



Provider Manual

2019

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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 Provider.MedMutual.com, Tools & Resources, 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 (Revised)

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 Provider.MedMutual.com under Tools & Resources, Healthcare Reform.

Uniform Claim Processing

To meet Healthcare Reform standards that provide uniform claim processing, Medical Mutual has complied with the Committee on Operating Rules for Information Exchange (CORE) Rule 360. Under this rule, payers are required to provide standardized denial or adjustment information of a claim using combinations of claim denial/adjustment code sets. 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 caqh.org/Host/CORE/EFT-ERA/CARCSRARCS_835_Rule.pdf.

Eligibility and Benefits

The Phase II CORE Rules for Eligibility and Benefits addresses ambiguities in information given to providers in the transaction process. As a result, the v5010 271 transaction requirements were expanded, and new constraints were added.

Medical Mutual has complied with all specified requirements and is CORE Phase II certified for generating eligibility information.

The Phase II CORE Rules 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 Operating Rule II for Eligibility and Benefits and the outlined services, please visit caqh.org/pdf/CLEAN5010/260-v5010.pdf.

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 Contracting representatives 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 ePortal

Medical Mutual offers secure online services for network providers registered through the [Provider ePortal](#). To register or view a demonstration of the [Provider ePortal](#), visit Provider.MedMutual.com.

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

My Account

Providers can subscribe to newsletters, bulletins and other correspondence electronically by selecting the My Account link and checking the appropriate settings under the Subscriptions tab.

News and Information

EFT Enrollment — By enrolling in Electronic Funds Transfer (EFT), providers receive claim payments electronically through ACH (Automated Clearing House) direct deposit.

Medical Mutual's EFT enrollment, changes and cancellations are administered by PNC® Bank. To set up or make changes to an EFT account, contact PNC Bank at 1(877) 597-5489, through email via email to remit.advantage@pnc.com or visit rad.pnc.com with your tax identification number (TIN), billing National Provider Identifier (NPI), and bank routing and account numbers. To ensure EFTs are processed correctly, inform PNC Bank 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.

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 ePortal 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 ePortal option, providers can add, edit or remove service and reimbursement locations or providers associated with their practice.

Organization and Administration

- New Applications — Individuals requesting access to the secure portions of the provider's ePortal account will be listed here. Primary Access Administrators (PAAs) should review the information users have submitted, particularly the tax identification numbers (TINs) to which they requested access. If you wish to approve the application, select the functionality appropriate to the user by checking the corresponding box(es) next to the user's name; then select the Approve Application button. If you wish to deny the application, enter a comment that describes why the user is being denied; then select click the Deny Application button.
- Manage Users — This option shows a list of users under the provider's account. Users will have the

ability to view information as designated by the provider.

- Manage SAAs — The PAA on the provider account has the option to appoint a Secondary Access Administrator (SAA). To designate an SAA, choose a user from the drop down menu for each TIN. The SAA will be able to approve new applicants and will determine the information those users can access. Creating an SAA does not limit the capabilities of the PAA. Only one SAA can be assigned to a TIN.
- ERA Recipients — Electronic Remittance Advice (ERA) recipients can have remittance advice notices delivered via e-mail. Once your practice's PAA has enrolled in the service, he or she can choose which registered user(s) will receive the ERA. To enroll in ERA, please contact your clearinghouse. Visit caqh.org/ORMandate_EFT.php for more information regarding CAQH CORE EFT/ERA Operating Rules.
- Org Info — With this option, the PAA can establish and maintain the primary address assigned to your group of TINs. The Provider ePortal is frequently updated to meet the needs of our providers.

Contact Information

Questions regarding information in this Manual should be directed to your Provider Contracting representative. Refer to the Provider Contracting regional office map at Provider.MedMutual.com, Contact Us to determine the office that supports your county.

Provider Contracting Offices

Southwest OH/Southeast IN/Kentucky (Cincinnati Office)

(513) 684-8140 / (800) 589-2583
(513) 684-8121 (fax)

MZ: 05-7502
300 East Business Way, Ste. 100
Cincinnati, OH 45241-2369

Northeast OH/Pennsylvania (Cleveland Office)

(216) 687-6064 / (800) 625-2583
(216) 687-7994 (fax)

MZ: 01-5B-3850
2060 East Ninth Street
Cleveland, OH 44115-1355

Central/Southeast OH (Columbus Office)

(614) 621-6900 / (800) 235-4026
(614) 621-4578 (fax)

MZ: 09-7502
One Columbus
10 West Broad Street, Suite 1400
Columbus, OH 43215-3469

Northwest OH/Northeast IN (Toledo Office)

(419) 473-7455 / (888) 258-3482
(419) 473-7024 (fax)

MZ: 22-2S-3845
3737 Sylvania Avenue
Toledo, OH 43623-4482

Eligibility and Benefits

Provider Inquiry Unit (live response) or 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

Coordination of Benefits

(800) 782-5869

Claims

Electronic Claims

Use Payer ID 29076

Claim Inquiries

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

EFT Enrollment/PNC

(877) 597-5489 or email to remit.advantage@pnc.com

Change Healthcare™ Electronic Claims (formerly Emdeon)

(877) 363-3666, option 3

Change Healthcare Payment Manager

(877) 469-3263 or 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

(866) 620-4027

Review Link

ReviewLink is the Company's web-based certification program for submitting select prior authorization requests. For more information, visit Provider.MedMutual.com, Quick Links and select ReviewLink.

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/ePortal 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 Provider.MedMutual.com, Products & Services, [Medical Mutual ID Cards](#) 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 Provider.MedMutual.com, Products & Services, Medical Mutual ID Cards.

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 on the basis of 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 surveys 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 Rights and Responsibilities, visit Provider.MedMutual.com, Quick Links and select 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 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.

¹ Indicates NCQA requirement.

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 are a provider who can address the special needs or preferences of covered persons who speak a language other than English, who are visually or hearing impaired, or who have specific social/cultural needs, then we need your help. Please notify the Company of the other language(s) you speak, the special service you provide or the need or preference you are able to address by visiting Provider.MedMutual.com, Tools & Resources and Forms to complete and submit the Cultural Competence Form. The information you provide will be kept in a database and referenced when a covered person calls us with special needs.

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 the Provider Contracting department by visiting Provider.MedMutual.com, Tools & Resources, Forms and selecting Provider Information Form.

- Providers enrolled in the Provider ePortal 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 their Provider Contracting department 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

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 CMS-1500 and UB-04 (CMS-1450) forms are available for viewing from CMS.gov.

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 lead 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 CCI edits consist of column 1/column 2 correct coding and mutually- exclusive edits. 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 in order 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

Under HIPAA legislation, the National Provider Identifier (NPI) number was created to standardize and help provide a universally accepted national identification and enumeration system for healthcare providers. The NPI is a unique identification number for healthcare providers to be used by all health plans so providers will no longer need multiple identifiers for the various programs and organizations with which they do business.

Insurance companies are now required under HIPAA to use the NPI for all electronic provider transactions, including claims. Claims may be submitted in one of three ways if your office received verification:

- Electronically,
- Directly from Medicare's Electronic Claim System,
- Or on a standard Paper CMS-1500 or UB-04 form.

If your office has received verification that a claim has been received (i.e., Notice of Payment (NOP) or Electronic Acceptance Report), do not resubmit the claim for adjustment inquiries. 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 our secure Provider ePortal, Change Healthcare, 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

MZ: 01-2B-4550
Claims Submission
Medical Mutual
PO Box 6018
Cleveland, OH 44101-1018

Network Access Services

MZ: 01-2B-4550
Network Access Services
Medical Mutual
PO Box 94648
Cleveland, OH 44101-1018

Billing Agents

A number of billing services contract with providers 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 the claim on a fully completed billing form as adopted by the National Uniform Billing Committee. 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. The 12-month filing limit does not apply to claims for Medicare Covered Persons whose certificates state that claims must be filed within the time limits set by the Centers for Medicare and Medicaid Services.

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. 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 can 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.

Tips for Handling Overpayment Adjustments

- Identify the Covered Person 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 Submit Inquiry Button on the provider ePortal or via paper and mailed to the address on the form.

The PAR Form is available on the Company's website by visiting Provider.MedMutual.com, Tools & 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. In order to realize those benefits, providers must assist by filling out claims completely and accurately. 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:

- Effective October 1, 2015, claims must include appropriate, clinically accurate ICD-10-CMS² codes or they will be rejected.
- ICD-9-CM codes will only be accepted for dates of service prior to October 1, 2015.
- Copies of claims are not acceptable.
- Use only standard UB-04 or CMS-1500 original forms.
- Print should be dark and legible. Do not use dot matrix printers.
- Decimal points and cents should ALWAYS be clearly indicated to avoid data entry and OCR errors that may possibly result in an incorrect reimbursement amount.
- Information on claims should be inside the borders of the appropriate field.
- Do not handwrite information in 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 in order 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 line of service should be in each detail line.

² ICD-10-CM is the International Classification of Diseases, Tenth Revision, Clinical Modification, as periodically amended, published by the U.S. Department of Health and Human Services as a standard means of defining medical diagnoses. ICD-9-CM codes should only be used for dates of service prior to October 1, 2015.

- For UB-04, the ICD-10-CM2 diagnosis code should include a decimal point between the third and fourth digits. Double spacing instead of using decimal points causes OCR to misread the data. Present on Admission value must be printed within the shaded portion of the diagnosis field.
- HCPCS Modifiers reported in Item 44 of the UB-04 should be submitted after the HCPCS/CPT procedure code and as a continuous string (no spaces between each modifier). The data must be kept within the box for Item 44.
- Do not list HCPCS/CPT procedure codes in Item 74 or 74a–e of the UB-04. Only ICD-10-CM2 should be listed.
- Do not indent data. Data should be placed flush left in any field.
- Dates (e.g., birthdates, date of service) must be within the boxes on the form. The date fields should be submitted as MMDDYY.
- 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.
- Handwritten forms, torn claims, taped claims and grossly misaligned claims are not eligible for OCR.
- Claims not billed on the UB-04 or CMS-1500 are not eligible for OCR.
- For the first claim submission, do not attach medical records. If needed, the Company will request them.
- 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 our secure Provider ePortal, Change Healthcare, 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 transmitted immediately.

Electronic Claims Processing Program

The Company and Change Healthcare have partnered to give providers a single point of entry for electronic claim submission. Electronic claims from providers are submitted to Change Healthcare or may be submitted directly to the Company. The provider's practice management system performs editing and allows for immediate correction of claims prior to transmission to Change Healthcare. Change Healthcare does additional editing prior to forwarding the claims to the Company.

Once received by the Company's front-end systems, the claims are further edited. 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 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. Any Medicare secondary claim where code MA18 does not appear on the Explanation of Medicare Benefits (EOMB), indicating that the claim was not automatically sent from Medicare intermediary to the Company should be submitted electronically. The Company processes electronic secondary claims in compliance with the standards established in the ANSI X12N 837I and 837P HIPAA Implementation Guides.

Note: Change Healthcare currently transmits all claims to Medical Mutual in 5010 format.

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.)
- Paper claims are NOT submitted for any Medicare Crossover claim that has been electronically crossed over to the Company by the Medicare intermediary. (A claim submitted on paper requires manual entry and will likely pend in the Company's system as a possible duplicate.)

Here are some key points for 837 Transactions:

- Determine if there are any changes to your National Provider Identifier (NPI) enumeration due to the 5010 Instructions noted below and register if needed.
- Provider Identification Number (PIN) is not HIPAA compliant and should no longer be submitted.
- Billing NPI is required for electronic submissions.
- Submit a Provider Information Form if you have any address changes to support 5010 instructions for Billing and Service Provider addresses; specifically for PO Box or Lock Boxes and the requirement for 9-digit ZIP codes per the 5010 Instructions.

Please contact your vendor/clearing house for information. Providers who submit directly to Change Healthcare should visit hipaasimplified.com. Additional resources 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 Change Healthcare™ reports for confirmation of claim receipt or errors
- Use the Covered Person's ID number from his/her ID card
- Use the provider's NPI number
- Additional 5010-Specific Requirements
 - Billing NPI is required
 - PO Box/Lock Box should be submitted in the Pay-to address. PO Box/Lock Box should not be submitted to the Billing Address.
 - Billing Provider should be submitted with the 4-digit zip code suffix

Benefits of Electronic Claims Filing

Providers realize a number of benefits by submitting claims electronically. These include:

Enhanced Efficiency

- Claims for all Company lines of business may be transmitted electronically.
- All Company electronic claims may be submitted together, eliminating the need to sort and mail claims to separate PO boxes.

- Claims for all specialties may be submitted electronically.

Enhanced Accuracy

- Built-in Edits: Electronic claims are more accurate due to edits that are built into the system.
- Audit Trail: The Change Healthcare Claim Submitter Reports establish an audit trail. The reports include pertinent information such as Covered Person control number, provider ID, and charges. Summary data is provided at the claim and batch level.
- Prompt Notification/Correction of Errors: Claims that do not successfully pass the electronic edit checks are flagged with rejection codes. This prompt notification of errors allows the provider to make necessary corrections before the claim is directed to the claim processing system. Corrected claims can then be resubmitted electronically.

For questions related to the submission and/or rejection of claims at Change Healthcare, call the Change Healthcare Commercial Help Desk at (877) 363-3666, option 2.

For questions related to the rejection of claims at the Company, call Voice Connect at (800) 362-1279. To begin sending claims electronically to the Company, please notify your billing service 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, the vast majority of 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 in excess of \$62 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 the accuracy, completeness and truthfulness of Provider's Risk Adjustment Data submitted to Medical Mutual.

Completing the CMS-1500 Claim Form

Providers can view a copy of the CMS-1500 form at CMS.gov.

Patient Information (Items 1–13)

Item 1: Not required by the Company

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

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 in place of the Covered Person's social security number.
- 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 (required)

This is the Covered Person who receives care.

Special Note:

- The name as it appears on the claim is compared by computer to the names registered as eligible 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.
- The Covered Person's name must be on the claim form.

Item 3: Patient's Birth date and sex (required)

Date of Birth: This is the date on which the Covered Person was born.

Special Note:

- Date of birth is used in conjunction with the name to verify that the patient is a Covered Person.
- The Covered Person's date of birth must be on the claim form.
- Be sure to complete this information on claims for newborns.
- Format MMDDYY or MMDDCCYY.
- Sex: Place an X in the correct box:
- Male Covered Person
- Female Covered Person

Special Note:

- This information is important for a number of 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.

Item 4: insured's (Cardholder's) name (required)

This is the name of the person in whose name coverage was issued; it is the name that appears on the ID card.

Special Note:

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

Item 5: Patient's address (required if different from insured's address)

This is the Covered Person's home address.

Item 6: Patient's relationship to insured (required)

Place an X in the box which represents the Covered Person's (whose name is in Item 2) relationship to the cardholder (whose name is in Item 4 on the claim form).

Special Note:

- SELF – The Covered Person (Item 2) is the cardholder (Item 4).
- SPOUSE – The Covered Person (Item 2) is married to the cardholder (Item 4).
- CHILD – The Covered Person (Item 2) is the dependent child of the cardholder (Item 4).
- OTHER – The Covered Person (Item 2) is none of the above.

- 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 7: Insured's Address (required)

This is the complete cardholder's home address, including the ZIP code and any suite number, which is the address of the person whose name is in Item 4.

Item 8: Reserved for NUCC Use**Item 9A–9D and Item 11D: Other Health Insurance (required if applicable)**

This must be completed if the Covered Person is enrolled under another health insurance policy, whether it is another insurance company or a second coverage with the Company.

Special Note:

- 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, some evidence that the claim has been processed by other coverage must be provided.
- The Company accepts commercial Coordination of Benefits (COB) Professional and Institutional claims electronically. The Company does not require a paper Explanation of Benefits (EOB) when commercial COB claims are submitted electrically. For paper submissions, a copy of the primary EOB must be attached.
- Always indicate NONE if the Covered Person has no other coverage.
- See Section 5 – Other Carrier Liability of this Manual for more information regarding claims submission when more than one insurance coverage is involved.

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)

(a) Employment: If the condition being treated is the result of an injury or illness incurred as a result of the Covered Person's job, place an X in the YES box, whether or not the claim has been submitted to or is covered by Workers' Compensation. Otherwise, mark the box indicating that the condition is not work-related.

(b) Auto Accident or

(c) Other Accident (Required if Applicable) If the Covered Person's condition is the result of an accident, whether or not work related, indicate the cause by marking the appropriate box.

(d) When applicable, use claim codes approved by NUCC.

Special Notes:

- AUTO – the injury resulted from an auto accident.
- OTHER – the injury resulted from other than an auto accident.
- 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 (not required)

This is a five- 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 (required if applicable).

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 (required if applicable).

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 14: Date of Current Illness (First symptom, injury or Pregnancy [IMP])—required if applicable

This is the onset date of the condition being treated.

