a Covered Person on LOA has: (1) Been discharged following return from LOA, (2) Not returned within 60 days including the day the LOA began, or (3) Been admitted to another institution.

Beginning on September 18, 2024, the following repeat admissions/leave of absence provisions apply:

A Covered Person who requires follow-up care or surgery may be:

- Discharged and readmitted or
- Placed on a leave of absence (LOA).

A discharge/readmission may not result in two payments. The Company may perform readmission reviews in accordance with Medical Mutual's Hospital Readmissions – Non-Medicare Advantage Reimbursement Policy and deny payments for readmissions in accordance with the provisions of such policy. For leaves of absence, the terms of such policy will also apply.

Special Payment Provisions

Services — Pre-episode (Pres.)/Same Day (SDS)/ Post-episode (POES) Window of Service

Prior to the effective date of Medical Mutual's Pre-Episode, Same Day and Post-Episode Services Reimbursement Policy, the following will apply:

The Company will not accept nor pay separate outpatient claims for PRES, SDS, and POES since payment for these services are included in the applicable Contracted Rate or Per Diem specified on the Agreement.

As it applies to this clause, PRES and SDS includes, without limitation, preadmission testing by either the provider or any affiliated providers performed before the Covered Person is admitted to the provider, emergency room services by either the provider or any affiliated providers that result in an

admission to the provider or a transfer, and observation room services by either the provider or any affiliated providers that result in an admission to the provider. POES is any service performed after discharge by either the provider or any affiliated providers, including, without limitation, post-discharge testing performed more than 24 hours after discharge, if the testing relates to the original admission, including testing mandated by law that is not efficacious unless performed after discharge.

Beginning on the effective date of Medical Mutual's Pre-Episode, Same Day and Post-Episode Services Reimbursement Policy, the terms of Medical Mutual's Pre-Episode, Same Day and Post-Episode Services Reimbursement Policy will apply.

Serious Reportable Events

Institutional providers should refer to Serious Reportable Events policy information in Section 3 – Clinical Quality and Health Services Programs.

Audit Provisions (Revised)

The Company reserves the right to audit specific claim payments on an individual or aggregate basis, regardless of whether such payment or payments have already been made and may make adjustments to such claims payments, including without limitation:

- Medical necessity or lowest cost setting determinations
- Bill/claim validation determinations of coding accuracy
- Fragmentations pursuant to the Agreement
- Adjustments required for failure to comply with submission of claim instructions or requirements of the Company
- PRES/SDS/POES billing for outpatient claims if another inpatient or outpatient claim has been submitted
- Billing for Serious Reportable Events

Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Medical Mutual follows the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)*. If, after reviewing a member's medical record for a claim submitted with a sepsis and/or severe sepsis ICD-10-CM code, Medical Mutual determines that sepsis and/or severe sepsis was not a valid diagnosis and/or not present on admission based on Sepsis-3 criteria, the diagnosis-related group (DRG) claim assignment may be adjusted accordingly with the appropriate DRG claim assignment had a sepsis and/or

severe sepsis ICD-10-CM code not been billed and that is supported by the member's medical record.

*Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Christopher Warren Seymour, MD, MSc; et al. "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)." JAMA. 2016;315(8):801-810.

Global Leadership Initiative on Malnutrition (GLIM)

Medical Mutual follows the Global Leadership Initiative on Malnutrition (GLIM) criteria for malnutrition. If, after reviewing a member's medical record for a claim submitted with a Mild protein-calorie malnutrition, Moderate protein-calorie malnutrition, Unspecified protein-calorie malnutrition, or Unspecified severe protein-calorie malnutrition ICD-10-CM code, Medical Mutual determines that malnutrition was not a valid diagnosis and/or not present on admission based on GLIM criteria, ICD-10-CM coding guidelines, and AHA Coding Clinic guidance, the diagnosis-related group (DRG) claim assignment may be adjusted accordingly with the appropriate DRG claim assignment had malnutrition not been billed and that is supported by the member's medical record.

Jensen GL, Cederholm T, Correia MITD, et al. (2019) GLIM Criteria for the Diagnosis of Malnutrition: A Consensus Report From the Global Clinical Nutrition Community JPEN J Parenter Enteral Nutr, Vol 43 (1) 32-40; ICD-10-CM Official Guidelines for Coding and Reporting; AHA Coding Clinic

Corporate Reimbursement Policies

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. The policies are accessible at MedMutual.com/Provider, Policies and Standards, Corporate Reimbursement Policies. The provider is responsible for submission of accurate claims.

Providers are required to review the Company Corporate Reimbursement Policies disclaimer, and upon acceptance, access to the site is granted. The Corporate Reimbursement Policies section lists Corporate Reimbursement Policies in alphabetical order.

Section 10 — Institutional Remittance Schedule and Summary

Check and Remittance Schedule Summary

This section provides samples of the Check Voucher, No Check Form, and Provider Invoice, as well as the Remittance Schedule forms: Adjustment (Take Back) Summary, Inpatient Remittance, and Outpatient Remittance. Each form includes an explanation of the columns.

The check or, as applicable, the No Check Form is the first page in the remittance mailing. Below the check is the remittance schedule summary. The summary is intended as a check stub and identifies any payment reduction or future payment reductions. This form will help in reconciling patient account balances when credits are applied.

The activity summary attached to the check has information to assist the provider in understanding how its check amount was calculated.

The invoice serves as an alternate method of recovery that allows the provider to submit a refund check rather than have a future check reduced by this outstanding balance.

EFT and ERA Enrollment

Providers can simplify the payment process by signing up to receive direct reimbursement through Electronic Funds Transfer (EFT). EFT is a safe alternative to paper checks. Benefits of using EFT include:

- Receive claim payments electronically through ACH Direct Deposit
- Improve cash flow by receiving payment sooner
- Eliminate bank fees associated with depositing paper checks or lockbox processing
- Dispense with physically tracking paper checks and deposits

- Receive online access to Explanation of Benefits (EOB)

Changes and cancellations are administered by One Inc. To make changes to an EFT account, contact One Inc at (877) 313-4898 or providers@oneinc.com. To ensure EFTs are processed correctly, inform One Inc. when there is an addition or change to a TIN or an NPI.

Visit caqh.org/ORMandate_EFT.php for more information regarding CAQH CORE EFT/ERA Operating Rules.

For more detailed instructions regarding EFT enrollment or to make changes or cancel EFT enrollment, please consult the Resources, EFT and ERA page of our website at MedMutual.com/Provider.

The Electronic Remittance Advice (ERA), or 835, is the electronic transaction which provides claim payment information in the HIPAA mandated 5010A1 format. Providers can save valuable time, reduce the payment posting process and eliminate paper notice of payment copies by registering for ERA. Enrollment is handled through EDI clearinghouses with a working relationship with Medical Mutual.

ERA enrollment changes and cancellations are handled by your respective EDI clearinghouse. Please contact your EDI clearinghouse to begin receiving ERAs from Medical Mutual.

Explanation of Remittance Schedule

Account summaries are listed in this order: Inpatient Paid and Adjusted Claims, followed by Inpatient Rejections. A separate page is started for Outpatient claims, which combines Outpatient Paid and Adjusted Claims, followed by Outpatient Rejections. All claims are arranged in **alphabetical order by the patients' last names**. The front of the Remittance Schedule includes:

INPATIENT REMITTANCE SCHEDULE																
Provider Name Provider Mailing Address										DATE Oct 21, XXXX						
										PROVIDER NUMBER						
										CHECK NUMBER						
										PAGE 1						
PATIENT BILLING NUMBER	DATE OF ADMIT	DATE OF DISCHARGE	COV DAYS	BILLED CHARGES	NON COVERED AMOUNT	RMK CODE	FEE SCHEDULE	DEDUCTIBLE /COPAY	COINSURANCE	OTHER PAID	PAID AMOUNT	SUBSCRIBER LIABILITY	WRITE OFF	P T	DRG CD	ADJ RSN
PROVIDER INQUIRY HOURS MON-THU 7:30AM - 7:30PM FRI 7:30AM - 6:00PM SAT 9:00AM - 1:00PM (800) 362-1279			0101													
PATIENT NAME: V165005		06/06/XXXX	07/06/XXXX	ID NUMBER: 3,652.27			Submit Inquiry	CLAIM NUMBER: 3,652.27		2,799.77	852.50	0.00	0.00	Z	561	
											852.50	INPAT SUBTOTAL				
											852.50	TOTAL ACTIVITY				

OUTPATIENT REMITTANCE SCHEDULE																		
Provider Name Provider Mailing Address										DATE Dec 6, XXXX								
										PROVIDER NUMBER								
										CHECK NUMBER								
										PAGE 1								
PATIENT BILLING NUMBER	DATE OF SERVICE	BILLED CHARGES	NON COVERED		CHARGES	UNITS	CPT CODE	RMK CODE	FEE SCHEDULE	DEDUCTIBLE /COPAY	COINSURANCE	OTHER PAID	PAID AMOUNT	SUBSCRIBER LIABILITY	WRITE OFF	PAYABLE FEE CODES	P T	ADJ RSN
PROVIDER INQUIRY HOURS MON-THU 7:30AM - 7:30PM FRI 7:30AM - 6:00PM SAT 9:00AM - 1:00PM (800) 362-1279			0101															
PATIENT NAME: 562 K004EA0		10/16/XXXX	354.21		ID NUMBER: 354.21			Submit Inquiry	CLAIM NUMBER: 354.21			343.77	10.44	0.00	0.00			5
TOTAL DAYS: 31		CARVE OUT DAYS: 0	NET DAYS: 31		INTEREST FOR 1 DAYS													
											10.44	OUTPAT SUBTOTAL						
											10.45	TOTAL ACTIVITY						

Explanation of Remittance Schedule		
Field Name	Provider Type	Description
Patient Name	Inpatient/Outpatient	The first 16 characters indicate the patient's last name, followed by 5 characters of the first name as they appear in box 8 of the UB-04
ID Number	Inpatient/Outpatient	Patient's certificate number as it appears in box 60 of the UB-04
Claim Number	Inpatient/Outpatient	13-digit number assigned by the Company to each claim on its receipt date

Patient Billing Number	Inpatient/Outpatient	Indicates the patient's control number (up to 14 alphanumeric chargers) assigned by the hospital as it appears in box 3A of the UB-04
Date of Service	Outpatient	Date services are provided
Date of Admit	Inpatient	Date of Admission as it appears in box 12 of the UB-04
Date of Discharge	Inpatient	Date of discharge as it appears in box 21 of the UB-04
Covered Days	Inpatient	Number of days approved for payment by the Company
Billed Charges	Inpatient/Outpatient	Total amount charged as it appears in box 47 of the UB-04
Non-Covered Amount	Inpatient	Amount of the charge(s) not covered due to contract limitations
Non-Covered Charges	Outpatient	Amount of the charge(s) not covered due to contract limitations
Non-Covered Units	Outpatient	Units applicable to the non-covered charge(s)
Non-Covered CPT Code	Outpatient	CPT code applicable to the non-covered charge(s)
RMK Code	Inpatient/Outpatient	Remark Code is a specific narrative explaining why a charge or portion of a charge is not allowed. Explanation of the Remark Codes appear on the back of the Remittance Schedule
Fee Schedule	Inpatient/Outpatient	Amount allowed under the Provider Agreement for services incurred
Deductible/Copay	Inpatient/Outpatient	Amount allocated towards the deductible as stipulated by the patient's contract/copayment amount is the patient's liability and subject to patient's contract stipulations
Coinsurance	Inpatient/Outpatient	Fee Schedule amount for covered services for which the patient is liable
Other Paid	Inpatient/Outpatient	Amount paid by other insurance carrier(s)
Paid Amount	Inpatient/Outpatient	Amount to be paid to the provider. Amounts are subtotaled at the end of the inpatient/outpatient claims.
Subscriber Liability	Inpatient/Outpatient	Total amount owed by patient
Write - Off	Inpatient/Outpatient	The amount the account is to be reduced by according to the Provider Agreement
Payable Fee Codes	Inpatient/Outpatient	The ambulatory patient group (APG) code by which the claim is processed
PT (Payment Type)	Inpatient/Outpatient	An explanation of these codes appears on the back of the Remittance Schedule (see additional table below)
DRG Code	Inpatient	The diagnosis related group code by which the claim is processed
ADJ RSN	Inpatient/Outpatient	The adjustment code is a specific narrative explaining why a charge or portion of a charge is adjusted. (See Adjustment Reason Codes list enclosed with your checks and remittances)

Payment Types (PT)		
1 Non-Network DRG	2 Non-Network DRG Outlier	3 Non-Network per Diem
4 Non-Network Percent of Charges	5 Medicare Comp	6 Non-Network Hourly Rate
7 Non-Network Per Diem & Charges	8 Non-Network Alternate Payment %	9 Non-Network ASPG
A Non-Network Per Case	B Network Per Case	E Network DRG
F Network DRG Outlier	G Network Per Diem	H Network Percent of Charges
I Network Alternate Payment %	J Network ASPG	K APG
L Network APG	M AOPOC	N Network AOPOC
O APG Outlier	P Network APG Outlier	Q APG Inlier

R Network APG Inlier	U Spot Negotiation	X Primary Allowed
Z Medicare Carve Out		

Explanation of Adjustment (Take Back) Summary Information

ADJUSTMENT (TAKE BACK) SUMMARY													
Provider Name Provider Mailing Address										DATE Dec 4, XXXX PROVIDER NUMBER ACCOUNT ID PAGE 1			
ADJ CODE	ADJ TYPE	PATIENT NUMBER	DESCRIPTION	ID NUMBER	CLAIM NUMBER	DATE OF SERVICE	DATE PAID	REFUND RETURNED CHECK NO.	ORIGINAL BALANCE	PRIOR BALANCE	TODAY'S RECOVERED AMOUNT	TOTAL RECOVERED AMOUNT	CURRENT BALANCE DUE
T81	C						12/04/XXXX		-1,900.50		1,900.50	1,900.50	0.00
T81	C						12/04/XXXX		-814.50		814.50	814.50	0.00
SUMMARY TOTAL									-2,715.00	0.00	2,715.00	2,715.00	0.00
TOTAL ADJUSTMENT BALANCE DUE													0.00

