Notice of Material Amendment to Contract

Medical Records Must Be Submitted within 14 Days

To be more responsive to our members’ needs and comply with national accreditation standards, effective April 1, 2016, providers are required to submit all requested medical records within 14 days from the date on the request letter. Providers are already required to provide requested medical records within 14 days of Medical Mutual’s request for Affordable Care Act and Medicare Advantage risk adjustment purposes. This requirement aligns Medical Mutual with government entities and other large healthcare insurers.

We appreciate your assistance and thank you for partnering with us to improve the health of individuals, families and our communities. Obtaining medical records from providers and facilities is an integral part of Care Management and Quality Improvement activities.

If you have any questions or concerns, please contact your Provider Contracting representative. For information on preparing for upcoming audits and medical records request, visit Provider.MedMutual.com and select Tools & Resources, Healthcare Reform Information.

New HMO Network Members Have No Out-of-Network Benefits for Non-Emergency Services

Beginning in 2016, certain group and individual members may choose from new HMO product offerings utilizing new HMO networks. Two new HMO networks have been established, one featuring ProMedica and the other featuring Mercy Health, with the possibility of additional HMO networks in the future. HMO plans offer a closed-panel benefit design that does not provide any out-of-network coverage for non-emergency services. When a transfer or referral is necessary, participating providers in an HMO network must direct members enrolled in a product utilizing such HMO network to other participating providers in that HMO network, subject to the member’s medical condition. The provider must obtain prior approval from Medical Mutual for transfers or referrals to providers who are not participating providers in the HMO network, except in the case of an emergency medical condition.

Article continued on next page.
Providers selected to participate in the ProMedica HMO network and Mercy Health HMO Network have been notified through notices of material amendment sent in July 2015 and August 2015 respectively.

Distinctive ID cards make identifying members participating in a plan using one of these new HMO networks simple. Please review the below ID card images. A banner across the top of the ID card’s front panel identifies the HMO product.

**Coverage Management Program: Quantity Limit List Expanding for Pharmacy Benefits**

Medical Mutual began updating its quantity limit program in November and will be rolling it out to all members with coverage management by 2016. This program limits the amount of medication Medical Mutual plans will cover per prescription for non-Medicare members.* These limits have been reviewed and approved by our Pharmacy Quality Management Committee.

We apply quantity limits to certain prescription drugs for a variety of reasons, including:

- To prevent medication abuse, misuse and/or overutilization
- To prevent the stockpiling of medications
- To promote adherence to medication regimens
- To ensure compliance with FDA and manufacturer dosing recommendations
- For other various clinical reasons, such as safety or efficacy

Quantity limits on drugs are documented on our comprehensive formulary, which is available on the Provider ePortal. Visit Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management, Prescription Formulary.

* Medicare members have a different formulary and are subject to different quantity limits. To view quantity limits for Medicare members, visit MedMutual.com/Medicare and select Medicare Advantage Plans with Prescription Drug, Important Plan Information, Medical Mutual/Medicare Part D Formulary.
Site of Care Management Begins
January 15, 2016

Select specialty medications that are already subject to prior authorization requirements will be subject to site of care management beginning January 15, 2016. Through site of care management, coverage for impacted medications is restricted to administration by home infusion, at a provider’s office or at a standalone infusion center.

Infusions administered in a hospital setting are not eligible for reimbursement unless the provider receives prior approval from Medical Mutual that the medical necessity criteria have been met.

Alternative infusion sites are recognized by the medical community as safe, medically appropriate and cost-effective sites of service for administration of select medications (e.g., immune globulins, enzyme replacement therapy, Remicade, Soliris). The goal of site of care management is to help our members receive their medications safely, conveniently and affordably.

Examples of commonly prescribed agents subject to site of care management include: alpha-1 proteinase inhibitors (e.g., Aralast, Glassia, Prolastin, Zemaira), immune globulins (e.g., Bivigam, Flebogamma, Gammagard, Privigen), Remicade (infliximab), Soliris (eculizumab), Synagis and Tysabri (natalizumab). To view the full list of medications subject to site of care management, visit Provider.MedMutual.com and select Care Management, Medical Drug Management.*

Members with a current prior approval will not be impacted. New requests and renewals of a previously approved medication will be subject to site of care management.