Special Note:

- The date of the present illness, injury or pregnancy.
- If the date of onset is incorrect, the amount of payment may be affected. Do not assume that the date of treatment is the date of onset. Always ask the Covered Person for this date or obtain it from your records.
- Format MMDDYY or MMDDCCYY
- The applicable qualifier should be entered to the right of the vertical dotted line:
 - 431 Onset of Current Symptoms or Illness
 - 484 Last Menstrual Period

Item 15: Other Date (required if applicable)

This is the applicable qualifier and date on which the provider was first consulted or contacted about the condition for which the Covered Person is being treated

- The applicable qualifier should be entered.
 - 454 Initial Treatment
 - 304 Latest Visit or Consultation
 - 453 Acute Manifestation of a Chronic Condition
 - 439 Accident
 - 455 Last X-ray
 - 471 Prescription
 - 090 Report Start (Assumed Care Date)
 - 091 Report End (Relinquished Care Date)
 - 444 First Visit or Consultation
- Format MMDDYY or MMDDCCYY

Item 16: Dates Patient Unable to Work in Current Occupation (Required if applicable)

If available and applicable, the beginning and ending dates are used to identify the period during which the Covered Person was totally and/or partially disabled.

- Format MMDDYY or MMDDCCYY

Item 17: Qualifier/Name of Referring Physician or Other Source (Required if applicable)

This is the name of the physician or other provider who referred the Covered Person for your services. This name must be on the claim form if services include a consultation.

- The applicable qualifier should be entered.
 - DN Referring Provider
 - DK Ordering Provider
 - DQ Supervising Provider

Item 17 A-B: ID Number of Referring Physician (required if services include a Consultation)

Enter the Other ID (non-NPI) and qualifier in 17a and the NPI number in 17b.

Item 18: Hospitalization Dates Related to Current services (Required if service is related to hospital admission)

Special Note:

- Date of admission and discharge are required for services related to an inpatient stay.
- Benefits for inpatient services cannot be correctly administered without these dates.
- Format MMDDYY or MMDDCCYY.

Item 19: Additional Claim Information (Designated By NUCC)

Special Note:

- Enter appropriate qualifiers describing the Identifier if required by the payer.

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

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

Professional	Placement of Z-Code Identifier
Paper	
CMS 1500 (previously HCFA 1500)	In the comment field at the header level (Box 19)
Electronic	
837p	In the professional claim line (SV101-7)

CMS-1500 Z-Code Identifier location, Box 19:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Item 20: Outside Lab — \$ Charges (required if applicable)

If services listed in Item 24C include laboratory tests, place an X in either the YES or NO box to indicate if those tests were performed at a laboratory outside your office. The charge(s) to your office for tests performed by an outside laboratory is required if YES is marked.

Item 21: Diagnosis or Nature of Illness or Injury (required)

Identify the specific medical condition(s) for which each service was rendered by inserting the ICD-9-CM code(s) for dates of service before October 1, 2015, or ICD-10-CM for dates of service beginning or after October 1, 2015.

Special Note:

- ICD Indicator “9” is required (indicating ICD-9-CM <October 1, 2015) and ICD indicator “0” is required (indicating ICD-10-CM), unless a new rule or law allows the use of the ICD-10-CM or ICD-10-PCS code set.
- List the primary and secondary ICD-9-CM (<October 1, 2015) or ICD-10-CM(s) in priority order.
- Diagnosis code(s) should be listed following the reference letter(s) in Item 21 of the CMS-1500 Claim Form. The reference letter of the primary diagnosis for each service must be indicated in Item 24E for each charge if there is more than one diagnosis.
- Diagnosis code(s) are required on all claims, regardless of the service rendered.
- Do not provide narrative description in this field
- ICD-9-CM (<October 1, 2015)/ICD-10-CM codes will not be accepted unless they are valid according to the instructions in the ICD-9-CM (<October 1, 2015)/ICD-10-CM books. Fourth and fifth digits must be included. A claim cannot be processed if the appropriate fourth and fifth digits are omitted, because those decimal positions define specific conditions.
- 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 (Not Required)

- The appropriate bill frequency code.
 - 7 Replacement of prior claim
 - 8 Void /Cancel of prior claim
- The original reference number for resubmitted claims from the Notice of Payment.

Item 23: Prior Authorization Number (not required)

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

Special Note:

- Items 24A–24J are used to provide specific information about the services or expenses being claimed.
- Six lines are available on each claim form.
- Only one charge is to be billed per line item.
- In some cases, multiple services may be combined as a single line item. (See Combining Multiple Services in this section.)
- To submit more than six line items, use a second form.
- All related claims should be submitted at the same time if possible. (DO NOT staple multiple forms together.)
- Superbills are unacceptable.
- The following fields must be completed for each service rendered.

Item 24: Dates of Service (required)

FROM (Required)

The date on which the Covered Person is seen and service is rendered or an expense is incurred.

Special Note:

- In the case of interpretation or other services performed at a later time, 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. For multiple dates, this is the first date of service.
- To combine multiple dates of service, refer to the special note below.
- Format MMDDYY or MMDDCCYY.

TO (Required When Multiple Dates of Service Are Combined)

Special Note:

- When multiple dates of service are combined, the last date of service (or ending date) must be indicated.
- When multiple dates of services span two different calendar years, the dates of service must not be listed on one claim form. The dates, units, and fee should be split and listed as a single line item. Separate claim forms must be submitted for services rendered in separate years.
- Format MMDDYY or MMDDCCYY.

Item 24B: Place of Service (POS) (required)

This is a code that indicates the place where the service was rendered.

Special Note:

- The Company follows the POS code guidelines, as standardized by CMS. For more information visit NUCC.org.
- Be sure to submit only CMS POS codes. Other POS designations may assign the same number or letter but have a different meaning.
- Because available benefits and the amount of payment sometimes depend on the place where the service was rendered, this information is required and must be accurate.
- 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.
- POS for each expense must be on the claim form.

Item 24C: EMG (Emergency Indicator) (Required if Applicable)

This is a code indicating if the services provided are in response to an emergency.

Special Note:

- Enter Y for Yes, or leave blank if No.

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

CPT/HCPCS Code

This is a five-digit code which identifies the specific procedure, service or medical supply being billed.

Special Note:

- 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 manual.
- Do not include CPT or HCPCS description.
- Use of the shaded “supplemental info” area should be kept to a minimum to report unusual circumstances, anesthesia time and NDC numbers.

Reporting an NDC on a CMS-1500 Claim Form

To report a National Drug Code (NDC) on a CMS-1500 claim form, enter the following information in the shaded “supplemental info” area of field 24 in the order listed below:

- NDC qualifier of N4 and NDC 11-digit numeric code.
- Note: If the leading zero(s) of the NDC has been omitted, add them to the claim and submit it in the correct 11-digit format.
- Drug description
- NDC unit of measure qualifier and quantity as follows:
 - F2 – International Units
 - GR – Gram (e.g., GR0.045)
 - ME – Milligrams
 - ML – Milliliter (e.g., ML1.0)
 - UN – Unit (e.g., UN1.000)

CMS-1500 NDC Example:

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURE (Explain Unit, CPT/HCPCS)
	From	To	From	To	From	To			
MM	DD	YY	MM	DD	YY				
1	N400173036301 Rantidine HCL ML 1.0								J2780
	06	01	12	06	01	12			

Valid HCPCS code(s) and NDC identifiers must be entered on the claim form. If the NDC does not have a specific 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 (11-digit numeric code), NDC Quantity and Unit of Measure are submitted in the 2410 loop.

Modifier

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 (Required)

The diagnosis pointer refers to the line number from Item 21 that relates to the reason the service(s) was performed. The reference letter from Item 21 must be included to the left of each charge, indicating the primary diagnosis for that service. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.

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. Services related to the primary diagnosis should have the diagnosis reference letter A in Item 24E.
- Diagnosis Pointer is a 1-digit value (A-L). Up to four pointers may be reported on each service line. Do not report “All” or any pointers greater than 4 or L.
- Completing The CMS-1500 Claim Form (continued)
- Do not report actual diagnosis codes in this field – use item 21 to report diagnosis codes.

Item 24F: \$ Charges (Required)

This is the provider’s charge for each service, represented by a procedure code in Item 24D.

Special Note:

- 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.

Item 24G: Days or Units (Required)

This is the number of dates, procedures, or other units of service.

Special Note:

- 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 24H: EPST/Family Plan (not required)

For Early and Periodic Screen, Diagnosis and Treatment related services.

Item 24I: ID Qualifier (Required if Applicable)

Enter the qualifier identifying the number in 24J if the number is non-NPI.

Item 24J: Rendering Provider ID (Required)

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

Provider Information (Items 25-33)

Item 25: Federal Tax ID Number — SSN/EIN (required)

This is the nine-digit Federal Tax ID number or the Social Security number of the provider/supplier to be paid. This number is required for payment and tax purposes. 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 (Not Required)

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 for Participating Providers. This information is for the provider's convenience and is not required by the Company.

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 (required)

The sum of all charges on the claim form is required as a balancing total for all claims including more than one line item.

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 29: Amount Paid (not required)**Item 30: Reserved for NUCC use (not required)****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.) (Required)**

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) (Required if Applicable).

This must be completed if different from billing address in Item 33. The servicing facility NPI should be submitted in this item.

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

This is the name of the entity to be paid and the address where payment/notice of payment should be sent.

Special Note:

- 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 cause a number of problems. Processing may be delayed due to differences in specialty or apparent duplicate billing when services have been performed by both providers.
- City name should not be abbreviated or shortened.
- Include ZIP + 4 when possible.

Coding Instructions for Selected Services and Related Billing Policies and Procedures

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 absolutely necessary 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

One-digit modifiers are combined to form a two-digit modifier that identifies the ambulance's place of origin with the first digit, and the ambulance's destination with the second digit. Two-digit modifier should be assigned to each procedure code to indicate the place of origin and destination.

One digit ambulance modifiers are as follows:

- D Diagnostic or therapeutic site other than "P" or "H" when these are used as origin odes
- E Residential, domiciliary, custodial facility
- G Hospital based dialysis facility (hospital or hospital related)
- H Hospital
- I Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J Non-hospital based dialysis facility
- N Skilled nursing facility
- P Physician's office
- R Residence
- S Scene of accident or acute event
- X (Destination code only) Intermediate stop at physician's office on the way hospital

Item 24F: Charges

Submit itemized services with a separate procedure code for each service for which an additional charge was billed.

Anesthesia

Anesthesia Modifiers

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. Unless otherwise negotiated, reimbursement amounts will follow CMS guidelines for modifier reimbursement.

- Anesthesia providers should bill Medical Mutual with the following modifiers on claims, as appropriate:
- AA Anesthesia services performed personally by anesthesiologist
- AD Medical supervision by a physician: More than four concurrent anesthesia procedures
- QK Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QS Monitored anesthesia care
- QX CRNA service with medical direction by a physician
- QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- QZ CRNA service without medical direction by a physician

If you are billing two separate claims or claim lines, one for CRNA and one for the Anesthesiologist, you should bill with all appropriate CRNA and Anesthesiologist modifiers on the appropriate lines. In addition, if you are requesting reimbursement for Physical Status Modifier (P1-P6), you must include P1-P6 modifier in Item 24, Box D on both claims or claim lines, CRNA and Anesthesiologist. 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.

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.

Paper Claims Submission

Base Units

Providers are not to 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. Modifiers are not to be billed when the

service is being billed as TOS 2³. The Covered Person cannot be billed for Physical Status Modifiers not allowed by the Company.

Qualifying Circumstances

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. Qualifying circumstances cannot be billed when the service is being billed as TOS 23. The Covered Person cannot be billed for qualifying circumstances not allowed by the Company.

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.

ASA code 01997 and Local codes W1000 and W1001 are no longer valid under HIPAA requirements. Claims submitted with any of these codes will be returned for incorrect billing and will delay reimbursement for the service.

Continuous Epidural Infusion

If Continuous Epidural Infusion is used as the primary method of anesthesia for a surgical procedure, insertion of the catheter is considered to be included in the base units for the procedure and is not reimbursed separately. Claims for the service should 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.

Local Code W1001 is no longer valid under HIPAA requirements. If any subsequent days of analgesia are billed under this code, the claim will be returned for incorrect billing and will delay reimbursement for the service.

³ The TOS is no longer a field on the claim form or electronic record; however, it will be derived within the adjudication system for processing.

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. Those procedures should be billed as separate line items, with the appropriate TOS3 code 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.

Endoscopic Billing Procedures

When submitting a claim for screening endoscopic services, for dates of service prior to October 1, 2015, please list the appropriate ICD-9-CM diagnosis code for screening (V76.50-V76.52) as the first diagnosis on the claim. For dates of service October 1, 2015, and greater, please list the appropriate ICD-10-CM diagnosis code for screening (Z12.10 - Z12.13, Z80.0, Z83.71).

The screening V 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 applicable CPT codes, HCPCS, and ICD-9-CM (<October 1, 2015)/ICD-10-CM surgical codes for endoscopic screening services are listed below.

Colonoscopy:

- CPT codes: 44388-45394, 44397, 44355, 45378, 45387, 45391-45392
- HCPCS codes: G0105, G0121

Flexible Sigmoidoscopy:

- CPT codes: 45330-45335, 45337-45342, 45345
- HCPCS codes: G0104

ICD-10-CM procedure codes can be found on the CMS website. Visit CMS.gov and select Medicare/Coding/ICD-10/2016-ICD-10-CM-and-GEMs.

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 more efficiently process medical drug claims and avoid delays in provider reimbursement.

Affected claims must have a valid Healthcare Common Procedure Coding System (HCPCS) code and NDC identifiers, which include the 11-digit drug code, 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 wasted amount

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.

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

Medical Mutual will deny claims not submitted as requested above.

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 has partnered with McKesson Diagnostic Exchange™ (DEX) to provide laboratories with unique Z-Code Identifiers.

Payment for select molecular diagnostic tests for dates of service on or after January 11, 2016, will be rejected without Z-Code Identifiers.

Tests associated with CPT codes in test Group 1, as represented in the table below, must be submitted for Z-Code Identifiers in the McKesson DEX to include on claims with dates of service on or after January 11, 2016. Claims with CPT codes from test Group 1 will be denied if the Z-Code Identifier is missing.

CMS Multiple Procedure Payment Processing

Medical Mutual uses the CMS Relative Value File for multiple procedure payment reduction. For dates of service on or after February 1, 2016, Medical Mutual expanded its current CMS Multiple Procedure Payment Reduction processing (which previously included multiple surgery processing) to include values 3, 4, and 5 on the CMS Physician Relative Value file.

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 following the procedure code.
- 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, as determined by the Company.

Some services that are classified as surgical procedures may be performed by anesthesiologists. The procedures most commonly 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.

If two or more lower extremity procedures are performed, the procedure with the highest fee schedule amount is allowed at 100 percent, the two procedures with the next highest fee schedule amounts are allowed at 50 percent and all other

Test Group	CPT Codes	Eff. Date for Incl.
Group 1		
MoPath Tier 1	81161, 81200-81383	Jan. 11, 2016
MoPath Tier 2	81400-81408	Jan. 11, 2016
MoPath Misc.	81479	Jan. 11, 2016
MAAA Codes	81500-81599	Jan. 11, 2016
New 2015 GSP Codes	81410, 81411, 81415-81471	Jan. 11, 2016
Molecular Cytogenetics	88271-88275	Jan. 11, 2016

It is expected that laboratories will provide information on the tests they perform now and will add any molecular diagnostic test to the McKesson DEX in the future if one is added to the menu of test they perform.

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

Claim Type	Placement of Z-Code Identifier
Paper	
UB04 or CMS 1450	In the comment field at the header level (Box 80)
CMS 1500 (previously HCFA 1500)	In the comment field at the header level (Box 19)
Electronic	
837p	In the professional claim line (SV101-7)
837i	In the professional claim line (SV202-7)

Prior to other CPT code test groups being added, Medical Mutual will inform providers of the effective date for inclusion of Z-Code identifiers for CPT codes prior to implementation.

For questions regarding this initiative, contact your Contracting Representative.

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.

procedures are allowed at 25 percent of their respective fee schedule amounts.

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 into 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, TOS4 and POS are the same for each service. Services before October 1 should not be combined on the same line item with services rendered during October, November or December. Many policies include a provision, Deductible Carryover, which allows deductibles taken during the last quarter of the 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:

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

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 considered to be 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 Medicare 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. The Medicare modifiers are listed in the following table.

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.

Medicare 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 submitted as an appeal.

Obstetrical Care

Physicians should use the global CPT codes for 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 services associated with the delivery.

Special Note:

- For the most current information visit Provider.MedMutual.com, Tools & Resources, Care Management, Corporate Medical Policies, Obstetrical 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, extensions⁴

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 pregnancy⁵.

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.⁵ 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.

⁴ Service may be considered in case of an emergency.