Explanation of Adjustment (Take Back) Summary Information	
Field	Description
Adjustment Code	Code used to describe the reason why the claim was adjusted
Adjustment Type	A Current or prior period adjustment C or O Refund/returned check received D or W Removal of adjustment Amount M Manual adjustment activity T Transfer of prior adjustment balance to another payee number U Update/change to original adjustment balance or refund/return check information
Patient Number	Patient's (history/account number)
Description	Last and first name of the patient or a description of the item that was adjusted. (Note: Non-detailed adjustment balances will be reported with the description prior credit balance.)
Certificate Number	Patient's ID Number
Claim Number	13-digit number assigned
Date of Service	Date the service was incurred
Date Paid	Date when the claim was adjusted as listed on the Remittance Schedule
Refund/Returned Check Number	Refund/returned check applied against prior balance owed
Original Balance	Original adjustment balance owed on this claim
Prior Balance	Adjustment balance carried forward from current balance due (last column) on the previous adjustment summary
Today's Recovered Amount	Amount that today's original balance is reduced by (paid on Remittance Schedule), based on claim payment activity including refund/returned checks or removal of adjustment amount
Total Recovered Amount	The cumulative recovered amounts through today

Current Balance Due	The original balance less the total recovered amount equals funds owed
Total Adjustment Balance Due	Amount carried forward to the next adjustment summary under prior balance: listed as the adjustment amount owed, as of the date of that adjustment summary toward the next activity summary

Explanation of Notice of Payment (NOP)

NOTICE OF PAYMENT													
Provider Name Provider Mailing Address										DATE Oct 21, XXXX			
										PROVIDER NUMBER			
										CHECK NUMBER			
										PAGE 1			
PATIENT BILLING NUMBER	DATE OF SERVICE	PROC CODE	PROVIDER CHARGES	* P T	* B C	RMK CODE	ALLOWED CHARGES	DEDUCTIBLE /COPAY	COINSURANCE AMOUNT	MED/OTHER INS PAID	AMOUNT PAID	PATIENT LIABILITY	WRITE OFF
PROVIDER INQUIRY HOURS MON-THU 7:30AM - 7:30PM FRI 7:30AM - 6:00PM SAT 9:00AM - 1:00PM (800) 362-1279			0101										
PATIENT NAME: 000100356151	08/20/XXXX	67825	259.00	U	E26		129.93			103.86	26.07	0.00	129.07
CLAIM TOTAL:			259.00				129.93			103.86	26.07	0.00	129.07
											26.07	TOTAL ACTIVITY	

Explanation of NOP (Notice of Payment) Information	
Field	Description
Patient Billing Number	Patient's (history/account) number assigned by your office from box 26 of the CMS-1500 Claim Form, limited to the first 9 positions
Date of Service	Date the service was incurred
Proc Code	5-digit CPT code
Provider Charges	Amount charged for the service incurred as it appears in box 24F of the CMS-1500 Claim Form
PT: (Payment Type)	U Traditional B SuperMed S Schedule O Other X Primary Allowed
BC: (Benefit Code)	B Basic M Major Medical S Supplemental Accident C Credit Reserve
RMK Code	Remark code refers to a specific narrative explaining why a charge, or a portion of a charge, was not allowed. The explanation of codes will appear on the last page(s) of the mailing.
Allowed Charges	Fee schedule in effect for this date of service, based on the patient's policy or flat dollar copayment.

Section 11 — Administrative and Plan Guidelines

The Company maintains preferred provider organization (PPO) plans, point of service (POS) plans, and health maintenance organization (HMO) plans. These guidelines outline the components of the PPO, POS and HMO plans and explain specific procedures to the provider. The guidelines only supplement the information provided throughout this Manual, not replace it.

The SuperMed® Network includes institutional and professional providers. Providers are required to refer members within the member's network. As with other managed care plans, prior authorization and concurrent review may be required as part of the program. In order for members to receive the highest level of benefits, network providers need to be utilized.

HMOs encourage each member (including each enrolled family member) to choose a primary care physician (PCP) from the most current HMO provider directory. If directory information for any PCP's office is incorrect, the PCP should notify his/her Provider Contract manager.

Network Products

The following section describes Medical Mutual's network products. The network products that the provider actually participates in are set forth in the provider's agreement with Medical Mutual.

SuperMed® PPO

Our provider network consists of both institutional and professional providers (formerly known as the SuperMed Plus® network). Much of Medical Mutual's business uses the SuperMed PPO network.

SuperMed® Professional

Professional network, PPO

SuperMed Classic®

Hospital network only; use of SuperMed Plus providers is strongly encouraged.

Medicare Advantage

The Medicare Advantage Network consists of contracted providers who have agreed to provide covered services to covered persons that have elected one of the following plan options:

MedMutual Advantage® Choice, Classic, Plus, Secure or Signature HMO

Under these options, all services must be provided within the Medicare Advantage Network unless an emergency or urgent need for care arises. There are no benefits for services rendered by a provider outside of the Medicare Advantage Network.

MedMutual Advantage® Premium, Preferred, Select or Access PPO

These options allow covered persons to access services from non-Medicare Advantage Network providers. Payment for services provided by a non-Medicare Advantage Network provider will be reduced in accordance with the covered person's policy.

SuperDental®

A preferred provider dental organization network product

Medical Mutual Service Accounts

The Company provides network services for various accounts including self-insured groups, health and welfare funds, third-party administrators and other insurance companies. When submitting claims, providers must always refer to the covered person's identification card.

POS Products

SuperMed Select®
SuperMed Preferred®

HMO Products

SuperMed HMO®
CLE-Care HMO Network
MedFlex Network
MedMutual Individual HMO Network
CLE-Care HMO Individual Network

HMO Provisions

If a provider is licensed, certified, accredited, or otherwise authorized in Ohio to furnish healthcare services and

participates in any of the previously listed HMO products, the following provisions apply.

1. Inconsistencies and Definitions

a) *Inconsistencies*

In the event of an inconsistency between terms of this HMO Provisions section and the terms and conditions set forth in the provider agreement, the terms and conditions of this HMO Provisions section shall govern. To the extent the provider agreement or this HMO Provisions section conflicts with any statute or regulation applicable to Medical Mutual, the statute or regulation shall have full force and effect. Except as set forth herein, all other terms and conditions of the provider agreement remain in full force and effect.

b) *Definitions*

Capitalized terms not defined in this HMO Provisions section have the definitions assigned to them in the provider agreement or, if no meaning is defined in the provider agreement, then in this Provider Manual.

2. Ohio Legal Requirements for HICS

To the extent required by Ohio's Health Insuring Corporation (HIC) law, as amended from time to time, the parties agree as follows:

a) *Stop-loss Assistance*

Medical Mutual agrees, upon written request, to assist provider in finding stop-loss or reinsurance carriers.

b) *Benefits*

Medical Mutual agrees to notify provider of the specific healthcare services for which the provider or healthcare facility will be responsible, including any limitations or conditions on such services, upon written request.

c) *Hold Harmless*

1) Provider agrees that in no event, including but not limited to non-payment by Medical Mutual, insolvency of Medical Mutual, or breach of this HMO Provisions section HMO Provision or existing agreements, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or person acting on his/her behalf for healthcare services provided pursuant to this HMO Provisions section and related agreements between the parties. This hold harmless provision does not prohibit provider from collecting charges for supplemental benefits,

coinsurance, copayments or deductibles as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for- service basis to covered persons, nor from any recourse against Medical Mutual or its successor.

2) Provider agrees that this hold harmless provision shall survive the termination of this HMO Provisions section and the existing agreements for authorized services rendered prior to termination, regardless of the cause giving rise to the termination and shall be construed to be for the benefit of the covered persons. This hold harmless provision is not intended to apply to services provided after this HMO Provisions section or existing agreements have terminated.

3) Provider agrees that this hold harmless provision supersedes any oral or written agreement to the contrary currently existing or hereafter entered into between provider and a covered person or persons acting on his/ her behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this HMO Provisions section.

4) Any modification, addition or deletions to this hold harmless provision shall become effective on a date no earlier than 15 days after the Superintendent of the Ohio Department of Insurance has received written notice of such proposed changes.

d) *Insolvency*

1) Provider agrees to continue to provide covered charges for services to covered persons in the event of Medical Mutual's insolvency or discontinuance of operations. Provider agrees to continue to provide covered charges for services to covered persons as needed to complete any medically necessary procedures commenced but unfinished at the time of Medical Mutual's insolvency or discontinuance of operations.

2) If a covered person is receiving necessary inpatient care at a hospital, the continuation of coverage may terminate at the earliest occurrence of any of the following:

- i. The covered person's discharge from the hospital.
- ii. The determination by the covered person's attending physician that inpatient care is no

- longer medically indicated for the covered person.
 - iii. The covered person's reaching the limit for contractual benefits.
 - iv. Thirty days after Medical Mutual's insolvency or discontinuance of operations.
- 3) Further, provider is not required to continue to provide covered charge for service after the occurrence of any of the following:
- i. The end of the 30-day period following the entry of a liquidation order under chapter 3903 of the Ohio Revised Code (ORC)
 - ii. The end of the covered person's period of coverage for a contractual prepayment or premium.
 - iii. The covered person obtains equivalent coverage with another health insuring corporation or insurer, or the covered person's employer obtains such coverage for the covered person
 - iv. The covered person or the covered person's employer terminates coverage under the contract.
 - v. Nondiscrimination. Provider agrees to provide healthcare services without discrimination on the basis of a patient's participation in the corporation or insurer, or the covered person's employer obtains such coverage for the covered person.
 - vi. A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A) (8) of section 3903.21 of the ORC.
- e) **Administrative Policies and Programs**
Provider's rights and responsibilities with respect to administrative policies and programs, including payments systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs are set forth in the existing agreements, this HMO Provisions section, Provider Manual, and are available on written request.
- f) **Records**
Provider agrees with respect to the healthcare plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for healthcare services rendered to a patient. This requirement shall not apply to circumstances when the provider appropriately does not render services due to limitations arising from the provider's lack of training, experience, or skill, or licensing restrictions.
- g) **Malpractice**
Provider agrees to notify Medical Mutual within 10 days (or sooner, if so provided under an existing agreement) after provider's receipt of notice of any reduction or cancellation of provider's malpractice insurance or professional liability coverage.
- h) **Promote Rights**
Provider agrees to observe, protect, and promote the rights of covered persons as patients.
- i) **Nondiscrimination**
Provider agrees to provide healthcare services without discrimination on the basis of a patient's participation in the healthcare plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for healthcare services rendered to a patient. This requirement shall not apply to circumstances when the provider appropriately does not render services due to limitations arising from the provider's lack of training, experience, or skill, or licensing restrictions.
- j) **Dispute Resolution**
The dispute resolution procedures in the agreement apply to disputes under this HMO Provisions section.
- k) **Consistency**
The parties agree that the terminology used in this HMO Provisions section and that are defined by ORC 1751 are to be used in this HMO Provisions section in a manner consistent with those definitions.
- l) **Oversight**
Provider understands and agrees that under Ohio law Medical Mutual has a statutory responsibility to monitor and oversee the offering of covered healthcare services to its covered persons.
3. **Definition**
For the purposes of this HMO Provisions section, the following word is defined as set forth below:
- "Contract" means the document specifying the covered charges for services provided to covered persons under the terms agreed upon between an employer or other group and Medical Mutual, or between a covered person and Medical Mutual.

Qualified Health Plan (QHP) Provider Provisions

If a Provider participates under a provider agreement in a Medical Mutual network that is used for Federally-Facilitated Exchange Qualified Health Plan(s) ("QHPs") offered by Medical Mutual, the following provisions apply:

1. Delegated Activities. Medical Mutual's activities or responsibilities under its contract with the Department of Health and Human Services ("HHS") that are delegated to Provider include the provision of healthcare services as described in the provider agreement between Provider and Medical Mutual ("Delegated Activities and Reporting Obligations").
2. Revocation of Delegated Activities. HHS and Medical Mutual reserve the right to revoke the Delegated Activities and Reporting Obligations or to specify other remedies in instances where HHS or Medical Mutual determine that Provider or Medical Mutual have not performed the Delegated Activities and Reporting Obligations satisfactorily or in a timely manner.
3. Regulatory Requirements. As applicable to the Delegated Activities and Reporting Obligations, Provider agrees to comply with all laws and regulations relating to the standards set forth in 45 C.F.R. § 156.340(a) including, but not limited to, maintaining compliance with:
 - a. The QHP Minimum Certification Standards set forth in Subpart C – 45 C.F.R. § 156;
 - b. The Exchange function requirements for Small Business Health Options Programs ("SHOP") and certification of qualified health plans set forth in 45 C.F.R. § 155 Subparts H and K and the functions of a SHOP set forth in 45 C.F.R. § 155.705; and
 - c. The Standards for maintenance of records and retention and compliance reviews for QHP issuers as set forth in 45 C.F.R. §§ 156.705 and 156.715.
4. Inspection of Records. Medical Mutual, the Secretary of HHS, the Comptroller General, the Office of Inspector General or their designees, each have the right to audit, evaluate, and inspect any matters relating to Medical Mutual's obligations as a QHP and the Delegated Activities and Reporting Obligations, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the Downstream Entity and entities related to HHS' contract with Medical Mutual) through 10 years from the final date of the final contract period of the agreement. For purposes of these Qualified Health Plan Provider Provisions, Downstream Entity means any party that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents. As a Downstream Entity, Provider agrees to fully cooperate with Medical Mutual during such audit or inspection by providing all available records and documentation within the time period specified by Medical Mutual, HHS, the Comptroller General, or the Office of Inspector General.
5. Maintenance of Records. Provider will maintain complete and accurate records with respect to all Delegated Activities and Reporting Obligations as required by HHS guidelines. Provider will maintain the records for a period of ten (10) years from the final date of the final contract period of the agreement. Provider acknowledges and agrees that the requirements of this Section 5 shall survive the termination of the provider agreement.
6. Exclusion or Debarment Compliance. Provider must review the HHS Office of Inspector General List of Excluded Individuals and Entities and the System for Award Management prior to hiring any individuals or contracting with any Downstream Entities performing or responsible for any duties under the provider agreement and must perform at least a monthly review of such lists against the names of all individuals or Downstream Entities who perform any duties under the provider agreement. Neither Provider nor any entity with which Provider is associated nor any person Provider employs may be excluded or barred from participation in the Exchange, ineligible for participation in federal programs or listed on an applicable list of debarred contractors. Neither Provider, nor any entity with which Provider is associated, will employ or contract with an excluded or barred individual. Provider shall immediately notify Medical Mutual if Provider or any entity with which Provider is associated or any of Provider's employees is threatened with or determined to be ineligible to participate under the Exchange or any other federal health care program or be placed on an applicable list of debarred contractors.
7. Compliance Program. Provider must maintain a compliance program that is intended, in good faith, to meet HHS requirements for Downstream Entities to Medical Mutual, consistent with the scope and nature

of the services provided under the provider agreement. Provider must maintain effective lines of communication with Medical Mutual's compliance officer and/or his or her designee regarding activities conducted on behalf of Medical Mutual. Provider agrees to comply with relevant provisions of Medical Mutual's compliance program.