For a list of medications requiring prior approval (including those subject to site of care management) or considered investigational, and to view a complete list of our Corporate Medical Policies, visit Provider.MedMutual.com and select Tools & Resources, Care Management.

*This list is subject to change.
Formulary/Coverage Management Updates

Your patients’ insurance plans may have certain coverage limits to ensure prescribed medications follow accepted medical guidelines and have cost-effective alternatives to treat the same condition.

Our members also participate in an open formulary program through Express Scripts® that helps manage prescription drug benefit costs.

Medical Mutual periodically reviews these medications, drug classes and formulary updates. Please visit Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management to view coverage management and prescription formulary updates.

New Specialty Drug Requirements for On- and Off-Exchange Members with Metal Plans

We are modifying specialty drug coverage for our on- and off-exchange members with metal plans beginning January 1, 2016, by making two changes:

1. Only a 30-day supply of a specialty drug will be covered each month.

2. All specialty drugs, other than HIV drugs, will have to be filled by an in-network specialty pharmacy. This will help ensure better care and results for members taking a specialty drug.

At this time, we have two specialty pharmacies in our network—Accredo and Gentry Health Services. Accredo is owned by Express Scripts and can fill prescriptions for all specialty drugs. Gentry Health is owned and operated by Discount Drug Mart and can fill prescriptions for HIV and Hepatitis C medications.

Specialty pharmacists from both organizations can provide counseling to our members by phone and help monitor how the member’s medication is working each month (e.g., to monitor side effects).

For your patients with Medical Mutual metal plans, prescriptions for specialty drugs should be called to Accredo at (800) 803-2523, or faxed to (888) 302-1028. You can also call in prescriptions for HIV or Hepatitis C drugs to Gentry Health at (844) 443-6879, or fax to (844) 329-2447.

We hope to include additional pharmacies in our specialty pharmacy network in the future.

The content of this article is effective as described above, but will be reflected in the first quarter 2016, Provider Manual.
Clinical Practice Guidelines

Medical Mutual is committed to partnering with our network providers to deliver the highest quality of care to our members. This effort includes adopting nationally recognized professional organization peer-reviewed clinical practice guidelines and making them available on our provider website. All published guidelines have been carefully reviewed by a panel of actively practicing, board-certified Medical Mutual physician reviewers and can be found on Provider.MedMutual.com by selecting Tools & Resources, Care Management, Clinical Quality, Guidelines.

Drug Coverage of Praluent and Repatha (PCSK9 Inhibitors)

The U.S. Food and Drug Administration (FDA) recently approved two new drugs to treat high cholesterol in certain individuals: Praluent (alirocumab) and Repatha (evolocumab). These self-administered specialty drugs are part of a new category of drugs called PCSK9 inhibitors. Both are only indicated as adjuncts to diet and maximally tolerated statin therapy (or other LDL lowering therapies in the case of homozygous familial hypercholesterolemia). Lifestyle modifications such as diet and exercise remain critical along with statin therapy for those where diet and exercise alone is not enough to control LDL-C.

The chart below outlines the indications that Medical Mutual provides coverage for after prior authorization criteria are met. They are also the only FDA-approved indications for each drug.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Praluent</th>
<th>Repatha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterozygous Familial Hypercholesterolemia [HeFH]</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hyperlipidemia in Patients with Clinical Atherosclerotic Cardiovascular Disease (ASCVD)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Homozygous Familial Hypercholesterolemia [HoFH]</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Please note these drugs are part of Medical Mutual's Enhanced Prior Authorization process. The enhanced review process includes requesting specific medical records regarding the patient's condition as it relates to these drugs. These records and any other information submitted will be thoroughly reviewed by a pharmacist or nurse specialist. This process will help us provide the best possible cholesterol management while reducing costs for our members and your patients.