⁵ HEDIS Technical Specifications 2008

Preventive Services Coding Reminder

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 and Advanced Nurse Practitioners

The Company directly contracts with Physician Assistants (PAs) and Advanced Nurse Practitioners (ANPs).

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 Contracting representative 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 nurse practitioners (certified nurse practitioners and clinical nurse specialists). All ANPs must register with the Company to

allow their claims to process, using their own provider number. ANP services rendered can no longer be billed by a supervising provider.

ANPs 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 ANP 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.

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.

HCPCS Codes Required for Revenue Codes 0634, 0635 and 0636

Health Care Procedure Coding System (HCPCS) 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 HCPCS 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 Contracting representative 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 does not appear 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

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 Medifil 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 sufficient 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 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 initial Medicare crossover claims on paper.

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 paper 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, 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

On April 1, 2008, the CMS implemented their program Hospital Acquired Conditions and Present on Admission Indicator Reporting (HAC and POA). Hospitals submitting inpatient claims to CMS for payment must report accurate POA data or the claims will be returned for correct submission of POA data.

Accurate POA coding is necessary to assure correct Medicare Severity Diagnosis Related Group (MS-DRG) assignment. A valid POA indicator needs to be recorded for each ICD-9-CM (<October 1, 2015)/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-9-CM (<October 1, 2015)/ICD-10-CM Official Guidelines for Coding and Reporting.

CMS POA indicators are:

Y = Diagnosis was present at time of inpatient admission

N = Diagnosis was not present at time of inpatient admission

U = Documentation insufficient to determine if condition was present at the time of inpatient admission

W = Clinically undetermined; unable to clinically determine whether condition was present at the time of inpatient admission

1 = When billing electronically, diagnosis code is exempt from POA reporting. This is the equivalent of a blank on a paper claim.

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:

For additional information regarding the following items, please refer to the NUBC Official UB-04 Data Specifications Manual 2013.

Item 1: Billing Provider name, address and Telephone number (Required)

This is the name and complete address of the provider submitting the bill. A telephone number is not required.

Item 2: Billing Provider's designated Pay-to address (Not required if same as item 1) The address the provider intends payment to be sent.

Item 3A: Patient Control number (Required)

This is the patient's unique alphanumeric number assigned by the provider to facilitate the retrieval of individual financial records and the posting of payments.

Item 3B: Medical/health record number (required if applicable) Used when the provider needs to identify the medical record of the patient.

Item 4: Type of Bill (Required)

This is a code indicating the type of facility, bill classification and frequency. The type of bill is a required element when coding a claim. Type of bill should 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 resubmission. For a detailed description and instructions regarding this item, please refer to the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual 2013.

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.

Item 5: Federal Tax Number (Required)

This is the number assigned to the provider by the Federal Government for tax reporting purposes. It is also known as a Tax Identification (ID) Number or Employer ID Number. To identify affiliated subsidiaries, use Federal Tax sub-ID.

Special Note:

The 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

Item 6: Statement Covers Period (Required)

The beginning and ending dates of services should be included on the bill.

Special Note:

The Statement Covers Period

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

Item 7: Unassigned (Reserved for assignment by the NUBC)**Item 8: Patient Name/Identifier (Required)**

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

Item 9: Patient Address (Required)

This is the mailing address of the patient, including street number and name or post office box, city, state, and ZIP code.

Item 10: Patient Birth Date (Required)

The date of birth of the patient.

Special Note:

- Format: MMDDCCYY

Item 11: Patient Sex (Required)

The sex of the patient as recorded at the date of admission, outpatient service, or start of care.

Special Note:

- Must be M or F

Item 12: Admission/Start of Care Date (Required)

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, Item 6
- Must be greater than or equal to Patient Birth Date, Item 10
- Must be less than or equal to the date the claim was received

Item 13: Admission Hour (Required if applicable)

This is the hour during which the patient was admitted for inpatient or outpatient care.

Special Note:

- Required on inpatient claims.
- Valid characters: 00 through 23

Item 14: Priority Type of Visit (Required)

A code indicating the priority of this admission/visit.

Item 15: Point of Origin for Admission or Visit (Required)

A code indicating the point of patient origin for this admission of visit.

Item 16: Discharge Hour (Required)

This is the hour that the patient was discharged from inpatient care. The 24-hour clock is used. This data element is not necessary for outpatient visits.

Special Note:

- Required on inpatient claims.
- Valid characters: 00 through 23

Item 17: Patient Discharge Status (Required)

A code indicating the status of the patient at the end of service for the period covered on the claim.

Item 18–28: Condition Codes (Required if applicable)

This is the code(s) used to identify condition(s) relating to this bill, which could affect payer processing.

Item 29: Accident State (Required if applicable)

The two-character state abbreviation where the accident occurred.

Special Note:

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

Item 30: Unassigned (Reserved for assignment by the NUBC)**Item 31–34: Occurrence Codes and Dates (Required if applicable)**

The code and associated date that define an event related to this claim that may affect payer processing.

Special Note:

- All dates should be entered in format MMDDYY

Item 35–36: Occurrence Span Codes and Dates (Required if applicable)

The code and associated date that define an event that relates to payment of this claim.

Special Note:

- All dates should be entered in format MMDDYY

Item 37: Unassigned (Reserved for assignment by the NUBC)**Item 38: Responsible Party Name and Address (Required if applicable).**

The name and address of the party to whom the claim is being submitted.

Special Note:

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

Item 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.

Item 42: Revenue Code (Required)

This is the code that identifies a specific accommodation, ancillary services or billing calculation.

Special Note:

- Always use the specific code that reflects the service provided.
- On a multiple page UB-04, all of 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.

Item 43: Revenue Description/ID Number/Medicaid Drug Rebate (Required if applicable).

This is an abbreviated description of the revenue categories included on the bill.

Special Note:

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

Item 44: HCPCs/Accommodation Rates/HIPPS Rate Codes (Required).

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.

Item 45: Service Date (Required)

This is the date the indicated service was provided, the date the bill was created/printed (Line 23) or the assessment reference date when billing Skilled Nursing Facility (SNF) Prospective Payment System (PPS) services.

Special Note:

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

Item 46: Service Units (Required)

This is a 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.

Item 47: Total Charges (Required).

Total charges pertaining to the related code for the current billing period as entered in the Statement Covers Period, Item 6.

Special Note:

- Do not prorate the charges to reflect the percent of charges you estimate as payable. Indicate actual total charges.
- Revenue Code 0001 must be listed on line 23 of Item 42, and associated Total Dollar Amount must be present in Items 47–48.

Item 48: Non-covered Charges (Required if applicable).

This item is for non-covered charges by the primary payer, pertaining to the related Revenue Code.

Special Note:

- If present, must be numeric.
- Must be less than or equal to Total Charges, Item 47.

Item 49: Unassigned (Reserved for assignment by the NUBC)

Item 50: Payer Name (Required).

This is the name identifying each payer organization from which the provider might expect payment.

Special Note:

- 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.

Item 51: Health Plan ID Number (Not required).

This number is used by the Health Plan to identify itself.

Special Note:

- Report the HIPAA mandated National Plan Identifier when it becomes mandated.

Item 52: Release of Information Certification Indicator (Required).

This is a code indicating whether the provider has a signed statement on file permitting the provider to release data to another organization in order to adjudicate the claim.

Special Note:

- The response is limited to information contained in this claim.

Item 53: Assignment of Benefits Certification Indicator (Required if applicable)

This is a code showing whether the provider has a signed form on file authorizing the payer to pay the provider directly.

Special Note:

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

Item 54: Prior Payments — Payer (Required if applicable).

This is the amount the hospital has received toward payment of this bill by the indicated payer.

Special Note:

- If present, must be numeric.
- Must be less than or equal to Total Charges, Item 47.

Item 55: Estimated Amount Due — Payer (not required)

This is the amount estimated by the hospital to be due from the indicated payer.

Special Note:

- If present, must be numeric.
- Must be less than or equal to Total Charges, Item 47.

Item 56: NPI — Billing Provider (Required).

This unique ID number assigned to the provider submitting the claim.

Item 57: Other (Billing) Provider Identifier (Not Applicable).

A unique ID number assigned to the provider submitting the bill by the payer.

Item 58: insured's name (required).

This is the name of the individual who carries the insurance (cardholder).

Special Note:

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

Item 59: Patient's Relationship to Insured (Required).

This is a code indicating the relationship of the patient to the insured identified in Item 58.

Item 60: Insured's Unique Identifier (Required).

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 are NOT allowed in this field.

Special Note:

- Do not place the Company service codes or other extraneous information in this item.
- A certificate number is usually 7, 9 or 12 characters in length. Alpha characters may be included.
- A certificate number is required if a payer was listed in Item 50.

Item 61: Insured's Group Name (Not required, but recommended).

This is the name of the group or plan through which the insurance is provided to the insured identified in Item 58.

Item 62: Insured's Group Number (Required).

This is the ID number, control number or code assigned by the carrier or administrator to identify the group under which the individual identified in Item 58 is covered.

Special Note:

- List the group number exactly as it appears on the patient's ID card.

Item 63: Treatment Authorization Codes (Required if applicable)

This is a number or other indicator designating that the treatment covered by this bill has been authorized by the payer identified in Items 50A, B, and C respectively.

Special Note:

- This is the certification number provided when the admission received prior authorization.

Item 64: Document Control Number (DCN) (Required if applicable).

The control number (claim number) assigned to the bill by the health plan or the health plan's agent as part of their internal control.

Special Note:

- Required when this claim is a replacement or void to previously adjudicated claim.
- Payer A's DCN should be shown in line A of Item 64, with the DCN for Payers A and B shown on lines A and B respectively.

Item 65: Employer Name (Not required).

This is the name of the employer that provides healthcare coverage for the individual identified in Item 58.

Item 66: Diagnosis and Procedure Code Qualifier (ICD Version indicator) (Required).

The Qualifier that denotes the version of International Classification of Diseases (ICD) reported.

Special Note:

- ICD indicator “9” is required (indicating
- ICD-9-CM (<October 1, 2015) and ICD indicator “0” is required (indicating ICD-10-CM), unless a new rule or law allows the use of the ICD-10-CM or ICD-10-PCS code set.

Item 67: Principle Diagnosis Code and Present on Admission Indicator (Required).

The ICD-9-CM (<October 1, 2015)/ICD-10-CM codes describing the principal diagnosis.

Special Note:

- This must be valid ICD-9-CM (<October 1, 2015) or ICD-10-CM diagnosis code.

Item 67A-Q: Other Diagnosis Codes and Present on Admission Indicator (Required if applicable)

The ICD-9-CM diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop, or that affect the treatment received and/or the length of stay.

Special Note:

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

Item 68: Unassigned (Reserved for assignment by the NUBC)

Item 69: Admitting Diagnosis Code (Required if applicable)

This is the ICD-9-CM (<October 1, 2015)/ICD-10-CM diagnosis code provided at the time of admission, as stated by the physician.

Special Note:

- Required on all inpatient admission
- If present, this must be a valid ICD-9-CM (<October 1, 2015)/ICD-10-CM Code.

NOTE: Enter the ICD-9-CM (<October 1, 2015) or ICD-10-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress; an abnormal finding on examination; a possible diagnosis based on significant findings; a diagnosis established from a previous encounter or admission; an injury; a poisoning; or a reason or condition (not an illness or injury), such as follow-up or pregnancy in labor. Report only one admitting diagnosis.

Item 70A–C: Patients Reason for Visit (Required if Applicable)

The ICD-9-CM diagnosis codes describing the patient’s reason for visit at the time of outpatient registration.

Special Note:

- Required for all “unscheduled” outpatient visits or upon the patient’s admission to the hospital.

Item 71: PPS Code (Required if applicable)

The PPS code assigned to the claim to identify the DRG based on the grouper called for in agreement with the primary payer.

Special Note:

- Required when the provider is under contract with the payer to provide this information.

Item 72A–C: External Cause of Injury (ECI) Code and Present on admission indicator (required if applicable)

ICD diagnosis codes pertaining to external cause of injury, poisoning or adverse effect.

Special Note:

- Required when an external cause of injury, poisoning or adverse effect is the cause for seeking care or occurs during the treatment.

Item 73: Unassigned (Reserved for assignment by the NUBC)

Item 74: Principal Procedure Code and Date (Required if applicable)

This is the code that identifies the principal procedure performed during the period covered by the bill, and the date on which the principal procedure was performed.

Special Note:

- Required on claim for an inpatient stay if a procedure was performed.
- Required on Home IV therapies.
- Date format: MMDDYY.
- Must be a valid ICD-9-CM/ICD-10-CM procedure code.

Item 74A–E: Other Procedure Codes and Dates (Required if Applicable)

These are the codes identifying the procedures, other than the principal procedure, performed during the billing period covered by the bill, and the dates are those on which the procedures were performed.

Special Note:

- Required on claim for an inpatient stay if a procedure was performed.
- Required on Home IV therapies.
- Date format: MMDDYY.
- Must be a valid ICD-9-CM/ICD-10-CM procedure code. Do not list HCPCS/CPT procedure codes in Item 74A–E.

Item 75: Unassigned (Reserved for Assignment by the NUBC)

Item 76: Attending Provider Name and Identifiers (Required).

The attending provider is the individual who has the overall responsibility for the care and treatment reported on this claim.

Special Note:

- Name is required on all inpatient claims or encounters.

Item 77: Operating Physician Name and Identifiers (Required if Applicable).

The name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).

Special Note:

- Name is required on all inpatient claims or encounters where a surgical procedure was performed.

Item 78–79: Other Provider Names and Identifiers (Required if Applicable)

This is an indicator which identifies the coding method used for procedure coding in Items 80 and 81A through 81E.

Special Note:

- Name is required on all inpatient claims or encounters.

Item 80: Remarks Field (Required if Applicable).

Area to capture additional information necessary to adjudicate the claim.

Special Note:

- Usage is in the judgment of the provider if it is believed additional information is necessary

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	
UB04 or CMS 1450	In the comment field at the header level (Box 80)
Electronic	
837i	In the professional claim line (SV202-7)

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

80 REMARKS

Item 81: Code-Code Field (Required if Applicable)

To report additional codes related to an item overflow.

Reporting a NDC on an UB-04 Claim Form

National Drug Code (NDC) identifiers must be included for all medications on all outpatient claims, in addition to all professional claims, submitted to Medical Mutual. Affected claims should have a valid Health Care Procedure Coding System (HCPCS) code and NDC identifiers, which include the 11-digit drug code, quantity of medication dispensed and unit of measure.

Enter the following information in the order listed below for Form Locator 43:

- Enter the NDC qualifier of N4.
- Enter the NDC 11-digit numeric code. The NDC must be submitted in the 5-4-2 format (no hyphens).
- Enter the drug description.
- Enter the NDC unit of measure qualifier as follows:
 - F2 – International Unit (F24.0)
 - GR – Gram (e.g., GR0.045)

- ML – Milliliter (e.g., ML1.0)
- UN – Unit (e.g., UN1.000)
- Enter the NDC quantity (Administered/Billed Amount) in the format 9999.99 (Note: Any spaces unused for the quantity should be left blank.)

Below is an example of the 24-position Description Field on Form Locator 43:

Valid HCPCS codes and NDC identifiers must be entered on the claim form. If the NDC does not have a specific HCPCS code, assign the appropriate miscellaneous code per Centers for Medicare and Medicaid Correct Coding Guidelines.

Special Note:

- Reminder, you cannot bill more than one NDC per revenue line.

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.

Eligibility

The Crossover program is open to all state hospitals. If a hospital determines that a patient's claims are not crossing over, it should contact the Electronic Claims department at (877) 363-3666, option 2. Inform the Company of the patient's HIC number (Medicare number), last name, first name, middle initial and sex.

The Crossover process is driven by an eligibility file that is sent to the Medicare intermediary which lists the Covered Persons who have supplemental insurance. By updating our eligibility file with the Covered Person's information, the Company ensures that future claims for that Covered Persons will crossover properly.

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 on an EOMB 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 fields are:

- Payer Name: Item 50B
- Deductible – Value Code A1 and dollar amount: Item 39
- Coinsurance – Value Code A2 and dollar amount: Item 40
- Prior Payments: Item 54A
- Amount Due: Item 55A

Note: Make sure the billing vendor is aware that claims which did not crossover electronically are being sent to the Company. Check with them to ensure that the proper Source of Payment Code (according to HIPAA guidelines) and Payer ID information are inserted on the electronic claim.

The Company currently requires an ICD-9-CM principal procedure code for all claims.

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 claims 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 paperless Detail Claims Received Reports and its Crossover reports together in one package.

The Company's Electronic Claims department [(877) 363-3666, option 2] receives a complete set of the Detail Claims Received Reports every day. If a provider has any questions regarding its reports, it should call the previously cited number.