8. Conflict of Terms or Conditions. If there is a conflict between these Qualified Health Plan Provider Provisions and the terms of the provider agreement, these Qualified Health Plan Provider Provisions shall control the regulatory obligations of Provider and Medical Mutual and the provider agreement shall control the relationship of the parties.
9. Modifications. These Qualified Health Plan Provider Provisions shall be modified as necessary to comply with applicable Federally-Funded Exchange QHP requirements, regulations and program instructions, including but not limited to all reporting requirements consistent with and in compliance with Medical Mutual's statutory and regulatory requirements as a QHP issuer. Provider shall require any Downstream Entity to likewise abide by these modifications.

Member Enrollment

Identification Cards

Each covered household will receive two identification (ID) cards for the family. All eligible dependents share the same ID card number. Member benefits and copayments are listed in the Member copayments section of the ID card.

Note: Be sure to submit paper claims to the address indicated on the member's ID card.

To view a sample covered person ID card, see Section 1 – Introduction.

Plan Referral Requirements

Services Provided in the Network

No referral is required when services are provided by a network institutional or professional provider.

Elective or Non-Emergency Services Outside the Network

For PPO plans, non-network services do not require a referral, but will be reimbursed at a lower benefit level, thereby, increasing the Covered Person's required payment. If the provider determines the Covered Person's care cannot be within the network, contact the provider number (on the Covered Person's ID card) for prior authorization before

services are rendered. In order for the Covered Person to receive the highest level of benefit reimbursement, services must have prior authorization. For HMO plans, elective and non-emergency services received from non-network providers are not covered, unless Medical Mutual determines a particular service is not available from a network provider.

Emergency Services Outside the Network

For life-threatening emergencies, covered persons should go to the nearest medical facility for treatment. Services will be reimbursed at the covered person's highest benefit level. No prior authorization is required.

Laboratory and Other Allied Providers

The SuperMed laboratory network consists of laboratories capable of meeting the service and quality standards, geographic requirements, and reimbursement levels established by the Company.

All SuperMed providers have the option to perform laboratory work in the office. Those laboratory services will be reimbursed in accordance with the established fee schedule, which is equal to and accepted by the laboratories. The provider may also refer laboratory work to one of the participating preferred laboratories in the SuperMed laboratory network.

Laboratory testing by a SuperMed preferred laboratory is not required when the following circumstances occur:

- An inpatient hospital stay is ordered
- Patient admittance testing (PAT) is performed by the admitting hospital
- The Company has also established SuperMed networks for the following services:
- Durable medical equipment (DME)
- Home infusion therapy
- Outpatient physical, speech, occupational and chiropractic therapies
- Acute rehabilitation facilities
- Skilled nursing facilities

SuperMed providers should use the SuperMed Network to minimize the covered person's out-of-pocket expense and facilitate the delivery of cost-effective healthcare. For telephone numbers and locations, please refer to the provider directory.

Administrative

Benefit Summary and Payment Structure

SuperMed covered persons receive the maximum level of benefits for covered services when rendered by a network provider. Payment for services rendered by a non-network provider will be reduced in accordance with the covered person's schedule of benefits.

Guidelines

Requests for Consultation from Another Provider

Consultations with Network Providers

A network provider must request consultations for his/ her patients from other network providers. Prior authorization is not required for covered persons when requesting consultation within the network. The provider directory serves as a reference tool.

Consultation with Non-Network Providers

If a non-network provider must be used for a consultation, the provider must obtain prior authorization from the Clinical Quality and Health Services department. Requests for non-network provider waivers will be reviewed by the Clinical Quality and Health Services department on an individual basis. Out-of- network request for consultation services by a network provider to a non-network provider will be denied, except in emergency situations or when services are unavailable in the network. Retrospective requests for consultation services will not be accepted after the delivery of services, except for emergency services.

On-Call and Vacation Coverage

On-call and vacation coverage should be made with another network provider.

If on-call arrangements cannot be made with another network provider, it is the PCP's responsibility to notify the Company of all patients seen by the non-network provider during the PCP's absence by calling Clinical Quality and Health Services.

Transfer and Referrals

In the case of a transfer or referral, providers should direct care to network providers if possible, subject to the covered person's medical condition. Except in the case of an emergency medical condition, providers must obtain prior authorization from Medical Mutual for transfers or referrals to providers who are non-network providers.

Post-termination Obligations

It is the responsibility of providers to cooperate with Medical Mutual to address the needs of covered persons after any termination of the Provider Agreement, including submission of patient lists. The provider agreement will continue to apply to covered services that began prior to termination, or that are directly related to ongoing healthcare services, as if the agreement were still in effect.

The provider:

1. Will not bill, charge or hold a covered person responsible for covered services provided pursuant to the agreement, except for the covered person's obligations, and
2. Agrees to continue to provide covered services to covered persons as needed to complete medically necessary procedures started but unfinished at the time of insolvency or other cessation of operations.

Waived Specialties

The Company may choose to pay for the services of non-network providers in certain specialties as if they were network providers. In that event, there is no out-of-network sanction to the patient. The provider's participating status with the Company is very important. A covered person may be responsible for the balance of a non-participating provider's charges. A provider's participating status may be determined by calling the Company's Provider Inquiry unit.

Services Provided in a Culturally Competent Manner Revision

Medical Mutual contracted providers must deliver covered services to all covered persons in a culturally competent manner, including those covered persons with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. Medical Mutual now offers CultureVision® as a resource to support cultural competency. Additional resources and training courses for providing culturally competent care can be accessed online at MedMutual.com/Providers > Resources > Cultural Competency Resources. -

Health Exchange

Consistent with federal guidance issued by the Department of Health & Human Services, Centers for Medicare & Medicaid Services regarding "Third Party Payment of Qualified Health Plan Premiums," it is Medical Mutual's policy not to accept premium payments and cost-sharing obligations from third parties, unless such third parties meet the requirements described in the March 19, 2014, Interim Final Rule issued by CMS. Provider agrees to not submit premium payments or payment of cost-sharing obligations for covered persons directly, or indirectly. Should provider attempt to pay premiums on behalf of members, Medical Mutual will return such payments at the time they are discovered. This may result in rejection of claims.

Section 12 — Medicare Advantage Plans and Guidelines

Plan Options

The Medical Mutual Medicare Advantage (MedMutual Advantage) Plan consists of a network of Medicare Advantage Network contracted providers who have agreed to provide covered services to covered persons that have elected one of the following Plan options:

MedMutual Advantage Choice, Classic, Plus, Secure, or Signature HMO (HMO)

Under these options, all services must be provided within the Medicare Advantage Network unless an emergency or urgent need for care arises. There are no benefits for services rendered by a provider outside of the Medicare Advantage Network.

MedMutual Advantage Premium, Preferred, Select or Access PPO (PPO)

These options allow covered persons to access services from non-Medicare Advantage Network providers. Payment for services provided by a non-Medicare Advantage Network provider will be reduced in accordance with the covered person's policy.

General Network Guidelines

The following guidelines outline the components of the MedMutual Advantage Plan and explain specific requirements to providers. These guidelines supplement information provided in detailed discussions of policies and procedures found elsewhere in the Provider Manual.

Medicare Advantage Network providers administer healthcare services to MedMutual Advantage covered persons.

The MedMutual Advantage Plan includes network hospitals, physicians and other healthcare providers. As with other Medical Mutual managed care plans, prior

authorization and concurrent review are required as part of the program. For a list of services requiring prior authorization under the MedMutual Advantage plan, please visit [MedMutual.com/Provider](https://www.MedMutual.com/Provider), Policies and Standards, and Prior Approval and Investigational Services.

The MedMutual Advantage Plan offers comprehensive coverage to its covered persons through several benefit packages. Some options have a fixed office visit copayment while others contain variable copayments and deductibles.

Advising or Advocating on Behalf of Covered Persons

Medical Mutual may not prohibit Medicare Advantage Network providers from advising or advocating on the behalf of covered persons. Medicare Advantage Network providers may advise covered persons on:

- The covered person's health status, medical care or treatment options (including alternative treatments that may be self-administered) with sufficient information to the individual to provide an opportunity to decide among all relevant options
- The risks, benefits and consequences of treatment or non-treatment
- The opportunity for the covered person to refuse treatment and to express preferences about future treatment decisions

Prohibiting Discrimination Based on Health Status

Medicare Advantage Network providers shall not deny or limit health services to covered persons based on any factor related to health status, including but not limited to medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

Standards of Care

Medicare Advantage Network providers will provide covered services in a manner consistent with professionally recognized standards of healthcare.

Medicare Advantage Network primary care physicians further agree to make a reasonable effort to complete an office visit/assessment for each MedMutual Advantage Plan covered person within ninety days of enrollment to identify potential serious, and/or complex medical conditions.

Services Provided in a Culturally Competent Manner

Medicare Advantage Network providers will deliver covered services to all covered persons in a culturally competent manner.

Medical Mutual requires that care is provided in a culturally competent manner and is accessible to all enrollees, including those:

- With limited English proficiency or reading skills.
- Of ethnic, cultural, racial, or religious minorities.
- With disabilities.
- Who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
- Who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
- Living in rural areas and other areas with high levels of deprivation.
- Otherwise adversely affected by persistent poverty or inequality.

Medical Mutual now offers CultureVision® as a resource to support cultural competency. Additional resources and training courses for providing culturally competent care can be accessed online at [MedMutual.com/Providers](https://www.MedMutual.com/Providers) > Resources > Cultural Competency Resources.

Requests for Services from Another Provider

Medicare Advantage Network providers will direct care within the Medicare Advantage Network subject to the covered person's medical condition. Reimbursement will be subject to the terms and conditions set forth in the covered person's policy.

Payment for Emergency and Urgently Needed Services

The Company shall make timely and reasonable payment to or on behalf of covered persons for emergency and urgently needed services obtained from a provider or supplier who is not in the Medicare Advantage Network.

Timely Notice of Demographic Changes

Provider Verification Outreach

Medical Mutual is committed to providing covered persons with the most accurate and up-to-date information about our provider network. As part of this initiative, we conduct provider outreach calls and other campaigns in an effort to improve data quality and ensure our records are as accurate as possible.

Medicare Advantage Network providers may receive a call from a Medical Mutual or CMS representative requesting

verification of your data that is currently in our provider database, including but not limited to address, phone number or open/closed practice status. Please be assured that this information is confidential and will be updated in our database if applicable

Medicare Advantage Network providers should familiarize themselves with the information displayed in the online provider directory and train all staff to communicate information accurately and completely. Medicare Advantage Network providers are required to validate monthly the provider demographic information and other information that is displayed in our online provider directory. Provider directories are available by visiting ProviderSearch.MedMutual.com.

Provider Directory Changes

- Medicare Advantage Network providers should review the provider directory to make sure their names, addresses, phone numbers, practice statuses and specialties are correct. Any changes should be submitted to the Provider Contracting department by visiting [MedMutual.com/Provider](https://www.MedMutual.com/Provider), Resources, Forms and selecting Provider Information Form.
- Providers enrolled in the Provider Portal also have the option to add, edit or remove providers, service locations and reimbursement addresses associated with their practices.
- The Company recognizes that a provider may choose at some point to change his/her practice status and limit it to current patients only or to open his/her practice to accept new patients. To allow ample time to update directories, Medicare Advantage Network providers are required to notify their Provider Contracting department in writing at least 90 days prior to the effective date of the practice status change. Updates must be communicated via the Provider Portal or by using the Provider Information Form. Providers should follow the instructions on the Provider Information Form for submission to Medical Mutual.

Advance Beneficiary Notice of Non-Coverage (ABN)

The Advance Beneficiary Notice of Non-Coverage (ABN) is not allowed to be used for Medicare Advantage members. While this notice is used with original Medicare beneficiaries, it is not permitted by the Centers for Medicare & Medicaid Services (CMS) for use with members of a Medicare Advantage plans.

If you believe an item or service may not be covered, or could be covered only under specific conditions, DO NOT HAVE THE MEDICARE ADVANTAGE MEMBER SIGN A WAIVER OR ANY OTHER ADVANCE NOTICE.

The appropriate process for you or the Medicare Advantage member to follow is:

- Contact Medical Mutual at the number listed on the member's identification card to confirm benefits and eligibility.
- Request a prior written advance determination of coverage (also known as a prior authorization request) from Medical Mutual. This should be completed in advance of providing the service to the member.
- If the service you are requesting is determined to be not covered, you and the Medicare Advantage member will receive a Notice of Denial of Medicare Coverage (NDMC). This notice will inform the Medicare Advantage member of his/her liability, which will provide documentation that the Medicare Advantage member was notified prior to the receipt of the service and that he/ she is liable for the full cost of the service.