To view detailed prior authorization criteria for both drugs, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management.

You may contact Accredo Specialty Pharmacy toll-free at (866) 759-1557 to start the fulfillment process. Accredo is authorized to dispense both Praluent and Repatha and offers many other services at no additional cost. These services include prior authorization assistance, reimbursement assistance and 24/7 access to specialty trained pharmacists or nurses.

These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.
Prior Approval Update for Drugs under the Medical Benefit

Effective February 28, 2016, the following prescription medications will require prior approval when requested under the member’s medical benefit through Medical Mutual:

- Arranon (nelarabine)
- Arzerra (ofatumumab)
- Erwinaze (asparaginase Erwinia chrysanthemi)

Effective April 30, 2016, the following prescription medications will require prior approval when requested under the member’s medical benefit through Medical Mutual:

- Margibo (vincristine sulfate)
- Gazyva (obinutuzumab)
- Istodax (romidepsin)

These lists are subject to change. For more information on prescription medications requiring prior approval or that are considered investigational, and to view a complete list of our Corporate Medical Policies, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies.

*When these medications are provided under a member’s prescription drug benefit, please contact the pharmacy benefit manager at the number on the member’s identification card for prior approval requirements.

Individual Prior Approval Fax Forms No Longer Required

Individual fax forms are no longer needed for medical drugs requiring prior approval.

Medical Mutual offers ExpressPAth, an online tool used to streamline the review process for medications that require prior approval under the Medical Mutual medical benefit.

ExpressPAth can help reduce your staff’s administrative burden and provide your patients with a shorter path to treatment. It also provides:

- Increased efficiency — No more phone calls or faxes to request your prior approval.
- Quick decisions — Some cases may receive instant prior approval determination.
- The ability to check the status of your requests online — You can sign up to receive email notifications once a decision is reached (approved or denied).
- Online renewals — Renew requests up to 90 days before they expire.

To register for ExpressPAth, visit Express-Path.com.

Alternatively, providers may use the Prior Approval Form available on Provider.MedMutual.com by selecting Tools & Resources, Forms, Prior Approval Form.
## 2015 Quality of Care Audit Results

We are pleased to present the results of Medical Mutual’s 2015 (2014 measurement year) Healthcare Effectiveness Data Information Set (HEDIS®) audit below. We are always striving to improve these measures and the health of our members. We ask for your help in encouraging our members to obtain recommended screenings, immunizations and examinations.

### Effectiveness of Care: Prevention and Screening

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Year 2014</th>
<th>Reporting Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (Annual Mammography)</td>
<td>69.50%</td>
<td>70.70%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>73.58%</td>
<td>74.71%</td>
</tr>
<tr>
<td>Chlamydia Screening (Ages 16-25)</td>
<td>38.55%</td>
<td>37.10%</td>
</tr>
</tbody>
</table>

### Effectiveness of Care: Behavior Health

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Year 2014</th>
<th>Reporting Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up for Children of Prescribed ADHD Medication (Initiation Phase)</td>
<td>36.48%</td>
<td>35.12%</td>
</tr>
<tr>
<td>Follow-up for Children of Prescribed ADHD Medication (Continuation/Maintenance Phase)</td>
<td>52.13%</td>
<td>53.74%</td>
</tr>
<tr>
<td>Antidepressant Medication Management: Acute Phase Treatment</td>
<td>67.31%</td>
<td>69.32%</td>
</tr>
<tr>
<td>Antidepressant Medication Management: Continuation Phase Treatment</td>
<td>52.13%</td>
<td>53.74%</td>
</tr>
<tr>
<td>Follow up after Mental Health Hospitalization: 7 Days</td>
<td>46.54%</td>
<td>52.75%</td>
</tr>
<tr>
<td>Follow up after Mental Health Hospitalization: 30 Days</td>
<td>69.29%</td>
<td>74.81%</td>
</tr>
</tbody>
</table>