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 intermediaries

The following Medicare intermediary submits Crossover claims to the Company:

- Group Health Incorporated (GHI)

Medicare Supplementary Hard Copy Claims Filing instructions

The best way for a hospital to ensure a fast turnaround of a Company Medicare supplementary payment is to Claims received with incomplete, missing or incorrect information will be rejected and returned. Submitting a paper claim that is properly completed allows the system to process it without manual intervention, which expedites payment.

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.

UB-04 Requirements	
UB-04 Item	Requirements
50B Payer	To properly identify the patient's primary, secondary and, if applicable, tertiary payers
39 A2 Deductible	The deductible amount is required when Medicare applies a deductible on the claim. The deductible amount to be supplied in items 39-41 A1: Value Code and Dollar Amount can be found on the Medicare Provider Remittance Advice in the DED-CASH column.

UB-04 Requirements, continued	
UB-04 Item	Requirements
40 A2 Coinsurance	The coinsurance amount is required when Medicare applies a coinsurance on the claim. The coinsurance amount to be supplied in items 40-A2: Value Code and Dollar Amount can be found on the Medicare Provider Remittance Advice in the COINSURANCE column.
41 B3 Estimated Responsibility	This item must contain Company estimated payment liability after Medicare has made payment. The estimated responsibility should be the total of Medicare's deductible plus coinsurance amounts. The Estimated Responsibility (amount) should be listed in items 39-41 B3: Value Code and Dollar Amount.
55 Amount Due	This item must contain the Company estimated payment liability after Medicare has made payment. The Company estimated amount due must appear on the same payer line (A, B, or C) as the Company in Item 50: Payer of the UB-04. 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, regardless of employee age, his/her spouse age 65 or over.

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 either 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 particular 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. The 12-month filing limit does not apply to claims for Medicare Covered Persons whose certificates state that claims must be filed within the time limits set by the Centers for Medicare and Medicaid Services.
- 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.

Attachment 1: Revenue Codes (Item 42)

Data Element: Revenue Code

Definition: This code identifies a specific accommodation or ancillary service, or billing calculation.

Procedures: Medicare: Required. To assist in a bill review, Revenue codes should be listed in ascending numeric sequence. Revenue codes may be listed at the zero detail level, except for the following:

29X, 304, 33X, 367, 40X, 420, 430, 440, 520, 55X-59X, 80X-85X.

These exceptions require detail coding.

Medicaid: Required

Medical Mutual of Ohio: Required

Bureau of Workers' Compensation (BWC): Required

Commercial: Required

CHAMPUS: Required

Field Attributes

1 field
23 lines
4 characters per line
Numeric
Right justified

Major Categories

001 Total Charge
List in Line 23 of Item 42

10X All Inclusive Rate

This is a flat fee, incurred on either a daily basis or a total stay basis for services rendered. The fee may over room and board plus ancillary services, or room and board only.

Subcategory	Standard Abbreviation
0 – All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1 – All-Inclusive Room and Board	ALL INCL R&B

11X Room and Board — Private Medical or General

This is a routine service charge for single bedrooms.

Subcategory	Standard Abbreviation
0 – General Classification	ROOM-BOARD/PVT
1 – Medical/Surgical/GY	MED-SUR-GY/PVT
2 – Obstetric	OB/PVT
3 – Pediatric	PEDS/PVT
4 – Psychiatric	PSYCH/PVT
5 – Hospice	HOSPICE/PVT
6 – Detoxification	DETOX/PVT
7 – Oncology	ONCOLOGY/PVT
8 – Rehabilitation	REHAB/PVT
9 – Other	OTHER/PVT

12X Room and Board — Semi-private, Two Bed (Medical or general)

This is a routine service charge incurred for accommodations with two beds.

Subcategory	Standard Abbreviation
0 – General Classification	ROOM-BOARD/SEMI
1 – Medical/Surgical/GYN	MED-SUR-GY/2BED
2 – Obstetric	OB/2BED
3 – Pediatric	PEDS/2BED
4 – Psychiatric	PSYCH/2BED
5 – Hospice	HOSPICE/2BED
6 – Detoxification	DETOX/2BED

7 – Oncology	ONCOLOGY/2BED
8 – Rehabilitation	REHAB/2BED
9 – Other	OTHER/2BED

Subcategory	Standard Abbreviation
0 – General Classification	R&B
4 – Sterile Environment	R&B/STERILE
7 – Self Care	R&B/SELF
9 – Other	R&B/OTHER

13X Semi-private — Three and Four Beds (Medical or General)

This is a routine service charge incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 – General Classification	ROOM-BOARD/&4BED
1 – Medical/Surgical/GYN	MED-SUR-GY/3&4BED
2 – Obstetric	OB/3&4BED
3 – Pediatric	PEDS/3&4BED
4 – Psychiatric	PSYCH/3&4BED
5 – Hospice	HOSPICE/3&4BED
6 – Detoxification	DETOX/3&4BED
7 – Oncology	ONCOLOGY/3&4BED
8 – Rehabilitation	REHAB/3&4BED
9 – Other	OTHER/3&4BED

14X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0 – General Classification	ROOM-BOARD/PVT/DLX
1 – Medical/Surgical/GYN	MED-SUR-GY/DLX
2 – Obstetric	OB/DLX
3 – Pediatric	PEDS/DLX
4 – Psychiatric	PSYCH/DLX
5 – Hospice	HOSPICE/DLX
6 – Detoxification	DETOX/DLX
7 – Oncology	ONCOLOGY/DLX
8 – Rehabilitation	REHAB/DLX
9 – Other	OTHER/DLX

15X Room & Board Ward (Medical or General)

This is a routine service charge for accommodations with five or more beds.

Subcategory	Standard Abbreviation
0 – General Classification	ROOM-BOARD/WARD
1 – Medical/Surgical/GYN	MED-SUR-GY/WARD
2 – Obstetric	OB/WARD
3 – Pediatric	PEDS/WARD
4 – Psychiatric	PSYCH/WARD
5 – Hospice	HOSPICE/WARD
6 – Detoxification	DETOX/WARD
7 – Oncology	ONCOLOGY/WARD
8 – Rehabilitation	REHAB/WARD
9 – Other	OTHER/WARD

16X Other Room and Board

This is any routine service charge for accommodations that cannot be included in the more specific revenue centers.

17X Nursery

This is the charges for nursing care for newborn and premature infants in nurseries.

Subcategory	Standard Abbreviation
0 – General Classification	NURSERY
1 – Newborn – Level I	NURSERY/LEVEL I
2 – Newborn – Level II	NURSERY/LEVEL II
3 – Newborn – Level III	NURSERY/LEVEL III
4 – Newborn – Level IV	NURSERY/LEVEL IV
9 – Other	NURSERY/OTHER See UB-92 Instructional Manual for newborn level descriptions.

18X Leave of Absence

This is the charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

Subcategory	Standard Abbreviation
0 – General Classification	LEAVE OF ABSENCE or LOA
2 – Patient Convenience	LOA/PT CONV
3 – Therapeutic Leave	LOA/THERAPEUTIC
5 – Nursing Home (for hospitalization)	LOA/NURS HOME
9 – Other Leave of Absence	LOA/OTHER

19X Subacute Care

Accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Level I — Skilled Care:

Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II — Comprehensive Care:

Moderate nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III— Complex Care:

Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV — Intensive Care:

Extensive nursing and technical intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

Subcategory	Standard Abbreviation
0 – General Classification	SUBACUTE
1 – Subacute Care – Level I	SUBACUTE/LEVEL I
2 – Subacute Care – Level II	SUBACUTE/LEVEL II
3 – Subacute Care – Level III	SUBACUTE/LEVEL III
4 – Subacute Care – Level IV	SUBACUTE/LEVEL IV
9 – Other Subacute Care	SUBACUTE/OTHER

20X Intensive Care

This is the routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategory	Standard Abbreviation
0 – General Classification	INTENSIVE CARE or ICU
1 – Surgical	ICU/SURGICAL
2 – Medical	ICU/MEDICAL
3 – Pediatric	ICU/PEDS
4 – Psychiatric	ICU/PSYCH
6 – Intermediate ICU	ICU/Intermediate

21X Coronary Care

This is the routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Subcategory	Standard Abbreviation
0 – General Classification	CORONARY CARE or CCU
1 – Myocardial Infarction	CCU/MYO INFARC
2 – Pulmonary Care	CCU/PULMONARY
3 – Heart Transplant	CCU/TRANSPLANT
4 – Intermediate CCU	CCU/Intermediate
9 – Other Coronary Care	CCU/OTHER

22X Special Charges

This is the charge incurred during an inpatient stay or on a daily basis for certain services normally considered part of routine services.

Subcategory	Standard Abbreviation
0 – General Classification	SPECIAL CHARGES
1 – Admission Charge	ADMIT CHARGE
2 – Technical Support Charge	TECH SUPPORT CHG
3 – UR Service Charge	UR CHARGE
4 – Late Discharge, Medically Necessary	LATE DISCH/MED NEC
9 – Other Special Charges	SPEC CHG/OTHER

23X Incremental Nursing Charge Rate

This is the charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 – General Classification	NURSING INCREM
1 – Nursery	NUR INCR/NURSERY
2 – OB	NUR INCR/OB
3 – ICU	NUR INCR/ICU
4 – CCU	NUR INCR/CCU
5 – Hospice	NUR INCR/HOSPICE
9 – Other	OTHER NUR INCR

24X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Subcategory	Standard Abbreviation
0 – General Classification	ALL INCL ANCIL
1 – Basic	ALL INCL ANCIL BASIC
2 – Comprehensive	ALL INCL COMP
3 – Specialty	ALL INCL SPECIAL
9 – Other All Inclusive Ancillary	ALL INCL ANCIL OTHER

25X Pharmacy

This is the charge for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist.

Subcategory	Standard Abbreviation
0 – General Classification	PHARMACY
1 – Generic Drugs	DRUGS/GENERIC
2 – Non-Generic Drugs	DRUGS/NONGENERIC
3 – Take-Home Drugs	DRUGS/TAKEHOME
4 – Drugs Incident to Other Diagnostic Service	DRUGS/INCIDENT OTHER DX
5 – Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 – Experimental Drugs	DRUGS/EXPERIMT
7 – Non-prescription	DRUGS/NONSCRIPT
8 – IV Solutions	IV SOLUTIONS
9 – Other Pharmacy	DRUGS/OTHER

Value codes A4, A5 and A6 are used in conjunction with Revenue codes 250, 254 and 255 to indicate the amount included in covered charges for self-administrable drugs. Amounts for non-covered self-administrable drugs should be charged using Revenue Code 250 in the non-covered column.

26X IV Therapy

This is the equipment charge or the administration of intravenous solution by specially trained personnel. This code should be used only when a discrete service unit exists.

Subcategory	Standard Abbreviation
0 – General Classification	IV THERAPY
1 – Infusion Pump	IV THERAPY/INFSN PUMP
2 – IV Therapy/Pharmacy Svcs	IV THER/PHARM/SVC
3 – IV Therapy/Drug/Supply Delivery	IV THER/DRUG/SUPPLY DELV
4 – IV Therapy/Supplies	IV THER/SUPPLIES
9 – Other IV Therapy	IV THERAPY/OTHER

27X Medical/Surgical Supplies and Devices

This is the charge for supply items required for patient care.

Subcategory	Standard Abbreviation
0 – General Classification	MED-SUR SUPPLIES
1 – Non-Sterile Supply	NON-STER SUPPLY
2 – Sterile Supply	STERILE SUPPLY
3 – Take-Home Supplies	TAKEHOME SUPPLY
4 – Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5 – Pacemaker	PACEMAKER
6 – Intraocular Lens	INTRA OC LENS
7 – Oxygen–Take-Home	O2/TAKEHOME
8 – Other Implants	SUPPLY/IMPLANTS
9 – Other Supplies/Devices	SUPPLY/OTHER

28X Oncology

This is the charge for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 – General Classification	ONCOLOGY
9 – Other Oncology	ONCOLOGY/OTHER

29X Durable Medical Equipment (Other than Rental)

This is the charge for medical equipment that can withstand repeated use excluding rental equipment.

Subcategory	Standard Abbreviation
0 – General Classification	MED EQUIP/DURAB
1 – Rental	MED EQUIP/RENT
2 – Purchase of New	DME MED EQUIP/NEW
3 – Purchase of Used DME	MED EQUIP/USED
4 – Supplies/Drugs for DME Effectiveness (HHA only)	MED EQUIP SUPPLIES/DRUGS
9 – Other Equipment	MED EQUIP/OTHER

30X Laboratory

This is the charge for the performance of diagnostic and routine clinical laboratory tests.

Subcategory	Standard Abbreviation
0 – General Classification	LABORATORY or LAB
1 – Chemistry	LAB/CHEMISTRY
2 – Immunology	LAB/IMMUNOLOGY
3 – Renal Patient (Home)	LAB/RENAL HOME
4 – Non-Routine Dialysis	LAB/NR DIALYSIS
5 – Hematology	LAB/HEMOTOLOGY

31X Laboratory – Pathological

This is the charge for diagnostic and routine laboratory tests on tissues and culture.

Subcategory	Standard Abbreviation
0 – General Classification	PATHOLOGY LAB OR PATH LAB
1 – Cytology	PATHOL/CYTOLOGY
2 – Histology	PATHOL/HYSTOL
4 – Biopsy	PATHOL/BIOPSY
9 – Other	PATHOL/OTHER

32X Radiology — Diagnostic

This is the charge for diagnostic radiology services provided for the examination and care of patients.

Subcategory	Standard Abbreviation
0 – General Classification	DX X-RAY
1 – Angiocardiology	DX X-RAY/ANGIO
2 – Arthrography	DX X-RAY/ARTH
3 – Arteriography	DX X-RAY/ARTER
4 – Chest X-ray	DX X-RAY/CHEST
9 – Other Radiology Diagnostic	DX X-RAY/OTHER

33X Radiology — Therapeutic

This is the charge for therapeutic radiology services and chemotherapy. Includes therapy by injection or ingestion of radioactive substances.

Subcategory	Standard Abbreviation
0 – General Classification	RX X-RAY
1 – Chemotherapy – Injected	CHEMOTHER/INJ
2 – Chemotherapy – Oral	CHEMOTHER/ORAL
3 – Radiation Therapy	RADIATION RX
5 – Chemotherapy – IV	CHEMOTHER-IV
9 – Other Radiology Therapeutic	RX X-RAY/OTHER

34X Nuclear Medicine

This is the charge for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials required for diagnosis and treatment of patients.

Subcategory	Standard Abbreviation
0 – General Classification	NUCLEAR MEDICINE or NUC MED
1 – Diagnostic	NUC MED/DX
2 – Therapeutic	NUC MED/RX
3 – Diagnostic Radiopharmaceuticals	NUC MED/ DXRADIOPHARM

4 – Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
9 – Other	NUC MED/OTHER

35X CT Scan

This is the charge for computed tomographic scans of the head and other parts of the body.

Subcategory	Standard Abbreviation
0 – General Classification	CT SCAN
1 – Head Scan	CT SCAN/HEAD
2 – Body Scan	CT SCAN/BODY
9 – Other CT Scans	CT SCAN/OTHER

36X Operating Room Services

This is the charge for services provided in the performance of surgical and related procedures, during and immediately following surgery.

Subcategory	Standard Abbreviation
0 – General Classification	OR SERVICES
1 – Minor Surgery	OR/MINOR
2 – Organ Transplant – Other Than Kidney	OR/ORGAN TRANS
7 – Kidney Transplant	OR/KIDNEY TRANS
9 – Other Operating Room Serv.	OR/OTHER

37X Anesthesia

This is the charge for anesthesia services.

Subcategory	Standard Abbreviation
0 – General Classification	ANESTHESIA
1 – Anes. Incident to Radiology	ANESTHE/INCIDENT RAD
2 – Anes. Incident to Other Diagnostic Services	ANESTHE/OTHER DX
4 – Acupuncture	ANESTHE/ACUPUNC
9 – Other Anesthesia	ANESTHE/OTHER

38X Blood

This is the charge for blood that must be separately identified for payer purposes.

Subcategory	Standard Abbreviation
0 – General Classification	BLOOD
1 – Packed Red Cells	BLOOD/PKD RED
2 – Whole Blood	BLOOD/WHOLE
3 – Plasma	BLOOD/PLASMA
4 – Platelets	BLOOD/PLATELETS
5 – Leukocytes	BLOOD/LEUKOCYTES
6 – Other Components	BLOOD/ COMPONENTS
7 – Other Derivatives (Cryoprecipitates)	BLOOD/DERIVATIVES
9 – Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

This is the charge for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 – General Classification	BLOOD/STOR-PR
1 – Blood Administration	BLOOD/ADMIN
2 – Processing and Storage	BLOOD/STORAGE
9 – Other Blood Storage and Processing	BLOOD/OTHER STORE

40X Other Imaging Services

This is the charge for imaging services, other than diagnostic or therapeutic radiology.