Medical Mutual expects all providers who are contracted to provide in-network benefits to MedMutual Advantage members to follow this process.

Clinical Quality and Health Services Programs, HEDIS® and Stars

Providers will participate in and actively cooperate with the Company's quality improvement (QI) program, utilization review (UR), case management programs and those policies and procedures that the Company determines are necessary to comply with NCQA or with similar governing bodies, to improve the quality of care and services and the covered person's experience.

Quality Improvement

The Clinical Quality Improvement Department ensures that MedMutual Advantage Plan members receive appropriate care and services according to regulatory guidelines. The Company has a comprehensive Quality Improvement (QI) program, that follows the Triple Aim

framework to optimize performance and meet the following goals:

- Improve the quality of healthcare services for covered persons and their access to services
- Communicate clinical information to providers and covered persons
- Achieve and maintain formal accreditation and Star Rating.
- Monitor and evaluate the quality and safety of healthcare provided to covered persons

The QI program applies to all aspects of clinical care and services provided to covered persons, and continually evolves to respond to the changing healthcare environment. All contracted professional and institutional providers are required to participate in the QI program to ensure high-quality care and service for our covered persons. Accordingly, Medical Mutual may request data from providers for quality improvement activities.

The Medicare Advantage QI program is designed to promote continual improvement in all areas of clinical care. We specifically focus on acute and chronic disease states, complex case management, high-risk conditions, high-volume care, inpatient care, ambulatory care and preventive healthcare to ensure that care is appropriate.

Our physician and nurse reviewers apply an outcome-oriented model that incorporates information obtained from a variety of sources, including:

- Medical and prescription claims data
- Covered person and provider satisfaction surveys
- Inquiry and investigation of covered person complaints
- Ongoing tracking and trending of potential quality of care and service issues identified in the course of daily care management and administrative activities
- Inquiry and investigation of all serious reportable events (SREs)
- Identification of potential covered person's safety issues through monitoring established tracking indicators
- Ongoing review of geographic and accessibility standards, medical record reviews, utilization studies and HEDIS® measures

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a data collection tool that measures performance on important metrics of care and service received by health plan covered persons. Medical Mutual uses this information to determine if care for our covered persons is meeting quality standards as set forth by the National Committee for Quality Assurance (NCQA) and

CMS. This measurement opportunity includes medical record audits to determine if there are any gaps in the care for MedMutual Advantage Plan covered persons. HEDIS results, along with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, provide both clinical quality and covered person satisfaction data to provide an overall picture of our MedMutual Advantage Plan covered persons' experience.

Star Quality Rating System

The Star Quality Rating system developed by CMS measures Medicare beneficiaries' experiences with their health plans and the healthcare system. The rating system uses quality measures that are recognized within the healthcare and health insurance industry that serve to provide beneficiaries with an objective means for choosing Medicare Advantage plans.

Star Measures

Medicare Star Ratings are comprised of a set of measures for Medicare Part C with a separate set of measures for Medicare Part D. The measures selected are reported using a combination of different data sources including:

- **HEDIS**
Some of the current quality measures in the national star ratings report card are calculated based on the collection of HEDIS data from claims and encounters submitted as well as medical record review
- **CAHPS Survey Data**
The CAHPS survey is conducted annually in the spring. Survey responses are collected from a sample of health plan members. Some Star rating measures are based on survey results, such as flu vaccination rates and rates of satisfaction.
- **Health Outcomes Survey (HOS) Data**
The HOS is conducted annually for Medicare members. Some Star rating measures are based on these survey results (e.g., questions related to falls risk, physical activity and incontinence.)
- **Health Plan Operational Data**
Some of the Star Rating measures evaluate the operational aspects of the health plan. Some examples include complaints and appeals rates.
- **Prescription Drug Event (PDE) Data**

PDE data provides information used to calculate medication adherence rates and identify when statins are dispensed for members.

Benefits to Providers

- Improve quality of care and health outcomes
- Improve patient relationships
- Improve relationship with the health plan
- Increase focus on preventive medicine and early disease detection
- Strengthen benefits to manage chronic conditions

Benefits to Patients/Members

- Ensure patients receive optimal quality of care that leads to positive health outcomes
- Improve the patient and healthcare provider relationship
- Expand focus on access to care
- Increase level of customer service
- Encourage early detection of disease and healthcare that matches individual needs of the patient

How Providers Can Help

- Continually encourage patients to obtain annual preventive screenings
- Create office best practices to identify noncompliant patients at the time of their appointments
- Submit accurate claims/encounters
- Use proper coding procedures to the highest degree of specificity
- Understand all the measures and how your practice impacts them
- Increase patient interactions by asking if patients have any questions

For More Information

- To learn more about the Stars Quality rating system, visit [cms.gov](https://www.cms.gov)
- To learn more about the HOS, visit [cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/index.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/index.html).
- To learn more about the CAHPS survey, visit [cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/index.html).
- To learn more about the HEDIS, visit [ncqa.org](https://www.ncqa.org)

Access to Care

To ensure Covered Persons have timely access to care, Medicare Advantage Network providers are to abide by the following minimum standards for appointment wait times.

Primary Care and Behavioral Health providers, including Mental Health and Substance Use Disorder providers:

Type of Service	Timeframe Requirements*
Urgently needed services or emergency	Patient must be seen immediately.
Non-emergent or non-urgent, but requires medical attention	Within 7 days
Routine and preventive care	Within 30 days

*Standards are based on business days.

Appointment wait times for all other provider specialty types are required to follow the guidelines referenced in Section 3 – Clinical Quality and Health Services Programs.

All providers must ensure that office wait times adhere to Medical Mutual's common standard appointment guidelines. These standards include:

Scheduled appointments

Wait times must not exceed 60 minutes. After 30 minutes, covered persons must be provided with an update on waiting time with an option of continuing to wait or rescheduling the appointment.

Walk-in Appointments

Wait times must not exceed 90 minutes. After 45 minutes, covered persons must be provided with an update on waiting time with an option of continuing to wait or rescheduling the appointment.

Providers must ensure response times for returning calls after hours do not exceed the following standards:

- Urgent calls: Must not exceed 20 minutes
- Non-urgent calls: Must not exceed one hour

Medicare Advantage Network Providers

- Will perform services that are medically necessary and for which the provider is qualified to perform for covered persons. Provider is solely responsible for the quality of covered services.
- Will make covered services available to covered persons 24 hours per day, 7 days per week, on the same basis as services made available to non-covered persons and will observe, protect

and promote the rights of covered persons as patients.

- Must ensure the hours of operation are convenient to the population served under the plan and do not discriminate against Medicare enrollees.

Grievances

The Quality Improvement team will address all Quality of Care grievances within the standard time frame of thirty days or expedited time frame of twenty-four hours, as applicable. The team will respond in writing after the investigation is complete. The Quality Improvement team will keep a record and track all issues, and then use this information for development of a quality improvement project when necessary.

For identified quality of care issues, the Quality Improvement team will work in conjunction with the QIO to ensure all MedMutual Advantage Plan covered persons are informed of the QIO Rights in grievance resolution letters, and the grievances are addressed according to CMS standards.

Pharmacy Programs

Medical Mutual has partnered with Express Scripts to develop a comprehensive and affordable prescription drug benefit that meets the prescription therapy needs of all its covered persons.

Formulary

Express Scripts and Medical Mutual have committees of physicians and pharmacists that develop and maintain a list of drugs that the MedMutual Advantage Plans cover. This list is also referred to as a formulary. The formulary allows the covered persons to access a robust variety of medications, including all of the medication classes required by CMS.

Medical Mutual offers Medicare Advantage plans with two different types of formularies. The MedMutual Advantage Plans shown below utilize the Premier Performance formulary, which has five levels, or tiers, based on the type and use of each individual medication. The lowest cost medications are located in Tier 1, and the cost increases with each higher tier.

- MedMutual Advantage Classic HMO
- MedMutual Advantage Secure HMO-POS
- MedMutual Advantage Choice HMO
- MedMutual Advantage Plus HMO
- MedMutual Advantage Select PPO
- MedMutual Advantage Preferred PPO
- MedMutual Advantage Premium PPO

Tier	Description
Tier 1	Preferred Generic Drugs
Tier 2	Generic Drugs
Tier 3	Preferred Brand and Generic Drugs
Tier 4	Non-Preferred Drugs
Tier 5	Specialty Drugs

The MedMutual Advantage Plans shown below utilize the High Performance formulary, which has six levels, or tiers, based on the type and use of each individual medication. The lowest cost medications are located in Tier 6, which includes low-cost generic maintenance (select care) drugs.

- MedMutual Advantage Signature HMO-POS
- MedMutual Advantage Access PPO

Tier	Description
Tier 1	Preferred Generic Drugs
Tier 2	Generic Drugs
Tier 3	Preferred Brand and Generic Drugs
Tier 4	Non-Preferred Drugs
Tier 5	Specialty Drugs
Tier 6	Select Care

To access the formularies, please visit MedMutual.com/Formulary.

Member cost of plan-covered insulin and combination products is capped at \$35 per month supply. Additionally, all adult Part D plan-covered vaccines are covered at a \$0 member cost share. For a list of plan-covered insulin, combination products, and vaccines, refer to the plan formularies.

Please note that Medicare has excluded certain categories of medications from coverage by Medicare Part D programs. Examples of commonly used drugs that are excluded from Medicare Part D coverage include:

- Medications used for cosmetic purposes such as hair growth
- Medication used to promote fertility
- Medications that, by federal law, do not require a prescription
- Medications used for erectile or sexual dysfunction
- Medications used for anorexia, weight loss or weight gain
- Medications used for the symptomatic relief of cough and cold
- Prescription minerals and vitamins other than prenatal vitamins and fluoride preparations

Coverage Management Programs

Medical Mutual uses coverage management programs to help make sure our covered persons get the prescription

drugs they need at a reasonable cost. These programs include:

- **Step Therapy**
The covered person must try another drug before the requested drug can be covered.
- **Quantity Limits**
Some drugs are only covered up to a certain quantity.
- **Prior Authorization**
The covered person must satisfy plan criteria before the requested drug can be covered.

An exception to any of these coverage management programs may be requested for MedMutual Advantage Plan covered persons if the covered person or covered person's prescriber believes that the coverage management program should not apply.

Formulary and Tier Exceptions

- **Formulary exception**
A request to obtain a Part D drug that is not included on a Medical Mutual formulary.
- **Tier exception**
A request to obtain a non-preferred drug at the lower cost-sharing terms applicable to drugs in a preferred tier. Please note that drugs in the specialty tier and approved non-formulary exception drugs are not eligible for a tier exception.

A formulary exception may be requested if a non-formulary drug is necessary for treating a covered person's condition and all covered Part D drugs on any tier of the formulary would not be as effective or would have adverse effects.

A tier exception may be requested if the covered person or covered person's prescriber feels that the preferred drug(s) would not be as effective as the requested non-preferred drug for treating the covered person's condition. Please note that not all drugs are eligible for a tier exception, for example, but not limited to, specialty drugs and non-formulary drugs approved through the exception process. Members should consult their Evidence of Coverage (EOC) document for more information.

All exception requests must include a supporting statement from the prescriber. Collectively, coverage management programs and exceptions are referred to as coverage determinations.

Formulary/Coverage Management Updates

A patient's prescription drug plan through Medical Mutual may have certain coverage limits to ensure prescribed medications follow accepted medical guidelines, and that cost-effective alternatives to treat the same condition are utilized.

These programs are developed by Medical Mutual and administered by Express Scripts®. Medical Mutual periodically reviews and updates these medications, drug classes and formularies. Please visit MedMutual.com/Provider, Policies and Standards, and Prescription Drug Resources to view our most current coverage management documents and prescription drug updates.

Submission of Coverage Determinations

To initiate a coverage determination (e.g., prior authorization, quantity limit exception or step therapy exception) request, please contact Express Scripts at:

Phone: (800) 935-6103

TTY: (800) 716-3231

Fax: (877) 251-5896

Mail: Express Scripts
Attn: Medicare Reviews
PO Box 66571
St. Louis, MO 63166-6571

Website: A coverage determination request form is available by visiting MedMutual.com/Medicare and selecting Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, Important Plan Information, Prescription Drug Coverage Determination and Redetermination Request.

Generally, Medical Mutual must provide a response within 72 hours for a standard request. For exceptions, Medical Mutual must provide a response within 72 hours after receiving your supporting statement. If the provider or the member feels that the member's health could be seriously harmed by waiting 72 hours for a decision, an expedited review may be requested. If the request to expedite is granted, Medical Mutual must provide a decision within 24 hours. For exceptions, Medical Mutual must provide a response within 24 hours of receiving the supporting statement.

If members feel that they are entitled to a reimbursement for their prescription, they can submit the request for reimbursement to Express Scripts at:

Fax: (608) 741-5483

Mail: Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

Website: A Medicare Part D Prescription Drug Claim Form is available by visiting MedMutual.com/Medicare and selecting Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, Important Plan Information, Out-of-Network Pharmacy Coverage and Prescription Drug Claim Form.

The following information is needed to complete the request for reimbursement:

- Date of Service
- National Drug Code (NDC)
- Drug Name
- Quantity
- Days Supply
- Drug Cost
- Admin Fee (if a vaccine)
- Prescription Number (Rx)
- Prescriber name and NPI
- Pharmacy name and NPI
- Copy of pharmacy receipt

Medical Mutual must provide a response within 14 days of receipt.

Prescription Drug Redeterminations (Appeals)

If the provider disagrees with a decision Medical Mutual made regarding a coverage determination, the provider or the member may request a redetermination (appeal). Visit www.MedMutual.com/PartDForms for more information.

Requests may be submitted to:

Mail: Medicare Clinical Appeals Department
Express Scripts
PO Box 66588
St. Louis, MO 63166-6588

Phone: (800) 935-6103

TTY: (800) 716-3231

Fax: (877) 852-4070

A decision will be provided within seven days for a standard redetermination. If the member's health would be jeopardized by waiting seven days, the provider or the member may request an expedited redetermination. Responses for expedited redeterminations will be provided within 72 hours.

