

Material in this newsletter is current as of May 2003.

MMO Appeals Procedure Updated; Second, Optional Level Added

Effective January 2003, Medical Mutual of Ohio (MMO) changed to a one-level appeal process for both covered persons and providers. This change was made as a result of new Department of Labor regulations, as well as new accreditation requirements. Effective July 2003, MMO is making a slight change to the appeal process to improve satisfaction among our providers and covered persons.

Effective July 1, 2003, MMO is adding a second, optional level of appeal, beyond the first required level now in place. This optional level is for cases that do not qualify for independent external review through the Ohio Department of Insurance. This additional, optional level is called a *voluntary* level. The first level is called *mandatory* because generally under state or federal law, a covered person who wishes to appeal a denied service or claim must proceed through the first level of appeal before receiving an external review through a state department of insurance or taking any action in court. The *voluntary* level is available but not required before any action is taken in court. Covered persons and providers will be notified when a voluntary level (second level) appeal is applicable via the letter they receive at the conclusion of their first appeal decision.

The voluntary level is applicable when the first level mandatory appeal is exhausted, and when under state or federal law, the covered person is not entitled to an independent external review through a state department of insurance. These situations include persons covered under self-insured plans that do not qualify for an independent external review by a state department of insurance; persons who are fully insured through MMO or are part of a Federal Employee Benefit Plan but do not qualify for independent external review, either because the denial was for a reason other than medical necessity or the cost to the covered person is less than \$500; or when *providers* are liable for the denied claim.

The first level mandatory appeal must still be requested **within 180 days** from receipt of the initial notice of denial, reduction in payment, or termination of benefits. The adverse determination may be received via the covered person's Explanation of Benefit (EOB); an adverse benefit determination letter from our Care Management Department; or the provider's Notice of Payment (NOP), Adjustment Summary, or Remittance Schedule. For pre-service or post-service standard appeals, MMO has 30 days from receipt of the request to make the decision. For urgent care appeals, MMO will make a decision within 72 hours from receipt of the request. All other guidelines related to appeals remain in effect.

The additional, voluntary level of appeal – which, again, are for cases that do not qualify for independent external review through the state's department of insurance – may be requested by the covered person or provider at the conclusion of the first level mandatory appeal. The request for this second review must be received by MMO **within 60 days** from receipt of the first appeal decision. The review will be completed within 30 days from receipt of request.

Reminder: Refer SuperMed Select Patients *In Network* Only

Primary care physicians (PCPs) are reminded to refer patients covered under SuperMed Select only to network specialists in order for their patients to receive the highest level of benefits. MMO is no longer waiving the benefit restriction on requests from PCPs to refer SuperMed Select patients out-of-network.

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RECOVERY OF CLAIM OVERPAYMENTS

When an overpaid claim is identified, Medical Mutual of Ohio (MMO) initiates a process to correct the overpayment. In all cases when an overpayment adjustment is done by MMO, 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. In line with Ohio law, when the invoice due date expires without an appeal or payment, MMO 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 1.800.362.1279 to have the overpayment adjustment, sometimes called a *take back*, put on hold. The appeal status is entered into MMO's on-line 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. If the provider does not contact MMO to request more time, the recovery will be automatically completed after the 35-day period.

When the 35-day period expires without an appeal or receipt of a refund, MMO will 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 MMO.

Note that **when a provider identification number is canceled or made inactive, MMO 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 MMO 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 patient associated with the adjustment, date of service, amount and reason for the adjustment.
- Validate that the provider identification 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 MMO, you may appeal the decision by completing a Provider Action Request (PAR) form and following the normal provider appeal process. Send the completed PAR form to Medical Mutual, P.O. Box 94917, Cleveland, OH, 44101-4917. PAR forms may be found on our Web site at www.medmutual.com under the *Provider Inquiries* section.

Medical Mutual and WebMD Envoy Team Up to Offer a Single Source for Key HIPAA-Compliant Services

Don't Lose Access to Important Information and Services

Sign up today for WebMD Office

Call 1-800-321-7223, or

e-mail: webmdmigration@mmoh.com.

All MMO providers who want access to Web-based referral systems, claim status information, policyholder and dependent data, and similar information must sign up for WebMD Office. Many services currently offered by MMO are being transferred to WebMD Envoy to ensure HIPAA compliance and make it easier for providers to perform a variety of transactions through a single source. WebMD Envoy is a recognized leader in clearinghouse systems and is making WebMD Office, a powerful Internet program, available to Medical Mutual providers who register for it. WebMD Office enables health care providers to conduct everyday transactions more efficiently and accurately.

MMO's ProviderLink program, which currently provides claim status and other information, is scheduled to be terminated and have its functions transferred to WebMD. ProviderLink will be shut down by October 16, with the exception of the component that provides information on paid and rejected claims. That component will remain accessible to current ProviderLink users for a limited period.

For more detailed information and ongoing updates on the status of the transfer of Web-based systems to WebMD, watch MMO's Web site at www.medmutual.com.

Positive Results for 2002 Provider Satisfaction Survey

Annually, MMO conducts a statewide Provider Satisfaction Survey to assist in maintaining or enhancing provider satisfaction in working with us. Survey respondents include office managers and other office staff. Both primary care and specialist offices are included in the survey sample.

Survey results for 2002 were generally very positive. The highest-rated items showing provider satisfaction are:

- Knowledge of local MMO Professional Contracting Office: 94.0%
- Helpfulness of local MMO Professional Contracting Office: 94.1%
- Satisfaction with MMO's credentialing process: 91.6%
- Knowledge of Provider Inquiry Phone Unit Professionals: 93.1%

Other survey items also demonstrated overall provider satisfaction with MMO's managed care plans, including satisfaction with MMO's accuracy in claims payment; provider informational/educational programs; the knowledge, and helpfulness of Provider Inquiry Professionals; and MMO's referral process.

An action plan has been developed to continue to improve provider satisfaction related to referral authorizations and process, provider education, and accessibility of Provider Inquiry Professionals.

Preparation for 2003 Provider Seminars Underway

Look for your invitation to MMO's 2003 Provider Seminars to arrive by late August into early September. These seminars are aimed at providing physicians and their office staff with the latest information on key MMO administrative and medical policies and procedures. They also address current topics of general interest and importance.

By mid August, the entire statewide seminar schedule will be available for viewing on MMO's Web site at: www.medmutual.com under the *Providers* Tab at the main menu.

Ensure that you are able to attend the seminar of your choice by responding quickly to your invitation, either by mailing back the tear-off form or by logging onto MMO's Web site to complete and send in the form through the internet.

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