Subcategory	Standard Abbreviation
0 – General Classification	IMAGE SERVICE
1 – Diagnostic Mammography	DIAG MAMMOGRAPHY
2 – Ultrasound	ULTRASOUND
3 – Screening Mammography	SCRN MAMMOGRAPHY
4 – Positron Emission Tomography	PET SCAN
9 – Other Imaging Services	OTHER IMAGE SVS

41X Respiratory Services

Charges for the administration of oxygen and certain potent drugs through inhalation or positive pressure, other forms of rehabilitative therapy through the measurement of inhaled or exhaled gases, and the analysis of blood or the evaluation of the patient's ability to exchange oxygen and other gases.

Subcategory	Standard Abbreviation
0 – General Classification	RESPIRATORY SVC
2 – Inhalation Services	INHALATION SVC
3 – Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 – Other Respiratory Services	OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage, and the utilization of effective properties of light, heat, cold, water, electricity, and assistive devices.

Subcategory	Standard Abbreviation
0 – General Classification	PHYSICAL THERP
1 – Visit Charge	PHYS THERP/VISIT
2 – Hourly Charge	PHYS THERP/HOUR
3 – Group Rate	PHYS THERP/GROUP
4 – Evaluation or Re-evaluation	PHYS THERP/EVAL
9 – Other Physical Therapy	OTHER PHYS THER

43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity.

Subcategory	Standard Abbreviation
0 – General Classification	OCCUPATION THERP
1 – Visit Charge	OCCUP THERP/VISIT
2 – Hourly Charge	OCCUP THERP/HOUR
3 – Group Rate	OCCUP THERP/GROUP
4 – Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 – Other Occupational Therapy	OTHER OCCUP THER

At the request of the American Occupational Therapy Association, the NUBC changed the description for Major Revenue Category 43X to: Services provided by a qualified occupational therapy practitioner for teaching manual skills and independence in personal care to stimulate mental and emotional activity.

44X Speech-Language Pathology

This is the charge for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 – General Classification	SPEECH PATHOL
1 – Visit Charge	SPEECH PATH/VISIT
2 – Hourly Charge	SPEECH PATH/HOUR
3 – Group Rate	SPEECH PATH/GROUP
4 – Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 – Other Speech- Language Pathology	OTHER SPEECH PAT

45X ER

This is the charge for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Subcategory	Standard Abbreviation
0 – General Classification	EMERG ROOM
1 – EMTALA Emergency Medical General Classification	ER/EMTALA
2 – ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 – Urgent Care	URGENT CARE
9 – Other Emergency Room	OTHER EMERG ROOM

Note: The Emergency Medical Treatment and Active Labor Act (EMTALA) requires a hospital with an emergency room to provide upon request within the capabilities of the hospital appropriate medical screening examination and stabilizing treatment to an individual with an emergency medical condition, or to

any woman in active labor, regardless of the individual's eligibility for Medicare.

46X Pulmonary Function

This is the charge for tests that measure inhaled and exhaled gases and the analysis of blood, and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Subcategory	Standard Abbreviation
0 – General Classification	PULMONARY FUNC
9 – Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

This is the charge for the detection and management of communication handicaps, centering in whole or in part on the hearing functions.

Subcategory	Standard Abbreviation
0 – General Classification	AUDIOLOGY
1 – Diagnostic	AUDIOLOGY/DX
2 – Treatment	AUDIOLOGY/RX
9 – Other Audiology	OTHER AUDIOLOGY

48X Cardiology

This is the charge for cardiac procedures rendered in a separate unit within the provider. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Subcategory	Standard Abbreviation
0 – General Classification	CARDIOLOGY
1 – Cardiac Cath Lab	CARDIAC CATH LAB
2 – Stress Test	STRESS TEST
3 – Echocardiology	ECHOCARDIOLOGY
9 – Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

This is the charge for ambulatory surgery not covered by other categories.

Subcategory	Standard Abbreviation
0 – General Classification	AMBUL SURG
9 – Other Ambulatory Surgical Care	OTHER AMBL SURG

50X Outpatient services

This is the charge for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service.

Subcategory	Standard Abbreviation
0 – General Classification	OUTPATIENT SVS
9 – Other Outpatient Services	OTHER/OUTPATIENT

51X Clinic

This is the clinic (non-emergency, scheduled outpatient visit) charge for providing diagnostic, preventive, curative, rehabilitative, and educational services to ambulatory patients.

Subcategory	Standard Abbreviation
0 – General Classification	CLINIC
1 – Chronic Pain Center	CHRONIC PAIN CL
2 – Dental Clinic	DENTAL CLINIC
3 – Psychiatric Clinic	PSYCH CLINIC
4 – Obstetric/Gynecologic Clinic	OB-GYN CLINIC
5 – Pediatric Clinic	PEDS CLINIC
6 – Urgent Care Clinic	URGENT CARE CLINIC
7 – Family Practice Clinic	FAMILY CLINIC
9 – Other Clinic	OTHER/CLINIC

Note: Revenue Code 51X is not to be used to bill the professional component of any clinic services. The professional component of any clinic services must be billed on a CMS-1500.

52X Freestanding Clinic

This is the charge for clinics that are not hospital based.

Subcategory	Standard Abbreviation
0 – General Classification	FREESTAND CLINIC
1 – Clinic Visit by Member to RHC/FQHC	FS-RURAL/CLINIC
2 – Home Visit by RHC/FQHC Practitioner	FS-RURAL/HOME
3 – Family Practice Clinic	FS-FAMILY PRACTICE
4 – Visit by RHC/FQHC Practitioner to a member in a SNF or Skill Swing Bed in a Covered Part A Stay	FR/STD FAMILY CLINIC
5 – Visit by RHC/FQHC Practitioner to a Member in a SNF (not in a Covered Part A Stay) or NF or ICF MR or Other Residential Facility	RHC/FQHC/SNF/ NONCOVERED
6 – Urgent Care Clinic	FR/STD URGENT CLINIC
7 – Visiting Nurse Service(s) to a Member's Home When in a Home Health Shortage Area	RHC/FQHC/HOME/ VIS NURSE
8 – Visit by RHC/FQHC Practitioner to Other Non-RHC/FQHC Site (e.g., Scene of Accident)	RHC/FQHC/OTHER SITE
9 – Other Freestanding Clinic	OTHER FR/STD CLINIC

53X Osteopathic Services

This is the charge for a structural evaluation of the cranium entire cervical, dorsal, and lumbar spine by a doctor of osteopathy.

Subcategory	Standard Abbreviation
0 – General Classification	OSTEOPATH SVS
1 – Osteopathic Therapy	OSTEOPATH RX
9 – Other Osteopathic Services	OTHER OSTEOPATH

54X Ambulance

This is the charge for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Note: A heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 – General Classification	AMBULANCE
1 – Supplies	AMBUL/SUPPL
2 – Medical Transport	AMBUL/MED TRANS
3 – Heart mobile	AMBUL/HEARTMOBL
4 – Oxygen	AMBUL/OXY
5 – Air Ambulance	AIR AMBULANCE
6 – Neonatal Ambulance Servicer	AMBUL/NEONAT
7 – Pharmacy	AMBUL/PHARMACY
8 – Telephone Transmission	EKG AMBUL/ TELEPHONIC EKG
9 – Other Ambulance	OTHER AMBULANCE

55X Skilled Nursing

This is the charge for nursing services that must be provided under the direct supervision of a licensed nurse, to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services, CORFS, or a service charge for home health billings.

Subcategory	Standard Abbreviation
0 – General Classification	SKILLED NURSING
1 – Visit Charge	SKILLED NURS/VISIT
2 – Hourly Charge	SKILLED NURS/HOUR
9 – Other Skilled Nursing	SKILLED NURS/OTHER

56X Medical Social Services

This is the charge for services, such as counseling patients, interviewing patients, and interpreting problems of social situations rendered to patients on any basis.

Subcategory	Standard Abbreviation
0 – General Classification	MED SOCIAL SVS
1 – Visit Charge	MED SOC SERVS/VISIT
2 – Hourly Charge	MED SOC SERV/HOUR

9 – Other Med. Social Services	MED SOC SERV/OTHER
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2 – Oxygen – State/Equip/Suppl/Under 1 LPM	02/STAT EQUIP/ UNDER 1 LPM
3 – Oxygen – State/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
4 – Oxygen – Portable Add-on	02/PORTABLE ADD-ON
9 – Other Oxygen	02 – Other

57X Home Health Aide (Home Health Agency Only)

This is the charge by a home health agency for personnel who are primarily responsible for the personal care of the patient.

Subcategory	Standard Abbreviation
0 – General Classification	AIDE/HOME HEALTH
1 – Visit Charge	AIDE/HOME HLTH/ VISIT
2 – Hourly Charge	AIDE/HOME HLTH/ HOUR
9 – Other Home Health Aide	AIDE/HOME HLTH/ OTHER

58X Other Visits (Home Health Agency Only)

This is the charge by a home health agency for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Subcategory	Standard Abbreviation
0 – General Classification	VISIT/HOME HEALTH
1 – Visit Charge	VISIT/HOME HLTH/ VISIT
2 – Hourly Charge	VISIT/HOME HLTH/ HOUR
9 – Other Home Health Visits	VISIT/HOME HLTH/ OTHER

59X Units of Service (Home Health Agency Only)

This is used by a home health agency which bills on the basis of units of service.

Subcategory	Standard Abbreviation
0 – General Classification	UNIT/HOME HEALTH
9 – Home Health Other Units	UNIT/HOME HLTH/ OTHER

60X Oxygen (Home Health Agency Only)

This is the charge by a home health agency for oxygen equipment, supplies, or contents, excluding purchased equipment.

If a beneficiary has purchased a stationary oxygen system, an oxygen concentrator or portable equipment, Revenue Code 292 or 293 applies. Durable Medical Equipment, other than oxygen systems, is billed under current Revenue Code 291, 292 or 293.

Subcategory	Standard Abbreviation
0 – General Classification	02/HOME HEALTH
1 – Oxygen – State/Equip/Suppl/or Cont	02/STAT EQUIP/ SUPPL/CONT

61X Magnetic Resonance Imaging Technology (MRI)

This is the charge for Magnetic Resonance Imaging of the brain and other parts of the body.

Subcategory	Standard Abbreviation
0 – General Classification	MRT
1 – MRI Brain (Including Brain Stem)	MRI BRAIN
2 – MRI Spinal Cord (Including Spine)	MRI SPINE
4 – MRI – Other	MRI OTHER
5 – MRA – Head and Neck	MRA HEAD AND NECK
6 – MRA – Lower Extremities	MRA LOWER EXTREMITIES
8 – MRA – Other	MRA – OTHER
9 – MRT – Other	MRT – OTHER

62X Medical/surgical supplies (extension of 27X)

This is the charge for supply items required for patient care. This category is an extension of 27X.

Subcategory	Standard Abbreviation
1 – Supplies Incident to Radiology	MED-SUR SUPP/ INCIDENT RAD
2 – Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/ INCIDENT ODX
3 – Surgical Dressing	SURG DRESSING
4 – FDA Investigational Devices	FDA INVEST DEVICE

63X Drugs Requiring Specific Identification (extension of 25X)

This is the charge for drugs and biologicals requiring specific identification as required by the payer. If HCPCS or a National Drug Code (NDC) is used to describe the drug, enter the code in column 44.

Subcategory	Standard Abbreviation
0 – Reserved	
1 – Single Source Drug	DRUG/SNGL SRC
2 – Multiple Source Drug	DRUG/MULT
3 – Restrictive Prescription	DRUG/RSTR
4 – Erythropoietin (EPO) less than 10,000 units	DRUG/EPO < 10,000 UNITS
5 – Erythropoietin (EPO) 10,000 or more units	DRUG/EPO > 10,000 UNITS

6 – Drugs Requiring Detailed Coding (a)	DRUGS/DETAIL CODE
7 – Self-Administrable Drugs Coding (b) ⁶	DRUGS/SELF ADMIN

64X Home IV Therapy Services

This is the charge for intravenous drug therapy services which are performed in the patient's residence. For home IV providers, the HCPCS Code must be entered for all equipment, and all types of covered therapy.

Subcategory	Standard Abbreviation
0 – General Classification	IV THERAPY SVC
1 – Non-routine Nursing, Central Line	NON RT NURSING/CENTRAL
2 – IV Site Care, Central Line	IV SITE CARE/CENTRAL
3 – IV Start/Change, Peripheral Line	IV STRT/CHNG/PERIPHRL
4 – Non-routine Nursing, Peripheral Line	NONRT NURSING/PERIPHRL
5 – Training Patient/Caregiver, Central Line	TRNG PT/CAREGVR/CENTRL
6 – Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL
7 – Training, Patient/Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL
8 – Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
9 – Other IV Therapy Services	OTHER IV THERAPY SVC

65X Hospice Services

This is the charge for hospice care services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition.

Subcategory	Standard Abbreviation
0 – General Classification	HOSPICE
1 – Routine Home Care	HOSPICE/RTN HOME
2 – Continuous Home Care	HOSPICE/CTNS HOME
5 – Inpatient Respite Care	HOSPICE/IP RESPITE
6 – General Inpatient Care (Non-Respite)	HOSPICE/IP NON-HOSPICE/IP NON-RESPITE
7 – Physician Services	HOSPICE/PHYSICIAN
8 – Hospice Room & Board – Nursing Facility	HOSPICE/R&B/NURS FAC

9 – Other Hospice	HOSPICE/OTHER
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Note: To receive the Continuous Home Care rate from Medicare under code 652, a minimum of eight (8) hours of care, not necessarily consecutive, in a twenty-four (24) hour period is required. Less than eight (8) hours is reported under code 651. A portion of an hour counts as an hour for this determination.

Billing Medicare under code 657 must be accompanied by a physician procedure code, which must be entered in Item 44. This code issued by the hospice to bill for charges for physician services furnished to hospice patients by the physician employed by the hospice or receiving compensation from the hospice for services rendered.

66X Respite Care (Home Health Agency Only)

This is the charge for hours of care under the Respite Care Benefit for services of a homemaker or home health aide, personal care services, and nursing care provided by a licensed professional nurse.

Subcategory	Standard Abbreviation
0 – General Classification	RESPITE CARE
1 – Hourly Charge/Nursing	RESPITE/NURSE
2 – Hourly Charge/Aide /Homemaker/Companion	RESPITE/AID/HMEMKR/COMP
3 – Daily Respite Charge	RESPITE DAILY
9 – Other Respite Care	RESPITE OTHER

67X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	Standard Abbreviation
0 – General Classification	OP SPEC RES
1 – Hospital Based	OP SPEC RES/HOSP BASED
2 – Contracted	OP SPEC RES/CONTRACTED
9 – Other Special Residence Charges	OP SPEC RES/OTHER

68X Trauma Response

Charges for a trauma team activation.

Subcategory	Standard Abbreviation
0 – Not Used	
1 – Level I	TRAUMA LEVEL I
2 – Level II	TRAUMA LEVEL II
3 – Level III	TRAUMA LEVEL III
4 – Level IV	TRAUMA LEVEL IV
9 – Other Trauma Response	TRAUMA OTHER

⁶ Revenue Code 636 relates to the HCFA common procedure codes; so, HCPCS is the recommended code to be used. The specified units of service in Item 46, related to the HCPCS code in Item 44 should be in the hundreds (100s), rounded to the nearest hundred. No decimal is required

69X Pre-hospice/Palliative Care Services

Subcategory	Standard Abbreviation
0 – General Classification	PREHOSPICE
1 – Visit Charge	PREHOSPICE/VISIT
2 – Hourly Charge	PREHOSPICE/HOUR
3 – Evaluation	PREHOSPICE/EVAL
4 – Consultation and Education	PRE HOSPICE/ CONS&ED
5 – Inpatient Care	PREHOSPICE/IP
6 – Physician Services	PREHOSPICE/ PHYSICIAN
9 – Other Prep Hospice/ Palliative Care Services	PREHOSPICE/OTHER

70X Cast Room

This is the charge for services related to the application, maintenance, and removal of casts.

Subcategory	Standard Abbreviation
0 – General Classification	CAST ROOM

71X Recovery Room

Charges related to the use of a recovery room

Subcategory	Standard Abbreviation
0 – General Classification	RECOVERY ROOM

72X Labor Room/Deliver

This is the charge for labor and delivery room services provided by specially trained nursing personnel, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Services provided by specially trained nursing personnel, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Subcategory	Standard Abbreviation
0 – General Classification	DELIV E ROOM/LABOR
1 – Labor	LABOR
2 – Delivery	DELIVERY ROOM
3 – Circumcision	CIRCUMCISION
4 – Birthing Center	BIRTHING CENTER
9 – Other Labor Room/ Delivery	OTHER/DELIV-LABOR

73X EKG/ECG (Electrocardiogram)

This is the charge for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 – General Classification	EKG/ECG
1 – Holter Monitor	HOLTER MONT
2 – Telemetry	TELEMETRY
9 – Other EKG/ECG	OTHER EKG ECG

74X EEG (Electroencephalogram)

This is the charge for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0 – General Classification	EEG

75X Gastrointestinal Services

This is the procedure room charge for endoscopic procedures NOT performed in the operating room.