Medication Therapy Management Program

The Medication Therapy Management (MTM) program was designed by the federal government to help Medicare members get the greatest benefit from their medications. The program uses pharmacists or other healthcare providers to help screen for adverse effects and identify other potential medication related issues or opportunities.

The MTM program is offered through Medical Mutual's arrangement with Clarest Health. The MTM program is not considered a part of the plan's benefit.

The MTM program is offered to Medical Mutual's Medicare members who meet all of the following criteria:

- Have at least three of the following conditions
 - Alzheimer's Disease
 - Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
 - Chronic congestive heart failure (CHF)
 - Diabetes
 - Dyslipidemia
 - End-stage renal disease (ESRD)
 - Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
 - Hypertension
 - Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
 - Respiratory Disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders)
- Take eight or more Part D maintenance drugs
- Have high medication costs as defined by Medicare (which may change from time to time)

The MTM program provides a medication review consultation to eligible Medicare members via telephone. The review is conducted by a pharmacist or other qualified healthcare provider. The pharmacist will review medications that the member takes including over-the-counter drugs and supplements. The pharmacist will answer any medication-related questions or concerns that the member may have. The pharmacist may also provide related education to the member as necessary. The member will receive a complete personal medication list (PML) and medication action plan (MAP) to remind him/her about what was discussed during the call and what he/she has to do. The pharmacist may reach out to the member's provider to discuss concerns, alerts or offer recommendations to optimize the member's drug therapy.

Please help Medical Mutual improve the health of members by making sure to respond to any questions or concerns identified as a result of MTM interventions.

The MTM program is subject to change. For more information about the MTM program, please visit MedMutual.com/Medicare and select Our Medical Plans, Medicare Advantage Plans with Prescription Drug, Important Plan Information, Prescription Drug Information, Medication Therapy Management.

Coverage and Formulary Changes or Updates

Medical Mutual covered persons taking a formulary drug will generally continue to have the drug covered during the coverage year except in the following circumstances:

- Information is released that demonstrates a formulary drug is no longer safe or effective
- A new and less costly generic version of the formulary drug becomes available

Medical Mutual will notify covered persons and providers at least 30 days in advance if a drug is removed from the formulary, moved to a higher cost sharing tier, or has restrictions added through a coverage management program.

Medicare Part C Transition Policy

The Centers for Medicare & Medicaid Services (CMS) requires new Medicare Advantage Plan members to be offered a 90-day continuity of care, or transition period, for active courses of treatment for Part C drugs and services. To ensure that your patients who are Medical Mutual Medicare Advantage Plan members do not experience any disruption in treatment after the 90-day transition period, please initiate an organization determination at your earliest convenience. See the Policy and Standards section of our MedMutual.com/Providers website for additional information.

Medicare Part D Transition Policy

Medical Mutual covered persons may receive a temporary supply of drugs that are non-formulary or subject to coverage management rules. Medical Mutual may grant a temporary one-month supply to a covered person within their first 90 days of membership. During this time period, the provider should complete a coverage determination request. (See the Submission of Coverage Determinations section.) Transition coverage is also provided for covered persons that are affected by a change in care setting or level of care (e.g., patient moves from a long-term care facility to a private home).

Covered persons that are residents of long-term care facilities also have transition coverage available.

Members will be notified at the pharmacy if they are receiving a drug that is subject to a transition fill. They will also receive a phone call or letter with this information. The letter will explain what the member and provider need

to do to continue coverage of the drug once the transition supply is exhausted. Providers will also receive a copy of the letter.

A more detailed explanation of our transition policy is available by visiting MedMutual.com/Medicare and selecting Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, General Plan Information, Learn More.

Pharmacy Network

Covered persons must fill their prescriptions at network pharmacies in order to incur the lowest out-of-pocket costs. Covered persons using non-network pharmacies may incur higher costs and must submit their receipts in order to receive reimbursement. Medical Mutual's pharmacy network includes retail pharmacies, long-term care pharmacies, home infusion pharmacies, specialty pharmacies, and Indian/tribal pharmacies, if any.

Depending on the group the covered persons are enrolled in, they may be eligible to participate in the Preferred Pharmacy Network. These pharmacies offer lower cost-sharing.

In some circumstances, a pharmacy may need to be used that is not in the plan's network. Below is an example of a situation when the plan will cover prescriptions filled at an out-of-network pharmacy:

- Self-administered medications that a covered person receives in an outpatient setting that may be covered under Part D. For consideration, please submit a paper claim (see Submission of Coverage Determinations section for details).

A listing of pharmacies in Medical Mutual's network, including Preferred Network status, if applicable, is available by visiting MedMutual.com/Medicare and selecting Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, General Plan Information, Learn More.

Mail-Order Pharmacy Services

Express Scripts is Medical Mutual's mail-order pharmacy. Members can get their prescription drugs conveniently shipped to their home through Medical Mutual's network mail-order delivery program.

Mail-order prescription requests may be submitted to:

E-Prescribe (Recommended):

Express Scripts Home Delivery: NCPDP ID 2623735, 4600 North Hanley Road, St. Louis, MO 63134

Fax: (800) 837-0959

(Secured fax line for doctors' offices only)

Phone: (888) 327-9791
(Physicians only)

Mail: 4600 North Hanley Road
St. Louis, MO 63134
(This is not the mail-to location for patients.)
Hours of Operations: 24/7

Website: Express-Scripts.com

A listing of extended-day supply retail pharmacies is available in the pharmacy directory which is available at MedMutual.com/Medicare.

Medicare Part D Vaccines

Adult Part D plan-covered vaccines are covered at a \$0 member cost share through all Part D coverage stages. For a list of Medical Mutual Part D plan covered vaccines, please refer to the plan formularies.

There are two parts to Medical Mutual's coverage of Part D vaccines.

- Cost associated with the vaccine itself
- Cost associated with vaccine administration

If covered persons receive the vaccine in the provider's office, they will be responsible for the entire cost of the vaccine, including the administration fee. A covered person can then submit a reimbursement request (see Submission of Coverage Determinations section for additional information).

- A covered person will be reimbursed the amount he or she paid, less normal coinsurance or copayment, less any difference the provider's office charges and what Medical Mutual normally pays.

Medicare Part B Drugs

Medicare Part B typically helps Medicare beneficiaries with their medical costs and does not provide prescription drug coverage. There are, however, some limited circumstances when medications are covered under the Part B benefit. This coverage does not apply to specific medications but rather to the treatment of certain diseases.

The coverage of drugs under Part B did not change after the implementation of Medicare Part D. Drugs that were covered by Part B remain covered by Part B and are excluded from coverage under the Part D benefit. The drugs covered by Part B typically fall into the following categories:

- Some vaccines (flu and pneumonia)

- Drugs that are treated as a supply to durable medical equipment (DME)
- Drugs furnished incident to a physician's service (e.g., provider "buy and bill")
- A limited number of self-administered drugs that are covered under Part B by Medicare regulations (e.g., immunosuppressive drugs for covered persons with Medicare-covered organ transplants, certain oral anti-cancer drugs, hemophilia clotting factors)

For prescription drugs dispensed at the pharmacy, Express Scripts will either adjudicate the claim at the point of sale (pharmacy) if sufficient information is available or indicate that a coverage determination review is required. Drugs provided incident to a physician's service will follow the same authorization and claim procedures as other physician services.

Please note that drugs covered under Part B will not follow the same copayment structure identified for Part D drugs.

Medicare Part B prescription requests may be submitted to:

Phone: (800) 424-7698

Fax: (888) 656-1948

Website: Contact - Prime Therapeutics [GatewayPA.com](https://www.gatewaypa.com)

Step Therapy for Part B Drugs

Medical Mutual requires review of some medical benefit drugs (primarily injectables and biologics) for step therapy requirements in addition to other policy and review requirements for Medicare Advantage members. Corporate medical drug policies reflect these requirements and are available on the Medical Mutual provider portal at [Medmutual.com/Provider](https://www.medmutual.com/Provider), Policies and Standards, then Prescription Drug Resources.

Step therapy does not apply to members who are already receiving active treatment with a non-preferred drug and is administered in accordance with all guidance from The Centers for Medicare & Medicaid Services (CMS).

Medicare Advantage members subject to step therapy requirements have the right to ask for an exception, or to appeal a request that was denied due to step therapy requirements.

Appeals

Pre-service appeal rights under Medicare are granted to members. As the member's healthcare provider, you may request an appeal on the member's behalf by following the

member appeal process. If you disagree with a decision Medical Mutual made regarding a coverage decision, you, after providing notice to the member, may request a reconsideration (appeal) without submitting written authorization from the member. Appeal request must be submitted within 60 calendar days of the date of the original denial notice.

Expedited appeal requests may be submitted to:

Phone: (855) 887-2273

Fax: (800) 221-2640

Post-service provider appeals follow the guidelines described in the Provider Manual, Section 4 – Appeals: Provider Appeals—Clinical Appeals. If it is determined that the appealed services were medically necessary, the denial will be overturned. For additional information regarding non-clinical Claim Payment Inquiries, see Section 4 – Appeals of the Provider Manual.

For Medicare Part D appeals, visit www.MedMutual.com/PartDForms for more information.

All other standard appeal requests may be submitted in writing to:

Mail: Member Appeals Medical Mutual
PO Box 94563
Cleveland, OH 44101-4563

Responses for a pre-service standard appeal will be provided within 30 days. Responses for a standard post payment standard appeal will be provided within 60 days.

If it is determined that the appealed services were medically necessary, the denial will be overturned. All appeal decisions that remain unfavorable will be forwarded to an Independent Review Entity (IRE) for an additional review.

See Section 4 — Appeals, for additional information regarding Non-clinical Claim Payment Inquiries.

Medicare Outpatient Observation Notice

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires all hospitals and critical access hospitals (CAH) to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours.

The Medicare Outpatient Observation Notice (MOON) is a standardized CMS document that must be provided to a patient or a surrogate. It explains the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such

as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice. A patient (or representative) must sign the MOON to acknowledge receipt. If he refuses to sign, hospital staff must document delivery of the MOON and the patient's refusal.

For additional information or to download a copy of the MOON, visit [cms.gov](https://www.cms.gov), Regulations-and-Guidance, Legislation, PaperworkReductionActof1995, PRA-Listing and search for form CMS-10611.

Detailed Notice of Discharge

A special type of appeal applies to hospital discharges. Hospitals must notify Medicare beneficiaries and MedMutual Advantage covered persons about their appeal rights and general liability. This will be accomplished by the hospital issuing the CMS form Important Message from Medicare (IM) within two calendar days of admission and obtaining the signature of the patient or representative to indicate his or her understanding. The hospital will provide a copy to the patient/representative and keep a copy for the facility.

If the covered person or the covered person's representative does not agree with the hospital's discharge decision, the covered person or the representative may appeal the decision to the QIO. The request for review must be made by midnight of the day of discharge. If the request is made after the deadline, the request will be accepted; however, the covered person is not protected from financial liability. Upon notification of the appeal from the QIO, the hospital is required to complete the Detailed Notice of Discharge. The IM and Detailed Notice of Discharge forms and further guidance on this ruling is available by visiting [cms.gov/BNI/12_HospitalDischargeAppealNotices.asp](https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp).

Providing Covered Persons with Notice of Their Appeal Rights

Skilled nursing facilities (SNFs), home health agencies, (HHA) and comprehensive outpatient rehabilitation facilities (CORFs) must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, visit [cms.gov/Medicare/Appeals-and-Grievances/MMCAG/downloads/NOMNCInstructions.pdf](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/downloads/NOMNCInstructions.pdf).

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 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.

Additional Medicare Advantage Guidelines

Billing for Hospital Readmissions

Prior to September 18, 2024, the following hospital admissions provisions apply:

A Covered Person who requires follow-up care or surgery may be:

- Discharged and readmitted or
- Placed on a leave of absence (LOA).

A discharge/readmission may not result in two payments. The Company may review an acute care hospital admission occurring after discharge from an acute care hospital if it appears that the two confinements could be clinically related and if the readmission could have been avoided or prevented. Two separate payments would be made for these cases unless the readmission and preceding admission are found, by application of criteria set forth in Medical Mutual's Hospital Readmissions Reimbursement Policy, to be clinically related and the readmission is found to have been avoidable or preventable, in which case the readmission may be denied.

Upon the request of the Company, providers must submit medical records pertaining to the initial admission and the readmission, including, but not limited to, complete

documentation of discharge planning, clinical status at discharge, and discharge instructions on each case.

NOTE: The Company will review and may deny a second admission to provider or any of its affiliated providers if the second admission occurs within 30 days of discharge from the provider if it appears the two confinements are clinically related and that the readmission is found to have been avoidable or preventable. The readmission review and second admission payment denial applies for those acute care hospitals and hospital systems reimbursed using a DRG or Case Rate methodology. When the readmission occurs at a different acute care hospital within the same hospital system, the readmission review and second admission payment denial will apply when the first admission was at an acute care hospital reimbursed using a DRG or Case Rate methodology.

LOA: Placing a patient on a leave of absence will not generate two payments. The provider may place a Covered Person on LOA when readmission is expected and the Covered Person does not require a hospital level of care during the interim period. Examples include, without limitation, a situation where surgery cannot be scheduled immediately, a surgical team was not available, bilateral surgery was planned, or further treatment is indicated following diagnostic tests but cannot begin immediately. Upon the request of the Company, providers must submit medical record documentation to support the rationale for the expected readmission and why the member does not require a hospital level of care during the interim period.

LOA Billing: The provider shall bill only for Approved Days. Non-covered Charges for LOA days (i.e., holding a bed) must be omitted from the claim. The claim must have only one corresponding authorization record from the Company. The claim must include leave of absence dates with occurrence span code 74 to report the dates the leave began and ended.

The Company and the Covered Person may not be billed for LOA days.

The provider may submit a claim if a Covered Person on LOA has: (1) Been discharged following return from LOA, (2) Not returned within 60 days including the day the LOA began, or (3) Been admitted to another institution.

Beginning on September 18, 2024, the following hospital readmissions provisions apply:

A Covered Person who requires follow-up care or surgery may be:

- Discharged and readmitted or

- Placed on a leave of absence (LOA).

A discharge/readmission may not result in two payments. The Company may perform readmission reviews in accordance with Medical Mutual's Hospital Readmissions—Medicare Advantage Reimbursement Policy and deny payments for readmissions in accordance with the provisions of such policy. For leaves of absence, the terms of such policy will also apply.

Permanent Out-of-Area Enrollment Not Offered

At this time, the Company does not offer a continued enrollment to MedMutual Advantage Plan covered persons when they no longer reside in the service area of the plan and permanently move into the geographic area designated by the Company as a continuation area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as a driver's license, state ID or voter's registration card. Should the Company elect to offer such an option, Medicare Advantage Network providers will be notified.

Renal Dialysis When Temporarily Outside of the Plan's Service area

The Company must make timely and reasonable payment to or on behalf of covered persons for renal dialysis services provided while they are temporarily outside the plan's service area. This is required even if dialysis services were obtained from a provider or supplier who is not in the Medicare Advantage Network.

Direct Access to Women's Specialists

The Company provides coverage for medically necessary specialty care and allows female covered persons direct access to women's health specialists within the Medicare Advantage Network for routine and preventive healthcare services provided as basic benefits. The term basic benefit means all Medicare-covered benefits (except hospice services). The Company will also arrange for women's specialty care outside of the Medicare Advantage Network when network providers are unavailable or inadequate to meet a covered person's medical needs. Prior authorization is required for out-of-network care when services are not available in plan.

Direct Access to Mammography and Influenza Vaccinations

Covered persons may self-refer to providers for screening mammography and influenza vaccinations.

Cost-sharing for Influenza and Pneumococcal Vaccinations

The Company may not impose cost-sharing for influenza and pneumococcal vaccinations on MedMutual Advantage Plan covered persons.

Continuation of Benefit Provisions

Medicare Advantage Network providers agree that in the event of the Company's or the MedMutual Advantage Plan's insolvency or other cessation of operations, covered services to covered persons will continue through the period for which the premium has been paid to the Company or the respective MedMutual Advantage Plan. Covered services to covered persons confined in an inpatient hospital on the date of insolvency or other cessation of operations will continue until their discharge.

Training in Self-care

Medicare Advantage Network providers must institute and maintain procedures to ensure that covered persons are informed of specific healthcare needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.

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 keep 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 these requirements. If deficiencies are identified, corrective action may be taken.

Submission and Certification of Complete and Accurate Data

Medicare Advantage Network providers will furnish the Company with all information necessary for it to meet its data reporting and submission obligations to CMS. This requirement includes, but is not limited to, all data necessary to characterize the context and purpose of each healthcare encounter on behalf of a covered person. Data should indicate:

1. The cost of MedMutual Advantage Plan operations;

2. The patterns of use of MedMutual Advantage Plan services;
3. The availability, accessibility and acceptability of MedMutual Advantage Plan services;
4. Information demonstrating the MedMutual Advantage Plan has a fiscally sound operation; and
5. Other matters as required by CMS.

Medicare Advantage Network providers agree to certify and assure the accuracy, completeness and truthfulness of data provided for submission to CMS.

CMS Disclosure Requirements

A Medicare Advantage Network provider agrees that the United States Department of Health and Human Services, the Comptroller General or their designees have the right to inspect, evaluate and audit any pertinent contracts, books, documents, papers, contracts, medical and other records and covered person care documentation of a Medicare Advantage Network provider or its subcontractors or transferees involving transactions related to the MedMutual Advantage Plan through ten years from the final date of the contract period for the MedMutual Advantage Plan, or from the date of the completion of any audit, or for such longer period provided for in 42 C.F.R. § 422.504(i)(2) or other applicable law, rule or regulation. For the purposes specified in this provision, a Medicare Advantage Network provider agrees to make available a Medicare Advantage Network provider's premises, physical facilities and equipment, records relating to covered persons, and any additional relevant information that CMS may require.

A Medicare Advantage Network provider agrees to supply all information necessary for the Company or the MedMutual Advantage Plan to meet its data reporting and submission obligations to CMS, including but not limited to data necessary to characterize the context and purpose of each encounter between a covered person and the Medicare Advantage Network provider ("Encounter Data") and data necessary to meet its reporting obligations under 42 C.F.R. § 422.516 and other applicable laws, rules and regulations.

Provider agrees to provide the requested medical records to Medical Mutual or its designee within 14 calendar days from Medical Mutual's or its designee's written request. Such records shall be provided to Medical Mutual or its designee at no additional cost.

If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation

process, financial adjustments will be imposed. The Medicare Advantage Network provider must submit required medical records expeditiously to comply with time frames established by CMS and/or the state department of insurance for the processing of grievances and appeals. To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information to the minimum necessary to accomplish the intended purpose of the disclosure of covered persons' information.

Medical Records Release

The Health Insurance Portability and Accountability Act (HIPAA) regulations are federal rules that govern the privacy of a member's protected health information (PHI) and establish requirements for the use and disclosure of PHI by Covered Entities, which includes healthcare providers, healthcare clearing houses and health plans. In accordance with HIPAA, a healthcare provider is permitted to disclose a member's PHI, including his/her medical records, to a health plan without a member's authorization or consent for the health plan's payment and healthcare operations activities. This includes, but is not limited to, providing data for quality assessment and improvement activities, disease management, case management and care coordination, evaluating health plan performance, accreditation, certification and credentialing activities, HEDIS and risk adjustment purposes.

Risk Adjustment

Medicare Advantage Network providers agree to accurately report ICD-10-CM diagnosis codes to the highest level of specificity. Medical record documentation shall be clear, concise, complete and legible, and signed with provider's credentials. Further, medical records must include a treatment plan for conditions present and include use of only standard abbreviations. Documentation of all conditions treated or monitored at the time of the face-to-face visit must support each reported diagnosis code. Providers agree to use best efforts to submit claims data in a timely manner, generally within 30 days from the date the covered service was rendered. National coding guidelines are accessible at <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf>

Payment and Incentive Arrangements

If any Company compensation arrangement uses a physician incentive plan (as defined at 42 C.F.R. § 422.208(a)) with individual physicians or physician groups, the following requirements will be met by Company and any first-tier entity with respect to its use of a physician incentive plan:

1. No specific payment will be made, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular covered person (indirect payments may include offerings of monetary value, such as stock options or waivers of debt, measured in the present or future); and
2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined by 42 C.F.R. § 422.208(d)) for services that the physician or physician group does not furnish itself, the Company will assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection that satisfies the requirements of 42 C.F.R. § 422.208(f). In addition, for any physician incentive plan, the Company will comply with the requirements of 42 C.F.R. § 422.210 regarding providing satisfactory assurances to CMS and providing information to any covered person who requests it.

Termination of a Provider Contract

The Company must make a good faith effort to provide written notice of a termination of a contracted Medicare Advantage Network provider at least 30 calendar days before the termination effective date. This notice must be given to all covered persons who are seen on a regular basis by the provider whose contract is terminating, whether or not the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

Notifying Physicians of Denial, Suspension and Termination

If the Company suspends or terminates an agreement under which a physician furnishes services to covered persons, the Company will give the affected physician written notice of the following:

1. The reasons for the action, including, if relevant, the standard profiling data used to evaluate the physician and the Company's accessibility standards; and
2. The affected physician's right to appeal the action and the process and timing for requesting a hearing as required by CMS.

Adherence to CMS Marketing Provisions

Medical Mutual will share patient marketing and informational materials about our plans, including benefit information and enrollment applications. We ask and encourage you to make these materials available to your patients. For our MedMutual Advantage Plan, providers must adhere to the following CMS requirements and restrictions:

Distribution

- Providers may display and distribute plan marketing materials in waiting rooms and other common areas.
- Providers may not distribute plan marketing materials or enrollment applications in exam rooms.

Neutrality

- Providers may furnish patients with the names of plans with which they contract or participate but must remain neutral in their discussion of health plan options. You may not encourage patients to enroll in a particular plan.
- Providers must agree to future requests from other health plans to distribute marketing/informational materials.
- Providers may not accept Medicare enrollment applications.

Assistance

- Providers may refer patients to the plan and other sources of information, such as Medical Mutual sales representatives, MedMutual.com, Medicare.gov and the Ohio Senior Health Insurance Information Program (OSHIIP) at <https://www.insurance.ohio.gov/Consumer/Pages/OSHIIP.aspx>.
- Providers may provide patients with information and assistance applying for low-income subsidies for Adherence to CMS Marketing prescription drug coverage through the Medicare Extra Help program.

Affiliation Announcements

- Providers may announce their affiliation with Medical Mutual and our MedMutual Advantage Plan. These announcements may be made through direct mail, email, phone or advertising.
- Do not describe benefits, premiums or cost-sharing in affiliation announcements, unless Medical Mutual provided the document or template.
- Continuing affiliation announcements must include a statement that the provider may also contract with other plans. This statement is not required for new affiliation announcements.

Eligibility

Coverage information provided by the Company is subject to change and limited to the provisions of the covered person's contract or group contract. Additionally, such information is neither intended to dictate treatment decisions, nor create any commitment for the payment of benefits. Providers can check member eligibility and benefits prior to rendering healthcare services to ensure there have not been any changes in coverage. Contact Medical Mutual's Provider Inquiry department to explain program policies, verify covered person's eligibility, clarify benefits and assist with claim inquiries.

Dual Eligible Beneficiaries

CMS and Medical Mutual prohibit discrimination in the delivery of health care services based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. This means that MedMutual Advantage providers cannot refuse to serve Qualified Medicare Beneficiary (QMB) status members because they receive assistance with Medicare cost-sharing from a State Medicaid program. MedMutual Advantage providers must have policies and procedures in place that prohibit such discrimination.

Federal law prohibits providers from collecting coinsurance, copayments, and deductibles from members enrolled in the QMB Program. These amounts can be submitted to a Secondary payer.

Covered Person Billing

Medicare Advantage Network providers should submit claims as instructed on the covered person's ID card. Use the number for billing and other transactions, such as checking claim status, patient eligibility and benefits. See Section 2 – Claims Submission of the Provider Manual for further information regarding billing guidelines.

Hospice Service Guidelines

A Medicare Advantage organization must inform each Medicare enrollee eligible to select under 42 C.F.R. § 418.24 – Election of hospice care – about the availability of such care if:

1. A Medicare hospice program is located within the plan's service area; or

2. It is common practice to refer patients to hospice programs outside that area.

Unless the enrollee dis-enrolls from the MedMutual Advantage Plan, a beneficiary electing hospice continues his/her enrollment in the MedMutual Advantage Plan and is entitled to receive, through the MedMutual Advantage Plan, any benefits other than those that are the responsibility of the Medicare hospice.

When a MedMutual Advantage Plan covered person has been certified as hospice eligible and the premium the Company receives from CMS is adjusted to hospice status, the financial responsibility for the covered person shifts from Medical Mutual to original Medicare. While these two conditions exist, original Medicare covers all original Medicare covered services. During this time, Medical Mutual is responsible for only those covered services that are included in the benefit package that are above original Medicare, or that are non-Medicare covered services, such as dental, vision, prescription drugs, etc.

Until both of these conditions are met, Medical Mutual will remain financially responsible for the covered person. The financial responsibility shifts to original Medicare on the first day of the following month, which is the date that CMS' premium to Medical Mutual has been adjusted to hospice status for the covered person.

Obligations of Federal Funds

Providers who receive reimbursement for services rendered to MedMutual Advantage Plan covered persons are paid for their services with federal funds and must comply with all federal laws, rules, and regulations applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act and the Anti-Kickback Statute.

Medicare Advantage Plans are prohibited from issuing payment to a provider or entity that appears on the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration (GSA) Excluded Parties List System (EPLS/SAM), Medicare Preclusion, or Medicare Opt-Out lists, with the possible exception of payment for services under certain circumstances, as provided in 42 C.F.R. § 1001.1901(c) (5). Any provider or entity that appears on one or more of these lists is not eligible to support the Medicare Advantage Plan and must be removed

immediately from providing services or support to Medical Mutual.

Fraud, Waste and Abuse

Detecting and Preventing Fraud, Waste and Abuse

Medical Mutual is committed to preventing, detecting, and correcting fraud, waste and abuse (FWA). Providers are also responsible for exercising due diligence in preventing, detecting and reporting FWA in accordance with the Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Compliance and Fraud, Waste and Abuse Plan.

Medical Mutual encourages providers to report any suspected FWA through the compliance hotline at (800) 762-8130, Compliance Connection at <https://www.medmutual.com/About-Medical-Mutual/Corporate-Profile/Compliance-Connection.aspx>, or in writing to:

Compliance Officer, MZ 02-4T-1900
Medical Mutual
100 American Road, Cleveland, OH 44144-2322

Fraud

Fraud requires the person to have the intent to obtain payment and the knowledge that his or her actions are wrong.

Medicare fraud is typically characterized by:

- Knowingly submitting false statements or making misrepresentations of fact to obtain a federal healthcare payment for which no entitlement would otherwise exist;
- Knowingly soliciting, paying and/or accepting remuneration to induce or reward referrals for items or services reimbursed by federal healthcare programs; or
- Making prohibited referrals for certain designated health services.

Examples of Medicare fraud include:

- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items or billing Medicare for appointments that the patient failed to keep; and
- Knowingly billing for services at a level of complexity higher than the service actually provided or documented in the file.

Waste

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims;
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed; and
- Overuse, underuse and ineffective use of services.

Abuse

Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary. As with benefits, the covered amount or pricing method may vary for different covered persons, as defined in the applicable provider agreement. Pricing provisions are necessary, meet professionally recognized standards and are priced fairly.

Examples of Medicare abuse include:

- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as up-coding or unbundling codes.