Subcategory	Standard Abbreviation
0 – General Classification	GASTR-INTS SVS

76X Treatment or Observation Room

This is the charge for the use of the treatment room or the charge for outpatient observation services.

Subcategory	Standard Abbreviation
0 – General Classification	TREATMENT/ OBSERVATION RM
1 – Treatment Room	TREATMENT RM
2 – Observation Room	OBSERVATION RM
9 – Other Treatment/ Observation Room	OTHER TREAT/ OBSERV RM

77X Preventive Care services

Subcategory	Standard Abbreviation
0 – General Classification	PREVENT CARE SVS
1 – Vaccine Administration	VACCINE ADMIN

78X Telemedicine

Subcategory	Standard Abbreviation
0 – General Classification	TELEMEDICINE

79X Lithotripsy

This is the charge for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abbreviation
0 – General Classification	LITHOTRIPSY

80X Inpatient Renal Dialysis

This is a waste removal process performed in an inpatient setting that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or

indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategory	Standard Abbreviation
0 – General Classification	RENAL DIALYSIS
1 – Inpatient Hemodialysis	DIALY/INPT
2 – Inpatient Peritoneal Non-CAPD	DIALY/INPT/PER
3 – Inpatient Continuous Ambulatory Peritoneal Dialysis CAPD	DIALY/INPT/CAPD
4 – Inpatient Continuous Cycling Peritoneal Dialysis CCPD	DIALY/INPT/CCPD
9 – Other Inpatient Dialysis	DIALY/INPT/OTHER

81X Acquisition of Body Components

This is the acquisition and storage costs of various organs used in transplantation.

Subcategory	Standard Abbreviation
0 – General Classification	ORGAN/ACQUISIT
1 – Living Donor	LIVING DONOR

82X Hemodialysis — Outpatient or Home

This is a waste removal process, performed in an outpatient or home setting, which is necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategory	Standard Abbreviation
0 – General Classification	HEMO/OP OR HOME
1 – Hemodialysis/ Composite or other Rate	HEMO/COMPOSITE
2 – Home Supplies	HEMO/HOME/SUPPL
3 – Home Equipment	HEMO/HOME/EQUIP
4 – Maintenance/100%	HEMO/HOME/100%
5 – Support Services	HEMO/HOME/SUPSERV
9 – Other Outpatient Hemodialysis	HEMO/HOME/OTHER

83X Peritoneal Dialysis — Outpatient or Home

This is a waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
1 – Peritoneal/Composite or other Rate	PERTNL/COMPOSITE
2 – Home Supplies	PERTNL/HOME/SUPPL
3 – Home Equipment	PERTNL/HOME/EQUIP
4 – Maintenance/100%	PERTNL/HOME/100%
5 – Support Services	PERTNL/HOME/SUPSERV
9 – Other Outpatient Peritoneal Dialysis	PERTNL/HOME/OTHER

84X Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home

This is a continuous dialysis process performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 – General Classification	CAPD/OP OR HOME
1 – CAPD/Composite or other Rate	CAPD/COMPOSITE
2 – Home Supplies	CAPD/HOME/SUPPL
3 – Home Equipment	CAPD/HOME/EQUIP
4 – Maintenance/100%	CAPD/HOME/100%
5 – Support Services	CAPD/HOME/SUPSERV
9 – Other Outpatient CAPD	CAPD/HOME/OTHER

85X Continuous Cycling Peritoneal dialysis (CCPD) — Outpatient or Home

This is a continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.

Subcategory	Standard Abbreviation
0 – General Classification	CCPD/OP OR HOME
1 – CCPD/Composite or Other Rate	CCPD/COMPOSITE
2 – Home Supplies	CCPD/HOME/SUPPL
3 – Home Equipment	CCPD/HOME/EQUIP
4 – Maintenance/100%	CCPD/HOME/100%
5 – Support Services	CCPD/HOME/SUPSERV
9 – Other Outpatient CCPD	CCPD/HOME/OTHER

86X Magnetoencephalography

Subcategory	Standard Abbreviation
0 – General Classification	MAGNETOENCEPH
1 – MEG	MEG

87X Reserved

88X Miscellaneous Dialysis

This is the charge for dialysis services not identified elsewhere.

NOTE: Ultrafiltration is the process of removing excess fluid from the blood by using a dialysis machine, but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviation
0 – General Classification	DIALY/MISC
1 – Ultrafiltration	DIALY/ULTRAFILT
2 – Home Dialysis Aide Visit	HOME DIALYSIS AIDE VISIT
9 – Misc. Dialysis Other	DIALY/MISC/OTHER

89X Reserved

90X Psychiatric/Psychological Treatments

This is the charge for psychiatric or psychological treatments not otherwise categorized.

Subcategory	Standard Abbreviation
0 – General Classification	PSYCH TREATMENT
1 – Electroshock Treatment	ELECTRO SHOCK
2 – Milieu Therapy	MILIEU THERAPY
3 – Play Therapy	PLAY THERAPY
4 – Activity Therapy	ACTIVITY THERAPY
5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
6 – Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY

91X Psychiatric/Psychological Services

This is the charge for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Subcategory	Standard Abbreviation
0 – General Classification	PSYCH SERVICES
1 – Rehabilitation	PSYCH/REHAB
2 – Partial Hospitalization Less Intensive	PSYCH/PARTIAL HOSP
3 – Partial Hospitalization Intensive	PSCH/PARTIAL INTENSIVE
4 – Individual Therapy	PSYCH/INDIV RX
5 – Group Therapy	PSYCH/GROUP RX
6 – Family Therapy	PSYCH/FAMILY RX
7 – Biofeedback	PSYCH/BIOFEED
8 – Testing	PSYCH/TESTING
9 – Other	PSYCH/OTHER

92X Other Diagnostic Services

This is the charge for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviation
0 – General Classification	OTHER DX SVS
1 – Peripheral Vascular Lab	PERI VASCUL LAB
2 – Electromyogram	EMG
3 – Pap Smear	PAP SMEAR
4 – Allergy Test	ALLERGY TEST
5 – Pregnancy Test	PREGNANCY TEST
9 – Other Diagnostic Service	ADDITIONAL DX SVS

93X Medical Rehabilitation Day Program

Medical Rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy and speech therapy.

The subcategories of 93X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported for in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

Subcategory	Standard Abbreviation
1 – Half Day	HALF DAY
2 – Full Day	FULL DAY

94X Other Therapeutic Services

This is the charge for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviation
0 – General Classification	OTHER RX SVS
1 – Recreational Therapy	RECREATION RX
2 – Education/Training	EDUC/TRAINING
3 – Cardiac Rehabilitation	CARDIAC REHAB
4 – Drug Rehabilitation	DRUG REHAB
5 – Alcohol Rehabilitation	ALCOHOL REHAB
6 – Complex Medical Equipment-Routine	CMLPX MED EQUIP-ROUT
7 – Complex Medical Equipment Ancillary	CMLPX MED EQUIP-ANC
8 – Pulmonary Rehabilitation	PULMONARY REHAB
9 – Other Therapeutic Services	ADDITIONAL RX SVS

95X Other Therapeutic Services (Extension of 94X)

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviation
0 – Reserved	
1 – Athletic Training	ATHLETIC TRAINING
2 – Kinesiotherapy	KINESIOTHERAPY
3 – Chemical Dependency (Drug and Alcohol)	CHEMDEP

96X Professional Fees

Charge for medical professionals that the hospitals or third-party payers require to be separately identified.

Subcategory	Standard Abbreviation
0 – General Classification	PRO FEE
1 – Psychiatry	PRO FEE/PSYCH
2 – Ophthalmology	PRO FEE/EYE
3 – Anesthesiologist (MD)	PRO FEE/ANES MD
4 – Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 – Other Professional Fees	OTHER PRO FEE

97X Professional Fees (Extension of 96X)

Subcategory	Standard Abbreviation
1 – Laboratory	PRO FEE/LAB
2 – Radiology – Diagnostic	PRO FEE/RAD/DX
3 – Radiology – Therapeutic	PRO FEE/RAD/RX
4 – Radiology – Nuclear Medicine	PRO FEE/NUC/MED
5 – Operating Room	PRO FEE/OR
6 – Respiratory Therapy	PRO FEE/RESPIR
8 – Occupational Therapy	PRO FEE/OCUPA
9 – Speech Pathology	PRO FEE/SPEECH

98X Professional Fees (Extension of 96X & 97X)

Subcategory	Standard Abbreviation
1 – Emergency Room	PRO FEE/ER
2 – Outpatient Services	PRO FEE/OUTPT
3 – Clinic	PRO FEE/CLINIC
4 – Medical Social Services	PRO FEE/SOC SVC
5 – EKG	PRO FEE/EKG
6 – EEG	PRO FEE/EEG
7 – Hospital Visit	PRO FEE/HOS VIS
8 – Consultation	PRO FEE/CONSULT
9 – Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third-party payers to be strictly convenience items and, as such, are not covered.

Subcategory	Standard Abbreviation
0 – General Classification	PT CONVENIENCE
1 – Cafeteria/Guest Tray	CAFETERIA
2 – Private Linen Service	LINEN
3 – Telephone/Telegraph	TELEPHONE
4 – TV/Radio	TV/RADIO
5 – Non-patient Room Rentals	NONPT ROOM RENT
6 – Late Discharge Charge – Admission Kits	LATE DISCHARGE ADMIT KITS
8 – Beauty Shop/Barber	BARBER/BEAUTY
9 – Other Patient Convenience Items	PT CONVENIENCE/OTH

Attachment 2: Acceptable Inpatient V Codes

V codes must be supplemented with secondary diagnosis which reflects condition for which therapy was needed. Note: Acceptable V codes do not guarantee payment. Payment is subject to contract benefits and limitations.

- V07.0
- V24.0
- V25.2
- V26.0
- V30.1
- V31.1
- V32.1
- V33.1
- V34.1
- V35.1
- V36.1
- V37.1
- V30.00-V30.01
- V31.00-V31.01
- V32.00-V32.01
- V33.00-V33.01
- V34.00-V34.01
- V35.00-V35.01
- V36.00-V36.01
- V37.00-V37.01
- V50.0-V50.2
- V51
- V52.0-V52.8
- V53.01-V53.02-V53.09

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: 01-5B-3984
2060 East Ninth Street
Cleveland, OH 44115-1355

Behavioral Health	1-800- 258-3186
Care Authorizations	1-800-294-8402
Prior Authorizations and Acute and Post-acute Authorizations	1-800-338-4114
Case Management	1-800-258-3175, option 3
Clinical Drug Management	1-866-620-4027
Clinical Quality Improvement	1-800-586-4523
Disease Management & Maternity Programs	1-800-861-4826

Clinical Quality and Health Services Program Components

The Clinical Quality and Health Services program includes Utilization Review, Case Management, Disease 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)

Disease and Maternity Management includes educational programs for chronic conditions 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 or not 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 Provider.MedMutual.com, Tools & Resources and Care Management. This listing provides a reference on how to submit a request, as well as relevant contact information.

The Company requires all contracting facilities and professional providers to obtain prior authorization for designated services. Failure to comply with the requirements may 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 prior authorization is not received by the Company before a claim is submitted, a retrospective review may be performed.

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.

The following chart indicates the time frame to process urgent and non-urgent prior authorization requests.

Service Is	Requesting Time	Company Response Time
Non-Urgent	Prior to Service	Within 10* to 15 calendar days from receipt of request
Urgent	Prior to Service	Within 48* to 72 hours from receipt of request
Urgent	Concurrent	Within 24 hours from receipt of request

*For plans governed by CMS.

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 NaviNet

NaviNet is a web solution from NantHealth that must be used by providers to submit certain prior authorization requests and through which plan decisions are communicated through a secure exchange between Medical Mutual and providers. It is available 24-hours per day 7 days per week. Registered users of NaviNet 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 through the bidirectional interface with the Focus Manager application.

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.

Care Continuum

Care Continuum is a medical drug prior authorization tool. Providers may submit prior authorization for medical drugs via phone (866) 620-4027, fax (866) 620-4028 or electronically at <https://www.express-path.com/>. Care Continuum answers phones for Medical Mutual 8:00 a.m. to 7:00 p.m., EST/EDT) Monday through Friday. Calls received outside of those times are transferred to Medical Mutual's Customer Care.

eviCore Landmark

eviCore Landmark provides prior authorization for therapy services including Chiropractic/Osteopathic Manipulative Therapy, Occupational Therapy, Physical Therapy and Speech Therapy. 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://uni.lmhealthcare.com/LHApps/>. Prior Authorization Requests may be submitted via fax for Physical, Occupational, and Speech Therapy at 1-888-565-4225. Prior Authorization requests for Chiropractic Service or Osteopathic Manipulation may be faxed to 1-800-599-8350.

ReviewLink

ReviewLink 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 hospital, acute physical

rehabilitation, skilled nursing and long-term acute care stays, as well as outpatient imaging. ReviewLink contains a Tools feature that identifies if a procedure is designated as inpatient or outpatient, and it identifies any separate prior authorization requirements.

For additional information about becoming a ReviewLink user, please contact your Provider Contracting representative.

Fax Forms

For services that require prior authorization that are not able to be submitted by way of NaviNet or ReviewLink, the Company publishes fax forms to facilitate the review process.

- **Imaging Procedure Request Forms**
Providers can submit imaging requests by fax by using the appropriate Imaging Request Forms. The forms are available from Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Document Standards & Related Forms, Imaging Request Forms.
- **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 Provider.MedMutual.com, Tools & Resources, Forms. Providers may also use ExpressPath to submit medical drug prior authorization requests.
- **Therapy Authorization Forms**
Therapy Authorization Forms for chiropractic, occupational, physical or speech therapy can be found on Provider.MedMutual.com, Tools & Resources, Forms, Therapy Authorization Forms. 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: 01-5B-3984
Clinical Quality and Health Services Department
Medical Mutual
2060 East Ninth Street
Cleveland, OH 44115-1355

MCG Health Medical Necessity Guidelines

MCG Health is Medical Mutual's vendor for medical necessity guidelines for inpatient, observation, surgical, ambulatory care, home care and behavioral health care. 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:

Provider.MedMutual.com, Tools & Resources, Care Management, Medical Necessity Criteria, 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 Provider.MedMutual.com, Tools & Resources and Care Management.

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 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: (866) 620-4027

Inpatient Review Guidelines

Admission Review

It is expected that all inpatient admissions be submitted for medical necessity review with the exception of routine obstetrical admissions. These routine obstetrical admissions are identified as follows:

- 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.

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 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 professional provider claims for accuracy, completeness, medical necessity and appropriate utilization of services and procedures. The sources used for clinical edits include:

- Centers for Medicare and Medicaid Services (CMS)
- Covered person's Summary Plan/Certificate of Coverage
- Corporate Medical Policy/Medical Necessity Criteria
- 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, etc.
- Correct coding for components of comprehensive procedures and mutually exclusive services
- Global surgical services
- Multiple procedure pricing
- Not medically necessary
- Experimental/Investigational services

Member Programs (Revised)

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

Disease Management Program

To assist individuals diagnosed with chronic diseases, Medical Mutual offers the Disease Management Program. This program helps members with chronic conditions to better manage their care. Specially-trained 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 Disease Management Program include:

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

*Excludes Medicare Advantage

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 Disease Management and Maternity Programs

If your patient is not currently enrolled in the Disease Management or Maternity Programs and would like to enroll, please advise that they call us at (800) 861-4826 or visit Provider.MedMutual.com and select the "Health & Wellness" tab.

Program brochures are available and may be ordered through Provider.MedMutual.com by selecting "Tools & Resources," then "Forms" and completing the Clinical Supply Requisition Form. 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 Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Mission section 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: 01-5B-7501
Clinical Quality Improvement Department
Medical Mutual
2060 East Ninth Street Cleveland, OH 44115-1355
(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.

Visit Provider.MedMutual.com, Tools & Resources, Care Management, Rx Management, Prescription Formulary to access the Basic or Basic Plus Formulary to access our 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 from the Express Scripts home delivery service. 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:

- Patients may mail the prescription(s) directly to the Express Scripts mail order.
- 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.
- Electronic prescriptions are accepted by Express Scripts mail order pharmacy.

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 Duration

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 Provider.MedMutual.com, Tools & Resources, Care Management, Rx Management, Coverage Management for the most current information. Drugs are periodically added to these programs. Criteria is regularly updated and drugs are added periodically to these programs.

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

1. Call Express Scripts at (800) 753-2851 Monday through Friday between 8 a.m. and 9 p.m., ET or complete and fax a Coverage Management fax form to initiate the review process. (If the prescription was mailed to the mail-order service, the pharmacy will contact the provider to initiate the review process.)
2. Express Scripts will send the provider and patient a notification letter confirming whether coverage has been approved (usually within two business days of receiving 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 letter.