FDR Oversight

As a Medicare Advantage Organization (MAO), Medical Mutual must adhere to Centers for Medicare & Medicaid Services (CMS) requirements. This includes overseeing compliance for First Tier, Downstream, and Related Entities (FDRs) through regular monitoring and audits as applicable.

Medicare Advantage Network providers, classified as First Tier Entities, must annually attest to compliance with CMS regulations and Medical Mutual's contractual obligations. The attestation can be found at attestation found at www.medmutual.com/Provider/Forms. Key requirements include:

- **Fraud, Waste, and Abuse (FWA) and General Compliance training** for all employees within 90 days of hire and annually.
- **Development and distribution** of compliance policies, procedures, and Standards of Conduct.
- **Exclusion list screening** of all relevant personnel before hiring and monthly thereafter.

- **Provision of an anonymous reporting mechanism** for suspected FWA or noncompliance.
- **Record retention** for ten years.
- **Oversight of subcontracted entities** and offshoring activities involving PHI, with an attestation submitted to Medical Mutual.
- **Absence of Conflicts of Interest** in administering or delivering Medicare Advantage benefits.

Repayment Rule

Under the Patient Protection and Affordable Care Act, providers are required to report and repay overpayments to the appropriate federal agency, intermediary or carrier within the later of 60 days after the overpayment is identified or the date that the corresponding cost report is due, if applicable. Overpayments that are not timely returned and reported will be treated as false claims under the False Claims Act.

Offshoring

Providers using offshore entities for Medicare Advantage services involving Protected Health Information (PHI) must notify Medical Mutual before doing so. Offshoring refers to services performed outside the 50 U.S. states, the District of Columbia, or U.S. Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). To inform Medical Mutual of the use of offshore entities, please complete an offshore attestation found at www.medmutual.com/Provider/Forms.

Reimbursement

All benefit payments are subject to the provider's contractual agreement with the Company and the provisions of the covered person's contract.

As with benefits, the covered amount or pricing method may vary for different covered persons, as defined in the applicable provider agreement. Pricing provisions are designated by the provider's contract.

In some instances, a deductible must be satisfied before the pricing method is applied.

CMS imposed specified budget cuts, known as sequestration, that include a two percent payment reduction to payments under the Medicare program, including Medicare Advantage Plans. Except for professional network providers that are reimbursed at the standard Medical Mutual Medicare Advantage Fee Schedule, providers will have the same sequestration reduction applied in the same manner as CMS, unless

noted otherwise in the provider agreement. The claims payment adjustment shall be applied to all claims after determining any applicable deductible, coinsurance and/or secondary payment adjustments. Covered persons' obligations are not subject to the two percent payment reduction. Providers shall not bill or otherwise attempt to collect from the covered person any portion of the two percent reduction.

The sequestration reduction amount for each affected claim will be identified on the provider's remittance advice.

Section 13 – Glossary of Terms

ADA – American Dental Association.

Adjustment – A correction or modification to data elements or payment to reflect a change in status.

Admission – The entry of a Covered Person as an Inpatient to a hospital or other healthcare facility.

Admitting Diagnosis – The statement of medical condition, cause, or disease observed when the patient is initially admitted to a healthcare facility.

Admitting Physician – The physician responsible for the admission of a patient to a hospital or other Inpatient healthcare facility.

Adult Med/Surg Per Diem – The payment rate, when applicable, for each approved day.

Advance Directives – Written instructions, such as a living will or durable power of attorney, for the provision of healthcare when an adult is incapacitated.

Affiliates – The Medical Mutual Family of Companies includes Medical Mutual of Ohio, Medical Health Insuring Corporation of Ohio, and any subsidiaries, collectively referred to as the Company.

Age Limit – The stated maximum age(s) beyond which eligibility or benefit participation must end.

AHA – American Hospital Association.

Alternative Outpatient Percentage of Charge (AOPOC) – A Percentage of Charge rate, which may be used as the rate of reimbursement for Outpatient Services, subject to and adjusted in accordance to the Provider Agreement to reflect a percentage of charge rate that is equivalent to the outpatient hospital rate.

AMA – American Medical Association.

Ambulatory Care – All types of healthcare services which are provided on an Outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term Ambulatory Care usually implies that the Patient has come to a location other than his/her home to receive services and has departed the same day.

Ancillary Packaging – The inclusion of certain ancillary tests, ancillary procedures or incidental procedures into the payment rate for a significant procedure or medical visit. (See Provider Agreement for changes to ancillary packaging.)

Ancillary Procedure – A Procedure that increases the time and resources expended during a visit but does not dominate the time or resources expended during the visit.

Ancillary Test – A procedure ordered by the physician to assist in patient diagnosis or treatment.

Anniversary Date – Date on which a cardholder or Group will be re-enrolled each year subsequent to his/her initial enrollment, or a 365-day period beginning with the effective date.

APC – Ambulatory Payment Classifications.

APC Based Outpatient Prospective Payment System (OPPS) – A reimbursement methodology where the APC is the primary unit of payment.

APC Weight – The value assigned to an APC that represents the APC's relative resource utilization, as determined and published by CMS.

APG – Ambulatory Patient Group.

APG Inlier – A claim for a Covered Person in which the charges for covered hospital services are less than the sum of the Company APG inlier thresholds for payable APGs.

APG Inlier Thresholds – The charges for covered hospital services, specific to each APG, below which the inlier payment will be made. (See contract for specified inlier thresholds.)

APG Outlier – A claim for a Covered Person in which the charges for covered hospital services are greater than the sum of the Company APG outlier thresholds for payable APGs.

APG Outlier Thresholds – The charges for covered hospital services, specific to each APG, beyond which the outlier payment will be made. (See contract for specified outlier thresholds.)

APG Weight – The value assigned to each APG indicated in the contract.

Appeal – A request from a Covered Person, provider, or authorized person to change the Company decision to deny reimbursement for inpatient or other healthcare services.

Approved Days – The number of days the Company has determined to be medically necessary.

Approved Program – A unit or service within the hospital or a hospital that is registered, certified or licensed by a state department or agency having jurisdiction or authority over such matters, or any other appropriate governmental unit, department or agency, and, when appropriate, accredited by The Joint Commission or the American Osteopathic Association.

Assignment – An agreement in which a patient assigns to another party, usually a provider, the right to receive payment from a third party for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In Medicare, if a physician accepts assignment from the patient, he/she must agree to accept the program payment as payment in full (except for specific coinsurance, copayment and deductible amounts required of the patient). Assignment, then, protects the patient against liability for charges that the Medicare program does not recognize as reasonable.

Attending Physician – The physician legally responsible for his/her care given to a patient.

Average Length of Stay – The average number of days for each DRG indicated in the contract.

Base, Basic – The Company coverage exclusive of medical. Basic coverage usually provides first dollar coverage for a wide range of non-specialty services.

Benefit – The entitlement to payment for covered services as identified in a policy and payable under the terms of the policy.

Benefit Days – Number of days for which the Company will make payment within a benefit period. Benefits are renewed with the start of each new benefit period.

Benefit Period – The span of time during which a Covered Person receives covered services, as listed in a policy, for which the Company will pay.

Cardholder – The person in whose name the Company coverage was issued; the name which appears on the ID card.

Carrier – A commercial health insurer or a government agency that underwrites or administers programs that pay for health services.

Carry-Over – A common provision under medical coverage whereby expenses incurred during the last three months of the year and that are used to satisfy all or part of the deductible for that year may also be applied toward the deductible required for the following year.

Case Mix Index – The weighted average of DRG weights for cases of Covered Persons at the hospital.

Certificate – The document that identifies the terms, conditions and limitations of benefits provided by or through the Company.

Chief Medical Officer – The physician responsible for the design and implementation of the Company's Quality Improvement Program, including the development, adoption, revision and distribution of specific clinical quality improvement policies, guidelines, and procedures. He/she works to identify and measure clinical services improvements and provides consultation to assist with the management of all Company utilization and credentialing activities.

Claim – A request to an insurer for payment of benefits under an insurance contract.

CMS – Centers for Medicare & Medicaid Services, formerly HCFA, the Healthcare Financing Administration of the Federal Government.

CMS National Unadjusted Payment Rate – The amount CMS reimburses for a particular Covered Service prior to geographic adjustments. This applies to APCs that do not have an APC Weight.

Coinsurance – A cost-sharing requirement under a health insurance policy that stipulates that the Covered Person will assume a portion or percentage of the costs for covered services. The health insurance policy provides that the insurer will reimburse a percentage of all or specified covered medical expenses in excess of any deductible amounts payable by the Covered Person. The Covered Person is then liable for the remaining percentage of the costs.

Commercial Carrier – A commercial insurance company other than a government agency.

Complaint – An oral or written expression of dissatisfaction.

Complementary Coverage – A program of benefits designed to provide additional benefits beyond those provided by other programs, such as Medicare, to an established maximum.

Comprehensive Major Medical – A type of coverage designed to include all covered services as medical benefits, usually subject to a deductible and copayment.

Concurrent Medical Care – Two or more physicians providing medical care during a medical admission, or one or more physicians providing medical care during a surgical admission.

Consult, Consultation – A professional opinion from a provider, usually a specialist, at the request of another provider regarding the diagnosis and/or treatment of a patient. The consultant usually reviews the history, examines the patient, and then provides a written opinion to the requesting practitioner.

Consulting Physician – A licensed doctor of medicine or osteopathy who has entered into an agreement with the Company to provide certain healthcare services to the Covered Persons upon appropriate referral.

Contract – A written agreement between an individual provider or group of providers and the Company to render healthcare services to Covered Persons.

Contract Year – A defined term in the agreement not necessarily tied to the agreement effective date. Most common use is for calculating charge increases and enforcing Max Charge Increases (MCI).

Coordination of Benefits (COB) – A method of preventing duplicate payments for care provided to a Covered Person having more than one healthcare policy.

Copayment (Copay) – A dollar amount of the covered services for which the Covered Person is responsible.

Cost Effective – The measurement of operational expenses relative to benefits realized.

Cost-to-Charge Ratio (CCR) – The factor applied to a Provider's Charges for Covered Services to determine the estimated costs for Covered Services.

Coverage – The extent of benefits provided under a healthcare policy.

Covered Person – An eligible employee or participant of the Group who has enrolled for coverage under the terms and conditions of the Group Contract.

Covered Service – Provider services, procedures, treatments, accommodations, supplies and products furnished to a Covered Person that are covered in accordance with his/her policy.

Current Procedural Terminology (CPT)¹ – A copyrighted system of terminology and coding developed by the American Medical Association (AMA) that is used for describing, coding, and reporting medical services and procedures.

Custodial Care – Care which does not require the constant supervision of skilled medical personnel to assist the patient in carrying out his/her activities of daily living; such care may

be taught to and administered by a layperson. Custodial care includes but is not limited to:

- Administration of medication which may be self-administered or administered by a layperson with training
- Assistance in walking, bathing, dressing, feeding, and preparing special diets Custodial care does not include care provided for its therapeutic value in the treatment of an injury, ailment, condition, disease, disorder or illness.

Data Entry – The act of entering information into a computer system for processing.

Deductible – An amount of Covered Services, usually stated in dollars, for which the Covered Person is responsible in a given period before the Company is required to pay for Covered Services.

Dependent – Cardholder's spouse or unmarried children, stepchildren, legally adopted children, any children for whom the parent is the legal guardian, or any children who by court order must be provided healthcare coverage by the cardholder or cardholder's spouse.

DHHS – Department of Health & Human Services.

Diagnosis – The statement of a medical condition, cause, or disease.

Diagnosis Code – A numerical or alphanumeric classification of the terms describing diagnoses of medical conditions, causes, or diseases.

Diagnostic Admission – An admission to a healthcare facility for the sole purpose of making a diagnosis (i.e., not for medical treatment or surgery).

Direct-Pay Cardholder – A person purchasing Coverage who is not enrolled through a Group.

Discharge – Release or dismissal from a healthcare facility.

Discharge Diagnosis – The diagnosis recorded and studied after all the data is accumulated in the course of a patient's stay in a healthcare facility.

DRG – Diagnosis Related Group.

DRG Weight – The value assigned to each DRG by CMS.

Durable Medical Equipment (DME) – Equipment, such as a wheelchair, which can withstand use, i.e., is not considered disposable; is primarily and customarily used to serve a medical purpose; generally is not useful in the absence of illness or injury; and is appropriate for use in the home.

ECF – Extended Care Facility.

Effective Date – 12:01 a.m. on the date when all contractual rights and obligations begin and from which point any term of time, usually commences.

Elective – Medical care which need not be performed on an urgent or emergency basis because reasonable delays will not unfavorably affect the outcome.

Eligibility – A term applied to enrollment, benefits, service reimbursement, etc., most commonly defined as the determination of whether a person qualifies for coverage or a provider qualifies for payment.

Endorsement – An amendment to a policy whereby its provisions are altered.

Enrolled, Enrollment – The procedure by which a Covered Person establishes eligibility.

Exclusion – A provision in a policy stating situations or conditions under which coverage is not afforded by the contract.

Experimental/Investigational – Any treatment, procedure, facility, equipment, drug, device or supply which the Company does not recognize as accepted medical practice or which has not received government approval when provided. Determination will be made by the Company in its sole discretion and will be conclusive.

Explanation of Benefits (EOB) – A written statement to a Covered Person and/or provider showing action taken on a claim.

Explanation of Medicare Benefits (EOMB) – A statement from Medicare to the Patient which explains the action taken on a claim for Medicare Part B benefits.

Facility – A hospital, SNF or other healthcare establishment, including physical plant, equipment and supplies used in providing health services. Coverage for care provided by a facility is limited by contract definitions of covered providers and specific benefit provisions.

Family Coverage – Policies that provide benefits for all eligible family members and membership at birth for additional children.

Family Deductibles – Deductible provision which limits the maximum deductible amount required for all Covered Persons under family coverage.

Fee Breakout – The act of separating a lump sum charge into its components relative to individual line items on a claim.

First Dollar Coverage – Coverage under an insurance policy which begins with the first dollar of expense incurred by the Covered Person for covered services. Such coverage, therefore, has no deductible, although it may have copayments or coinsurance.

Group – A body of Covered Persons enrolled with the Company through an employer, association or other organization that has complied with applicable enrollment regulations.

Group Contract – The written agreement between a Group and Medical Mutual that sets forth the respective rights and obligations of each, in connection with the insurance or administration of the health benefit plan offered by the Group to its Covered Persons.

Group Number – A numerical or alphanumerical identification assigned to an enrolled account.

HCPCS – Healthcare Procedure Coding System used by CMS to denote medical services and supplies.

Hospice Program – Provides benefits to terminally ill Covered Person at home or in a specialized facility.

Hospital – An institution that offers a full range of diagnostic, medical, and surgical services for injured and ill people 24 hours a day.

Hospital Code – A code used by the Company to denote the specific institution where services were rendered.

Hospital Rate (value of one) – The payment rate indicated in the contract.

ICD-9-CM – International Classification of Diseases 9th Revision or successor edition ICD-10-CM2.

Identification (ID) Card – The healthcare card provided to a Covered Person by the Company. It shows the ID number, effective date, and type of coverage.

Identification (ID) Number – Cardholder's policy number or contract number.

Immediate Family – Cardholder and his/her spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, brothers, sisters, children and stepchildren by blood, marriage or adoption.

In-Hospital Benefit Period – A span of time beginning when a Covered Person is admitted to a hospital and ending when a Covered Person has been discharged from the hospital for a number of consecutive days specified by the policy.

Incidental Procedure – An integral part of a medical visit usually associated with professional services that does not require substantial time, resources or supplies.

Incurred – A charge is considered incurred on the date the Covered Person receives the service or supply for which the charge is made.

Indemnity Schedule – A list of fixed amounts for covered services as determined by the Company.

Individual Consideration – A claim that has to be manually reviewed because an established allowance has not been made.

Inpatient – A Covered Person who receives care as a registered bed Patient in a Hospital or other healthcare facility for which a room and board charge is made; a classification of facility where such healthcare service is rendered.

Inpatient Services – Covered services usually rendered at an inpatient healthcare facility under medically necessary circumstances.

Institutional Providers – As defined or limited by each contract include:

- Acute Care Facility
- Acute Care Facility – Rehab
- Ambulatory Surgery Center
- Children's Hospital
- Dialysis Center
- Home Health Agency
- Hospice
- Long-Term Acute Care Facility
- Outpatient Psychiatric Center
- Psychiatric Hospital
- Skilled Nursing Facility
- Substance Abuse Hospital

Itemized Bill – Bill indicating patient's name, provider's name, date of each service, description and charge for each service.

Line Item – One or more charge items associated with a specific service combined on a single service line of a claim.

Local Codes – Procedure codes assigned by the Company or assigned by a third party and used by the Company that are not defined by HCPCS.

LOS – Length of Stay.

Major Medical – Supplemental coverage to pay a specified percentage of hospital, medical and other related expenses above a stated deductible and within maximum amounts.

Mandatory Second Surgical Opinion Program – A policy provision that requires a Covered Person to obtain a second opinion be obtained before certain surgical procedures are performed.

Median Negotiated Payment Rate – The median of all (designated) county contracting hospital's traditional outpatient hospital rates.

Medical APG – A grouping process that describes medical treatment received by a Covered Person.

Medical Emergency – The sudden and unexpected onset of a medical condition requiring immediate medical attention. Medical emergencies include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions that the Company determines to be medical emergencies. The Company will consider a condition to be a medical emergency only if:

- Severe symptoms occur suddenly and unexpectedly
- Immediate care is secured
- The illness or condition, as finally diagnosed or as indicated by its symptoms, is one which would normally require immediate medical care

Medically Necessary (Medical Necessity) – A service, procedure, treatment, accommodation, supply or product that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which the Company determines is appropriate with regard to standards of good medical practice; is consistent with the diagnosis; is not primarily for the convenience of a provider, a patient or a patient's family; and is the most appropriate level of service, procedure, treatment, accommodation, supply or product which can be safely provided to a Covered Person. When applied to the care of a Covered Person in a hospital setting, that means that the Covered Person's medical symptoms or condition require that the services, procedure, treatment, accommodation, supply or product cannot be safely or adequately provided to the Covered Person in a non-hospital setting.

Medicare – The program of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medifil – A policy designed to supplement Medicare.

Member – A cardholder and, if two persons or family coverage is in force, the cardholder's eligible Dependents.

Member Demographics – The Covered Person's identification number, date of birth, gender and address.

National Account – A group or set of groups whose members reside in more than one plan area, and who have

signed an agreement with one or more Company products or programs to provide uniform benefits to its members.

National Provider Identifier (NPI) – The standard unique health identifier for healthcare providers.

Network Provider – A professional or institutional healthcare entity or facility that has entered into a written agreement with the Company to provide healthcare services to Covered Persons and is tied to a particular network.

Non-emergency – Medical care which need not be performed immediately because reasonable delays will not unfavorably affect the outcome.

Non-group – Coverage not purchased through a group, sometimes referred to as direct pay.

Non-network Provider (Non-participating Provider) – A provider who has not entered into a Provider Agreement with the Company or is part of a particular network.

Non-urgent Care – Care that does not meet the definition of Urgent Care.

Notice of Payment (NOP) – Explanation of Benefits for payment issued directly to the provider of service.

ODJFS – Ohio Department of Job and Family Services.

Other Carrier Liability (OCL) – Responsibility of a third party for any portion of the expenses incurred for healthcare services.

Out-of-Pocket – Expenses incurred directly by a patient without benefit of insurance including deductibles and copayments.

Outlier – A case of a Covered Person with a length of stay that exceeds the Company outlier trim point.

Outpatient – The status of a Covered Person who receives services or supplies through a Hospital, Other Facility Provider, Physician or Other Professional Provider while not confined as an Inpatient.

Outpatient Case Mix Index (OCMI) – The weighted average of the Company APG weights per claim. (See contract for outpatient cases of Covered Persons at the hospital.)

Outpatient Code Editor (OCE) – Software that processes claims for outpatient institutional providers.

Outpatient Services – Covered hospital services ordinarily furnished by a hospital or other facility for care and treatment rendered to a Covered Person that are medically necessary and not considered Inpatient services.

Patient – A person under treatment or care.

Persistent Symptoms – Symptoms which last longer than 48 hours, need medical attention, and are not urgent in nature.

Pharmacy and Clinical Quality and Health Services – The Company division includes Clinical Credentialing and Wellness. The three departments operating under Clinical Quality and Health Services include Care Authorization, Comprehensive Care and Care Transitions.

Physician – A Doctor of Medicine or Osteopathy, possessing the necessary current unrestricted license to practice medicine.

Physician Reviewers – A physician used by the Company on a consulting basis to assist its nurse reviewers in making utilization management decisions. Most physician consultants are board certified, and all maintain active practices.

PPO – Preferred Provider Organization.

Pre-admission Testing (PAT) – An arrangement with hospitals to provide tests on an outpatient basis prior to admission which would have normally been performed during admission.

Primary Care Physician (PCP) – An individual physician (MD or DO) or medical group contracting with the Company to provide primary care and case management services to Covered Persons.

Prior Authorization – The Company processes administered and implemented by its Clinical Quality and Health Services department for specific covered services and procedures that require prior review, including all elective inpatient hospital admissions (prior authorization of inpatient care or admission to a SNF is the responsibility of the hospital or SNF).

Procedure – A medical or surgical service rendered to a patient by an institutional or professional provider of healthcare, including all healthcare not classified as an accommodation or any ancillary benefit.

Procedure Code (also see Current Procedural Terminology and HCPCS) – A standard numeric equivalent for a medical service or supply.

Professional Provider – Only the following persons or entities that are licensed as required:

- Advance Nurse Practitioner
- Nurse Midwife
- Certified Nurse Practitioner
- Clinical Nurse Specialists

- Ambulance
- Anesthetists (including CRNAs)
- Applied Behavioral Therapist
- Audiologists
- Chiropractors
- Convenience Clinics
- Genetic Counselor
- Hearing Aid
- Home Infusion
- Licensed Professional Clinical Counselors
- Licensed Independent Social Workers
- Mobile Radiology – Mammography
- Occupational Therapists
- Opticians
- Optometrists
- Oral Surgeons
- Outpatient Rehabilitation Centers
- Physicians
- Physician Assistants
- Physical Therapists
- Podiatrists
- Psychologists
- Reference Labs
- Sleep Centers
- Speech Therapists
- Suppliers of Durable Medical Equipment (DME)
- Urgent Care Centers
- Advance Nurse Practitioner
- Nurse Midwife
- Certified Nurse Practitioner
- Clinical Nurse Specialists
- Ambulance
- Anesthetists (including CRNAs)
- Applied Behavioral Therapist
- Audiologists
- Chiropractors
- Convenience Clinics
- Genetic Counselor
- Hearing Aid
- Home Infusion
- Licensed Professional Clinical Counselors
- Licensed Independent Social Workers
- Mobile Radiology – Mammography
- Occupational Therapists
- Opticians
- Optometrists
- Oral Surgeons
- Outpatient Rehabilitation Centers
- Physicians
- Physician Assistants
- Physical Therapists
- Podiatrists
- Psychologists
- Reference Labs
- Sleep Centers
- Speech Therapists
- Suppliers of Durable Medical Equipment (DME)

- Urgent Care Centers

Provider Manual – A document furnished to the Company's participating providers that describes the procedures and forms that must be used to comply with the Company's administration and care management programs for its various products and programs. The Provider Manual is referenced in the Provider Agreement and is considered an extension of the Agreement. In the event there are any inconsistencies between the Agreement and the Manual, the Agreement is the controlling document.

Prosthetic Devices – Items used to substitute for a body part, such as pacemakers, artificial limbs, and braces.

Provider Agreement Related Complaints and Grievances – Formal process for filing written complaints and grievances about issues that fall outside the Company's care management, claim, and benefit review appeal procedures as detailed in Section 4 – Appeals of this Manual. For complaints about fee-schedule reimbursement or some other issue related to the Provider Agreement, providers should first contact their Provider Contract manager.

PT – Physical therapy or therapist.

Receiving Hospital – The hospital that receives the Covered Person who has been transferred from another hospital.

Referral – The method, applicable to certain products, by which PCPs obtain medically necessary specialty services for their patients. (Policies and procedures related to referrals are detailed in Section 3 – Clinical Quality and Health Services Programs.)

Rejection – Indicates the final disposition of a reported service on which payment cannot be made.

Rider – A legal document that amends a contract, either by expanding or decreasing its benefits, or adding or excluding certain conditions from the coverage.

Semi-private Accommodations – A room with more than one bed in a hospital, SNF or other type of healthcare facility.

Significant Procedure – A procedure which is normally scheduled constitutes the reason for the visit and dominates the time and resources expended during the visit.

Significant Procedure Consolidation – The collapsing of multiple related significant procedure APGs into a single APG for the purpose of the determination of payment.

SNF – Skilled Nursing Facility.

Specialist/Consulting Physician – A provider who has been trained in a certain area of medicine and usually is not regarded by the Company as a PCP.

Specialty Care/Specialty Service – Any covered service other than PCP service and institutional service required by a Covered Person and authorized by the Company to meet the medical needs of such Covered Person.

SSA – Social Security Administration.

SSO – Second Surgical Opinion. (See also Mandatory Second Surgical Opinion Program.)

Subrogation – Recovery of benefits paid when it is found that another party is legally responsible for payment of expenses.

Status Indicators – As determined by CMS, letters assigned to individual services by the Outpatient Code Editor that indicate how the service paid under the APC based OPPTS.

Supplemental Major Medical – A type of major medical coverage which provides benefits, usually subject to a deductible and copayment, for certain services not included under the Company policy.

Supplier – A company or person who furnishes durable medical supplies for either purchase or rent, or an ambulance service.

Supply/Supplies – Medical items, usually of a disposable nature, such as bandages, tongue depressors, and rubbing alcohol. Supplies should be distinguished from permanent and durable capital goods.

Therapy Services – Services and supplies used to promote recovery from an ailment, injury, condition, disease, disorder or illness. The services or supplies must be ordered by a Professional Provider who is performing within the scope of his/her license.

Third-party Payer – Any organization that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g., the Company, commercial insurance companies, Medicare, and Medicaid). The individual generally pays a premium for such Coverage in all private and some public programs. The organization then pays bills on his/her behalf. Such payments are called third-party payments and are distinguished by the separation between the individual or institution providing it (the second party) and the organization paying for it (the third party).

Title XVIII – Medicare

Traditional – Basic Company and/or major medical coverage, as opposed to alternative healthcare options such as HMO or PPO.

Transfer –

- Transfer of a Covered Person between a transferring hospital and a receiving hospital, which hospitals are not the same;
- Transfer between the hospital's medical/surgical unit and its psychiatric, substance abuse or physical rehabilitation unit, provided each unit is an approved program; or
- Transfer between one specialty unit of the hospital and another, provided each unit is an approved program.

Transferring Hospital – A hospital which initially admits and subsequently transfers a Covered Person to a hospital other than itself or to itself in a transfer.

Unit Flag – The indicator (Y = Yes, N = No) assigned to each APG that denotes whether the service units (per Item 46 of the claim) are applied in the APG payment calculation.

Urgent Care – Any request for medical care or treatment that occurs when applying the time periods for making non-urgent care decisions could result in the following circumstances:

- Could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Utilization Review (UR) – The evaluation and promotion of the efficient use of professional medical care services, procedures and facilities.

Waiting Period – A span of time an individual must wait either to become eligible for insurance coverage or for a specific benefit. This generally does not refer to the amount of time it takes to process an application for insurance, but rather is a defined period before benefits become payable.

Waive (d)/Waiver – Not applied, as in Waiver of Deductible.

Workers' Compensation – State social insurance program which provides benefits to workers for medical services necessary for the treatment of illness or injuries resulting from or incurred in the course, and as a result of, employment.