4. Express Scripts offers electronic prior authorization, as well as an online provider portal called ExpressPath. Using ExpressPath, providers are able to initiate new prior authorization requests, complete existing prior authorization requests, or check the status of previously submitted prior authorization requests. To use this tool, access the ExpressPath Prior Authorization Portal for providers at provider.express-path.com.

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, are typically excluded from coverage, and reimbursement is not available under the applicable benefit plan. Examples of these ingredients include: flurbiprofen, gabapentin, ketamine, lipoderm base, cyclobenzaprine HCL powder and baclofen powder, among others. Most of the ingredients in this exclusion list are bulk powders that are not FDA approved for use in humans. With this in mind, providers should consider prescribing a commercially available, FDA-approved medication. Patients will be required to pay the full cost of a compound drug if it contains an ingredient that is not covered. For questions about excluded compound drug ingredients, 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 medical and pharmacy information. Providers are mailed alert notifications of potential problems related to medical therapies, such as over/under utilization, multiple prescribers, drug-disease interactions and drug interactions based on a sophisticated, outcome-driven system that combines medical and prescription drug information. In addition, the dispensing pharmacists are notified online of these potential problems. Providers are asked to review these alerts and determine the appropriate treatment course for their patients.

Other Education

Express Scripts will reach out to providers with educational opportunities regarding generic and formulary drugs available for patients.

Clinical Practice and Continuity of Care Guidelines

Clinical Practice Guidelines

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 Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, and Clinical Practice Guidelines. Guidelines may include:

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

Continuity of Care Guidelines

Responsibilities of the Referring Provider when Requesting Consultation

Improve Information Sharing When a Consultation is Necessary

Prior to the patient's evaluation, the referring provider should supply the consulting physician with a hard copy of all necessary information, including:

- Reason for the consultation:
Why are you sending the patient for a consultation?
- Pertinent clinical information:
What information can you provide to the consultant that will best help the patient?
- Intended scope of the consultant's role:
Do you wish to have the consultant play an ongoing role in the patient's care or not?

- Desired method(s) of communication back to you: Do you want a preliminary report, or will a final written report suffice? Indicate the method of communication you prefer (e.g., fax, phone, mail)

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

Minimize Treatment Conflicts and Facilitating Patient Management

The consulting physician should send a written summary of the evaluation and treatment to the referring provider within 14 days of the first visit.

Note: Any preliminary report should be followed with a final report. Conventional methods include:

- Standardized form
- Letter

Summary Communication Form

The Continuity of Care Patient Summary Communication Form Z5417-CMT may be ordered by completing the Clinical Supply Requisition Form, which can be found at Provider.MedMutual.com, Tools & Resources, Forms, Clinical Supply Form.

Medical Record Management Preventive Care Flow Sheet

Record when care was rendered (e.g., vaccines, screenings including depression, anticipatory guidance counseling).

Medication

Keep a current medication list, including over-the-counter and prescribed medications by other physicians.

Laboratory and Diagnostic Test Results

Ordered outpatient lab and diagnostic testing results should be received and reviewed in a timely manner.

The ordering physician should document the date lab and diagnostic tests were reviewed (i.e., initial each page) and record subsequent actions, as needed.

Use a system to track pending tests and be sure to initial and date all received reports.

Behavioral Health Provider Responsibilities and Guidelines

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.

Exchange of Information

The behavioral health consultant is responsible for obtaining a signed consent from the covered person permitting important clinical information to be communicated in writing to the referring provider.

If the covered person gives his/her consent, the behavioral health consultant is responsible for exchanging the covered person's evaluation information and care plan to the referring provider. The communication should be completed within 30 days of the initial evaluation.

Communication Components

The communication should contain the following components, when applicable:

- Clinical Evaluation: Pertinent features of the behavioral health evaluation
- Diagnostic Tests: Results of diagnostic studies and procedures that have been completed and recommendations for additional testing when applicable
- Clinical Impression: covered person's diagnostic and/or differential diagnosis
- Treatment Plan: Therapy rendered by the behavioral health provider and ongoing management recommendations (psychotropic medications, psycho-therapy, behavior modifications, referral to community resources)
- Follow-up: Recommendations concerning who should provide follow-up care and when those services should be performed

Summary Communication Form

The Behavioral Health Patient Summary Communication Form Z5443-CMT, which includes a section for patient consent to release medical information, may be ordered by completing the Clinical Supply Requisition Form, which can be found at Provider.MedMutual.com, Tools & Resources, Forms, Clinical Supply Form.

Availability Goals and Accessibility Standards

Geographic Access Standards

Provider Type	Service Area	Commercial (Managed Care) Access Standards
PCPs (Family Medicine, General Practice and Internal Medicine)	Urban	3 providers within 8 miles of member
	Suburban	2 providers within 15 miles of member
	Rural	1 provider within 15 miles of member
Pediatricians and OB/GYNs	Urban	2 providers within 8 miles of member
	Suburban	2 providers within 15 miles of member
	Rural	1 provider within 30 miles of member
Key Specialists and Behavioral Health Providers	Urban	2 providers within 8 miles of member
	Suburban	1 provider within 15 miles of member
	Rural	1 provider within 30 miles of member
Hospitals	Urban	1 hospital within 10 miles of member
	Suburban	1 hospital within 10 miles of member
	Rural	1 hospital within 30 miles of member
Psychiatric Facilities	Urban	1 hospital within 15 miles of member
	Suburban	1 hospital within 15 miles of member
	Rural	1 hospital within 30 miles of member
Substance Abuse and Physical Rehab Facilities	Urban	1 hospital within 15 miles of member
	Suburban	1 hospital within 15 miles of member
	Rural	1 hospital within 30 miles of member
Ancillary Access		
Ambulatory Surgery Centers, Freestanding Radiology and Skilled Nursing Facilities	Urban	1 facility within 10 miles of member
	Suburban	1 facility within 15 miles of member
	Rural	1 facility within 30 miles of member
Home Healthcare	Urban	1 facility increment for each tiered level of occurrence based on membership
	Suburban	
	Rural	

Key Specialists

- Advanced Nurse Practitioners
- Cardiology
- Chiropractor
- Dermatology
- Gastroenterology
- General Surgery
- Licensed Independent Social Workers
- Licensed Professional Clinical Counselors
- Obstetrics/Gynecology
- Oncology
- Ophthalmologists
- Orthopedics
- Otolaryngology
- Physical Therapy
- Podiatry
- Psychiatry
- Psychology
- Urology

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.

Type of Service	Description	Performance Goal
Emergency	Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment Example: Major trauma injury, chest pain, severe abdominal pain, new onset shortness of breath	Immediate appointment or patient is directed to nearest emergency room or call 911.
Urgent Care	Onset of symptom(s) or health problem requiring prompt, but not immediate, medical attention Example: Minor trauma injury, unrelieved fever, signs/ symptoms of urinary tract infection, children with ear pain and fever	Appointment available within 24 hours of initial request . As appropriate members may be directed by the provider or 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.
Routine (Ongoing, non-urgent symptoms)	Follow-up care for non-acute symptoms Example: Visits for recurring/chronic problems	Appointment available within 30 days .
Preventive Care	Routine, regularly scheduled health assessment Example: Well-child visits, routine physical or gynecological exam	Appointment available within 30 days .
After Hours Care	Accessibility to healthcare provider outside of normal business hours	24-hours-a-day/7-days-a-week on-call coverage system where patients can speak with a healthcare provider. There is accessibility to a healthcare provider outside of normal business hours.

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)

The following table displays the Company's Behavioral Health Accessibility Standards.

Type of Care Needed	Definition	Performance Goal
Non-Life-Threatening Emergency	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 Nurse Line to seek care at an Emergency Department.
Urgent	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 covered person 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 Nurse Line to seek care at an Urgent Care Center.
Initial Visit for Routine Care	Any behavioral health concern that is of a non-emergent or non-urgent nature Example: Reactions to environmental life stressors that affects the covered person's ability to perform daily functions or the ability to adapt to day-to-day situations	Members are scheduled to be seen within 10 business days of contacting the provider. Excludes follow-up care for an existing problem.
Follow up Routine Care	Follow up care for any behavioral health concern that is of a non-emergent or non-urgent nature	Within 30 days or as agreed upon by the member and the practitioner. Includes visit at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit.

*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 Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Documentation, Standards & Related Forms.

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 subsection 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 Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Documentation Standards & Related Forms.

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, the following sample forms and policies are available at Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Documentation Standards & Related Forms.

- Behavioral Health Client Intake Record
- Confidentiality Policy
- Follow-up on Broken or Missed Appointments Policy
- Handicapped Patient Policy
- Medication Record
- Summary Sheet – Adult
- Summary Sheet – Pediatric
- For Member Rights and Responsibilities, see Section 1 – Introduction.

Standard Benefit Exclusions

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 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 policy effective date or for hospital or skilled nursing facility services received during any inpatient stay beginning before the policy effective date
- Incurred after the covered person stops being a patient, except as specified under the Benefits after Termination of Coverage section of the policy
- For which payment was made or would have been made under Medicare Part A or B if benefits were claimed. (Note: This applies when the covered person is eligible for Medicare even if the covered person did not apply for or claim Medicare benefits. This does not apply if federal law dictates the covered person's coverage is primary and Medicare is the secondary payer of healthcare expenses.)
- Primarily for outpatient educational, vocational or training purposes
- For conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or intellectual disability, except as specified (Benefit exclusions may vary based on state regulations.)
- For standby charges of a physician
- For arch supports and other foot care or foot support devices only to improve comfort or appearance, which include, but are not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses and toenails
- 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 request 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:

- A claim that is denied payment due to failure to comply with the care management program;
- Claims denied as not medically necessary; or
- Claims denied as investigational or experimental.

There are two appeals available to the provider.

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
- For claims denied as not medically necessary or as investigational or experimental, the appeal will be reviewed by a board certified physician reviewer of the same or similar specialty that typically manages the condition associated with the service or claim under appeal. This reviewer will not be the reviewer who participated in the initial decision about this service or claim nor a subordinate of the reviewer who made the initial 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 appeal will be reviewed by a second board certified physician reviewer of the same or similar specialty that typically manages the condition associated with the service or claim under appeal. This reviewer will not be a reviewer who participated in any prior decisions about this service or claim, nor a subordinate of the reviewers who made the prior decisions.
- The Company will issue a decision within 30 days after receiving all required information from the provider.

Expedited Appeals

- The Company shall render a decision within 72 hours after receiving all required information from the provider.

Filing a Clinical Appeal

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

- 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.

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 Company's Provider ePortal on our website. Appeals filed via the Provider ePortal 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 ePortal.

- Expedited appeals may be submitted via telephone at the phone number 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 at Provider.MedMutual.com, Tools & Resources, Forms for web-based HTML or fillable PDF versions of the PAR Form.
 - The PDF version should be used to submit paper inquiries by mail with supporting medical documentation.
 - The web-based HTML PAR Form should only be used when no supplementary records are attached.
- From the Provider.MedMutual.com secure Provider ePortal Dashboard, select the Claims & Eligibility tab, and then select the Claims tab. Perform a search using the most appropriate search functionality. The Submit Inquiry button is available on the individual claims status page and on the remittance details page. This version allows providers to attach supporting medical documentation and submit the request electronically.

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, certain prescription drug appeals follow a two-level appeal process. Each level will be decided by Express Scripts within 15 days of receipt of the request. Expedited appeals requests will be processed within 72 hours.

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

Clinical Appeals Department
Express Scripts
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 Contracting representative.

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 Contracting representative.

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, regardless of employee age, his/her spouse age 65 and over. 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 either the 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, 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: 01-10B-1900
Subrogation Department
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355

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

Provider Inquiries

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 Contracting representative.

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/VoiceConnect™

Customer Care is set up to respond to questions from Professional and Institutional providers. Additionally, 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/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–R 7:30a–7:30p F 7:30a–6:00p S 9:00a–1:00p
VoiceConnect™	(800) 362-1279	24-hour voice response system
Network Access Customers Customer Service	(800) 601-9208	M–R 7:30a–7:30p F 7:30a–6:00p S 9:00a–1:00p

Provider Website Resources

Providers can check member eligibility and benefits directly through the secure Provider ePortal (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 Provider ePortal. 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 ePortal, 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

Providers can access the PAR Form:

- Online at Provider.MedMutual.com, Tools & Resources, Forms for web-based HTML or fillable PDF versions of the PAR Form.
 - The PDF version should be used to submit paper inquiries by mail with supporting medical documentation.
 - The web-based HTML PAR Form should only be used when no supplementary records are attached.

- From the Provider.MedMutual.com secure Provider ePortal Dashboard, select Claims & Eligibility tab, then select Claims tab. Perform a Search using the most appropriate search functionality. The Submit Inquiry button is available on the individual claim status page and on the full remittance details page. This version allows providers to attach supporting medical documentation and submit the request electronically.

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 Provider.MedMutual.com, Tools & Resources, Forms — 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.

Imaging Procedure Request Forms

MRI/MRA and PET scan prior authorization phone requests are not accepted by Medical Mutual. Providers can submit imaging requests through ReviewLink or fax by visiting Provider.MedMutual.com, Tools & Resources, Care Management, Clinical Quality, Document Standards & Related Forms, Imaging Request Forms and selecting the appropriate imaging fax form.

Medical Drug Management Forms

Providers should use the Prior Authorization Form for medical drugs requiring prior authorization. The form is available at Provider.MedMutual.com, Tools & Resources, Forms. Providers may also use ExpressPAth to submit medical drug prior authorization requests.

Cultural Competence Form

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 are a provider who can address the special needs or preferences of the Company covered persons who speak a language other than English, who are visually impaired, or who have specific social/cultural needs,

then we need your help. Please use the Cultural Competence Form to notify the Company of the other language(s) you speak, the special service you provide, or the need or preference you are able to address, the information you provide will be kept in a database and referenced when a covered person calls us with special needs.

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.

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.

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 Provider.MedMutual.com, Tools & Resources, Provider Publications. 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 Contracting representative. 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

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 or when a claim is submitted with modifier 22 following the procedure code, which indicates unusual complexity.

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 Provider.MedMutual.com, Tools & Resources, Payment 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

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.

Please note: The Company does not accept and will deny interim claims, except in certain circumstances, and they 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.)

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 765, 766, 767, 768, 774, 775)
- 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)

- Bone Marrow Transplant (MS-DRG 014, 016, 017)
- Pancreas Transplant (MS-DRG 010)
- Kidney Transplant (MS-DRG 652)
- 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 inhail 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 of 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 [Provider.MedMutual.com](#), Tools & Resources, and Provider eServices.

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

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 related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.

Upon the request of the Company, providers must submit medical records pertaining to the initial admission and the readmission.

NOTE: The Company will review and may deny a second admission to provider or any of its affiliated providers no matter how many days have elapsed since the discharge from the provider if it appears the two confinements are related.

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.

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 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

- Not returned within 60 days including the day the LOA began, or
- Been admitted to another institution.

Special Payment Provisions

Services — Pre-episode (Pres.)/Same Day (SDS)/ Post-episode (POES) Window of Service

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.

Serious Reportable Events

Institutional providers should refer to Serious Reportable Events policy information in Section 3 – Clinical Quality and Health Services Programs.

Audit Provisions

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
- Charges for APG Inlier and/or Outlier cases
- Billing for Serious Reportable Events

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 Provider.MedMutual.com, Tools & Resources, Payment 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 following 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)

Medical Mutual's EFT enrollment, changes and cancellations are administered by PNC[®] Bank. To facilitate the registration process, please have your TIN, NPI and bank routing number available.

For more detailed instructions regarding EFT enrollment or to make changes or cancel EFT enrollment, please consult the Tools & Resources, EFT/ERA Enrollment portion of our provider website.

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 Outpatient 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:

Patient Name

The first 16 characters indicate the patient's last name, followed by 5 characters of the first name as they appear in Item 8 of the UB-04. Names are arranged alphabetically by the patients' last names.

ID Number

Patient's certificate number as it appears in Item 60 of the UB-04

Claim Number

13-digit number assigned by the Company to each claim on its receipt date

Patient Billing Number

Indicates the patient's control number (up to 14 alphanumeric characters) assigned by the hospital as it appears in Item 3A of the UB-04.

Date of Service

Date services are provided

Billed Charges

Total amount charged as it appears in Item 47 of the UB-04

Non-covered Charges

Amount of the charge(s) not covered due to contract limitations

Non-covered Units

Units applicable to the non-covered charge(s)

Non-covered CPT Code

CPT code applicable to the non-covered charge(s).

RMK CD

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

Amount allowed under the Provider Agreement for services incurred

Deductible/Copay

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

Fee Schedule amount for covered services for which the patient is liable

Other Paid

Amount paid by other insurance carrier(s)

Paid Amount

Amount to be paid to the provider. Amounts are subtotaled at the end of inpatient and outpatient claims

Subscriber Liability

Total amount owed by patient.

Write-off

The amount the account is to be reduced by according to the Provider Agreement

Payable Fee Codes

The ambulatory patient group (APG) code by which the claim is processed

PT (Payment Type)

An explanation of these codes appears on the back of the Remittance Schedule:

- 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

ADJ RSN

The adjustment code is a specific narrative explaining why a charge or a portion of a charge is adjusted. (See Adjustment Reason Codes list enclosed with your checks and remittances.)

Explanation of Adjustment (Take Back) Summary Information**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 NOP Information**Patient Billing Number**

Patient's (history/account) number assigned by your office from Item 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 Item 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

Deductible

Amount of the charge that is applied towards the deductible, based on the patient's policy

Coinsurance Amount

Percentage of the allowed charges after deductibles payable by the patient

Med/Other Ins. Paid

Amount paid by another insurance (i.e., Medicare, COB, Workers' Compensation), when applicable

Amount Paid

Amount to be paid for the service incurred, based on the patient's policy

Patient Liability

Amount owed by the patient after the allowed amount has been paid (i.e., deductible amount, copayments, or non-covered services)

Contractual Write-off

Difference between charges and contracted rate

Explanation of Inpatient 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:

Patient Name

The first 16 characters indicate the patient's last name, followed by 5 characters of the first name as they appear in Item 8 of the UB-04. Names are arranged alphabetically by the patients' last names.

ID Number

Patient's certificate number as it appears in Item 60 of the UB-04

Claim Number

13-digit number assigned by the Company to each claim on its receipt date

Patient Billing Number

Indicates the patient's control number (up to 14 alphanumeric characters) assigned by the hospital as it appears in Item 3A of the UB-04

Date of Admit

Date of admission as it appears in Item 12 of the UB-04

Date of Discharge

Date of discharge as it appears in Item 21 of the UB-04

Covered Days

Number of days approved for payment by the Company

Billed Charges

Total amount charged as it appears in Item 47 of the UB-04

Non-covered Amount

Amount of the charge(s) not covered due to contract limitations

RMK CD

Remark Code is a specific narrative explaining why a charge or a portion of a charge is not allowed. Explanation of the Remark Codes appears on the Remittance Schedule back.

Fee Schedule

Amount allowed under the Provider Agreement for services incurred

Deductible/Copay

Amount allocated towards the deductible as stipulated by the patient's contract/Copayment amount is the patient's liability and subject to the patient's contract stipulations

Coinsurance

Fee Schedule amount for covered services for which the patient is liable

Other Paid

Amount paid by other insurance carrier(s)

Paid Amount

Amount to be paid to the provider. Amounts are subtotaled at the end of inpatient and outpatient claims

Subscriber Liability

Total amount owed by patient

Write-off

The amount the account is to be reduced by according to the Provider Agreement

PT (Payment Type)

An explanation of these codes appears on the back of the Remittance Schedule:

- 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

DRG Code

The diagnosis related group code by which the claim is processed

ADJ RSN

The adjustment code is a specific narrative explaining why a charge or a portion of a charge is adjusted. (See the Adjustment Reason Codes list enclosed with your checks and remittances.)

Section 11 — Administrative and Plan Guidelines (Revised)

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 Contracting representative.

Network Products (Revised)

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 or Plus 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 or Select 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
HMO Health Ohio®
Dayton HMO Network
MedFlex Network
Mercy Health HMO Network
Northeast Ohio HMO Network
OhioHealth HMO Network
ProMedica HMO 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.

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.

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.

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

Out-of-network services do not require a referral, but will be reimbursed at a lower benefit level, thereby, increasing the

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 should 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.

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 Plus, Choice or Classic 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 or Select 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 MedAdvantage 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 Provider.MedMutual.com and select Care Management, Prior Authorization & Investigational Services (Medicare Advantage).

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, including those covered persons with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds.

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.

Prior Authorizations Required for All Home Health Services for Medicare Advantage

Effective January 1, 2017, prior authorization is required for all home health services for your patients who have Medical Mutual MedAdvantage plans. We previously only required prior authorization for home health aides. We updated our Medicare Advantage Prior Authorization Requirements List for 2017 and posted it on the Medical Mutual provider portal at Provider.MedMutual.com. Click Tools & Resources > Care Management > Prior Approval & Investigational Services, then Medicare Advantage Plans (2017) to see the updated document.

As noted, prior authorization is now required for the following home health services:

- Home Health Aide Services
- Home Health Skilled Nursing Visits
- Home Health Occupational Therapy
- Home Health Physical Therapy
- Home Health Speech Therapy

To request prior authorization, please complete the form linked within the Prior Authorization Requirements List and follow the directions for submitting your request.

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 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 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 immediately updated in our database.

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 Provider.MedMutual.com, Tools & Resources, Forms and selecting Provider Information Form.
- Providers enrolled in the Provider ePortal 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 ePortal or by using the Provider Information Form.
- Provider Information Forms should be submitted to the respective Provider Contracting office as the form instructs.

Advance Beneficiary Notice of Non-Coverage (ABN)

The Advance Beneficiary Notice of Non-Coverage (ABN) is not permitted to be used for Medicare Advantage members. While this notice may be used with original Medicare beneficiaries, it is not acceptable for use with members of Medical Mutual's Medicare Advantage plans.

If you believe an item or service may not be covered, or could be covered only under specific conditions, 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.

DO NOT HAVE THE MEDICARE ADVANTAGE MEMBER SIGN A WAIVER OR ANY OTHER ADVANCE NOTICE.

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 accreditation standards or with similar accrediting bodies, such as The Joint Commission, to improve the quality of care and services and the covered person's experience. Providers have the right to appeal any UR/QI determination in accordance with the Company's established appeals process.

Disease Management

Disease Management includes educational programs for chronic conditions. To assist individuals diagnosed with chronic diseases, Medical Mutual offers our Disease Management Program. Information obtained from our Disease Management Program is aligned to the Chronic Care Improvement Program (CCIP). The program helps covered persons with chronic conditions better manage their care. Specially-trained health coaches offer structured education and support to increase a covered person's knowledge about his/her disease, the potential complications and the importance of complying with their prescribed treatment plan. Conditions currently covered by our Disease Management Program include:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes

Quality Improvement

The Clinical Quality Improvement Department collaborates with Medicare-approved Quality Improvement Organizations (QIOs) to ensure that MedMutual Advantage Plan enrollees receive appropriate care and services as set forth by the Centers for Medicare and Medicaid Services (CMS) regulatory guidelines. The Company has a comprehensive QI program that it continually redesigns to 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
- 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.

Medical Mutual may gather data to measure provider quality through multiple sources, including those identified above, and providers agree that such data may be used by Medical Mutual for quality improvement activities.

The Medicare Advantage QI program is designed to promote continual improvement in all areas of clinical care. We participate in quality improvement projects (QIPs) as mandated by CMS through collection, integration and analysis of data. 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 our covered persons are meeting quality standards as set forth by CMS. Part of this measurement opportunity includes random audits of medical records 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.

Medical Mutual focuses on the following HEDIS measures for its MedMutual Advantage Plan covered persons:

- Adult BMI Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening
- Non-recommended PSA-Based Screening in Older Men
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Comprehensive Diabetes Care
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Osteoporosis Management in Women Who Had a Fracture
- Antidepressant Medication Management
- Follow up after Hospitalization for Mental Illness
- Annual Monitoring for Patients on Persistent Medication
- Potentially Harmful Drug Disease Interaction in the Elderly
- Use of High Risk Medications in the Elderly
- Medicare Health Outcomes Survey
- Fall Risk Management
- Management of Urinary Incontinence in Older Adults
- Osteoporosis Testing in Older Women
- Physical Activity in Older Adults
- Flu Vaccinations for Adults Ages 65 and Older
- Medical Assistance with Smoking and Tobacco Use Cessation
- Pneumococcal Vaccination Status for Older Adults
- Adults Access to Preventive/Ambulatory Health Services
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Guidelines for Utilization Measures
- Frequency of Selected Procedures
- Ambulatory Care
- Inpatient Utilization—General Hospital/Acute Care
- Identification of Alcohol and Other Drug Services
- Mental Health Utilization
- Antibiotic Utilization
- Plan All-Cause Readmissions

Access to Care

In an effort to ensure Covered Persons have timely access to care, Medicare Advantage Network providers are required to follow the guidelines referenced in Section 3 – Clinical Quality and Health Services Programs. Providers must also ensure wait times in the provider office do not exceed the following standards:

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

Grievances

The Quality Improvement team will address all grievances within the standard or expedited time frames. The team will respond in writing upon receipt of the grievance and again after the investigation is complete. The Quality Improvement team will keep a record and track all issues, then use this information for development of a QIP 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 person grievances are addressed according to CMS standards.

Pharmacy Programs

Medical Mutual has partnered with Express Scripts to develop a comprehensive, valued and affordable prescription drug benefit that meets the prescription therapy needs of all its covered persons.

Formulary

Medical Mutual has a committee of physicians and pharmacists that develop and maintain a list of drugs that our MedMutual Advantage Plans cover. This list is also referred to as a formulary. Our formulary allows our covered persons to access all of the medication classes required by CMS.

Our MedMutual Advantage Plan formulary 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.

Tier	Description
Tier 1	Preferred Generic Drugs
Tier 2	Non-Preferred Generic Drugs
Tier 3	Preferred Brand Drugs
Tier 4	Non-Preferred Brand Drugs
Tier 5	Specialty Tier Drugs

To access a copy of our formulary, please visit MedMutual.com/medicare and select Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, General Plan Information, Learn More.

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 limit.
- 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 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.

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

Your 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 Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management to view our most current coverage management documents and prescription drug updates.

Please note that Medical Mutual continues to require prior authorization for all of the following drugs filled under the pharmacy benefit:

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

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) 328-9799
Mail: Medicare Reviews
Express Scripts
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, General Plan Information, Learn More.

Generally, we must provide a response within 72 hours for a standard request. For exceptions, we must provide a response within 72 hours after receiving your supporting statement. If you or the member feels that the patient's health could be seriously harmed by waiting 72 hours for a decision, you may request an expedited review. If your request to expedite is granted, we must provide a decision within 24 hours. For exceptions, we must provide a response within 24 hours of receiving your supporting statement.

Prescription Drug Redeterminations (Appeals)

If you disagree with a decision we made regarding a coverage determination, you 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, you or the patient 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. Medical Mutual sponsors the MTM program that is offered through our relationship with Express Scripts.

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
 - Osteoporosis
 - Chronic heart failure (CHF)
 - Dyslipidemia
 - Hypertension
 - Diabetes
 - End-stage renal disease (ESRD)
 - Depression
 - Asthma
 - Chronic obstructive pulmonary disease (COPD)
- Take seven or more chronic Part D medications
- 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 us improve the health of our members and your patients 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 Medical Mutual Medicare Plans, Medicare Advantage Plans with Prescription Drug, General Plan Information, Learn More.

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 60 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.

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 30-day 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. Our pharmacy network includes retail pharmacies, long-term care pharmacies, home infusion pharmacies, specialty pharmacies, and Indian/tribal pharmacies. A listing of pharmacies in our network 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 our network mail-order delivery program.

Mail order prescription requests may be submitted to:

- 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 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:

- 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:** (866) 620-4027
- Fax:** (866) 620-4028
- Mail:** Medical Mutual
4750 E. 450 South, Suite 2130
Whitestown, IN 47075-8404
- Website:** Contact ExpressPAth at express-path.com

Five-Star Quality Rating System

The Five-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 ratings are based on measures of a health plan's rating across five categories known as domains.

- Staying healthy: screenings, tests and vaccines, such as annual PCP visits and colorectal cancer screening
- Managing chronic conditions, such as diabetes, COPD, etc.
- Plan responsiveness, care and quality, such as getting needed care as well as getting appointments and care quickly

- Member complaints, problems getting services and choosing to leave the plan, such as complaints about the health plan
- Customer service, such as timely appeal decisions

Star Measures

Medicare star ratings are comprised of a set of measures across the five domains for Medicare Part C with a separate set of measures for Medicare Part D (prescription drug plan). 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 as referenced earlier in this section. For example, the antidepressant medication management measure is collected through a review of claims and encounters, whereas the controlling blood pressure measure is reported using only medical record review.
- **CAHPS Survey Data**
The CAHPS survey, referenced earlier in this section, is conducted annually in the spring. Survey responses are collected from a sample of Medicare health plan members who receive the survey. Some star rating measures are based on survey results, such as flu and pneumonia shot 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 survey results, such as questions related to falls risk, physical activity and urine leakage.
- **Health Plan Operational Data**
Some of the star rating measures are also based on data reported to CMS by health plans. Some examples include complaints and appeals rates.

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 protection
- 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 of the measures and how you impact 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/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2016-Technical-Notes-Preview-2-v2015_09_02.pdf
- To learn more about the HOS, visit 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.
- To learn more about the HEDIS, visit ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx.

Appeals

Provider Appeals: Medical Coverage and Claim Decision Reconsiderations

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.

If the member's health condition would be seriously 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 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.

Expedited appeal requests may be submitted to:

Phone: (855) 887-2273

Fax: (800) 221-2640

Mail: MZ 01-5B-4200
Clinical Quality and Health Services
Department
Medical Mutual
2060 East 9th Street
Cleveland, OH 44115-1355

All other standard appeal requests may be submitted in writing to:

Mail: MZ: 01-4B-4809
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.

All hospitals and CAHs are required to provide this notification beginning March 8, 2017. For additional information or to download a copy of the MOON, visit 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.

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.

In the event the SNF is not able to deliver the NOMNC and obtain signature(s) the same day Medical Mutual issues the NOMNC for the member or member's representative, the SNF provider is responsible for re-issuing a NOMNC to the member or member's representative with the appropriate Last Approved Day (LAD) to allow the member at least two calendar days in advance of the service ending.

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

Liability for the member, who decides to stay past the LAD, will begin the day following the last approved day as

specified on the NOMNC, should the member choose not to appeal the termination of services.

Additional Medicare Advantage Guidelines

In addition to the standards referred to in this Provider Manual, these guidelines are required by CMS and must also be followed to maintain standing as a Company Medicare Advantage Network provider.

Billing for Hospital Readmissions

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 related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.

Upon the request of the Company, providers must submit medical records pertaining to the initial admission and the readmission.

NOTE: The Company will review and may deny a second admission to provider or any of its affiliated providers no matter how many days have elapsed since the discharge from the provider if it appears the two confinements are related.

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.

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 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:

- Not returned within 60 days including the day the LOA began, or
- Been admitted to another institution.

Permanent Out-of-Area Enrolment 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.

Provision of Covered Services to Covered Persons 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.

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

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 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, certification and credentialing activities, HEDIS surveys 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 [cdc.gov/nchs/data/icd/icd10cm_guidelines.2014.pdf](https://www.cdc.gov/nchs/data/icd/icd10cm_guidelines.2014.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 covered persons 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](https://www.MedMutual.com), [Medicare.gov](https://www.Medicare.gov) and the Ohio Senior Health Insurance Information Program (OSHIIP) at [Insurance.Ohio.gov/Consumer/Pages/ConsumerTab2.aspx](https://www.Insurance.Ohio.gov/Consumer/Pages/ConsumerTab2.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 (made after the first 30 days) must include a statement that the provider may also contract with other plans. This statement is not required for new affiliation announcements (made within the first 30 days).

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 not 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

Federal law bars Medicare providers from balance billing dual eligible beneficiaries. No Medicare Advantage provider may collect Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from an individual who is eligible for both Medicare and Medicaid. Medicare providers must either accept Medical Mutual's payment as payment in full or bill the state of Ohio for the applicable Medicare cost-sharing.

Verify your practice has procedures in place to ensure that MA health providers do not discriminate against enrollees based on their payment status, e.g., Qualified Medicare Beneficiary. Specifically, MA health providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

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, that are non-hospice related, 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) or on the U.S. General Services

Administration (GSA) Excluded Parties List System (EPLS), with the possible exception of payment for emergency services under certain circumstances, as provided in 42 C.F.R. § 1001.1901(c) (5). Any provider or entity that appears on one or both 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. Providers can access additional information at the following websites.

- The OIG's LEIE can be found at oig.hhs.gov/exclusions
- The GSA's EPLS can be found at sam.gov

These websites are not sponsored, maintained or controlled by 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 mmo.intercedeservices.com, or in writing to:

Compliance Officer, MZ 01-10B-1900
Medical Mutual
2060 East 9th Street
Cleveland, OH 44115-1355

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 designated Medicare Advantage Organization (MAO), Medical Mutual must comply with and meet certain Centers for Medicare & Medicaid Services (CMS) requirements. We are obligated to oversee compliance for our First Tier, Downstream and Related Entities (FDRs), and establish and implement an effective system for routinely auditing and monitoring compliance. Medical Mutual requires providers to submit an FDR attestation form annually.

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.

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 or Group 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 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 Contracting representative.

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 OPSS.

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.