### Effectiveness of Care: Respiratory Conditions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Year 2014</th>
<th>Reporting Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>82.28%</td>
<td>82.36%</td>
</tr>
<tr>
<td>Appropriate Treatment for Children with URI</td>
<td>82.47%</td>
<td>85.14%</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>21.38%</td>
<td>22.47%</td>
</tr>
<tr>
<td>Use of Spirometry in the Assessment and Diagnosis of COPD</td>
<td>36.38%</td>
<td>36.43%</td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation: Bronchodilator Therapy</td>
<td>81.67%</td>
<td>75.26%</td>
</tr>
<tr>
<td>Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid</td>
<td>76.76%</td>
<td>73.48%</td>
</tr>
</tbody>
</table>

### Effectiveness of Care: Medication Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Year 2014</th>
<th>Reporting Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis</td>
<td>87.37%</td>
<td>87.58%</td>
</tr>
<tr>
<td>HbA1C Screening</td>
<td>87.19%</td>
<td>86.90%</td>
</tr>
<tr>
<td>HbA1C Poor Control</td>
<td>33.61%</td>
<td>33.50%</td>
</tr>
<tr>
<td>Dilated Retinal Exam</td>
<td>47.24%</td>
<td>50.08%</td>
</tr>
<tr>
<td>Nephropathy Monitoring</td>
<td>83.69%</td>
<td>83.69%</td>
</tr>
<tr>
<td>B/P Control &lt;140/90</td>
<td>64.39%</td>
<td>64.18%</td>
</tr>
</tbody>
</table>

*Each year, the National Committee for Quality Assurance (NCQA) identifies certain measures that can be rotated (i.e., insurers may use the prior year’s results for the current measurement year).
Changes to 2016 HEDIS BMI Specifications

In 2016, HEDIS technical specifications require a BMI percentile to be included on medical records for members younger than age 20 on the date of service. This is a change from 2015, when a BMI percentile was required only for members younger than age 19 on the date of service.

Medical records for members age 20 and older may include only a BMI.

Unnecessary Imaging Occurs for Patients with Low Back Pain

Too often, imaging studies are performed within 28 days of low back pain diagnosis before other intervention types are tried.

According to the Agency for Healthcare Research and Quality, diagnostic imaging is usually not needed for patients with acute low back pain. HEDIS measures the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (e.g., plain X-ray, MRI, CT scan) within 28 days of diagnosis. This is an inverted rate, which means a high score correlates with appropriate treatment (i.e., imaging studies did not occur).

The state of Ohio average for this measure is 73.68 percent, which is the 25th percentile.

We recognize that as a standard of care, chiropractors perform X-rays prior to manipulation, and these X-rays are included in the NCQA study. However, once we have accounted for the X-rays ordered by chiropractors, there are still a large number of imaging studies being done by primary care providers within 28 days of the diagnosis of low back pain.

Reminder about Your Patients who are TeamCare Members

Providers are reminded to call Medical Mutual regarding all prior authorizations for members of a TeamCare group, including Central States Funds and UPS, at the number on the back of the member’s ID card. Members of a TeamCare group are easily identified by the TeamCare logo on the top left of their member ID card. Any eligibility, COB or benefit questions should be directed to Central States Funds at (800) 323-5000.
These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member’s specific benefit plan.

Spine and Extremity MRI Prior Approvals: When Less is More

Because many musculoskeletal MRIs are done with the intention of performing surgery (depending upon the results), it is considered accepted medical practice to optimize medical management first.

Often, a number of different therapeutic modalities may result in improvement or resolution of the presenting signs and symptoms, thereby eliminating the need for more aggressive treatment.

Prior to ordering an MRI, it is recommended that therapeutic doses of anti-inflammatory and/or analgesic medications be utilized (typically) daily for more than three weeks whenever possible and clinically appropriate. In addition, if physical or occupational therapy has been initiated, please allow your patient to undergo a reasonable number of treatments prior to determining that conservative medical management has failed.

Thank you for partnering with us to deliver both high-quality care and value to our members. Working together, we can improve the health of individuals, families and our communities.

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised between July 1 and September 30, 2015, are outlined in the chart on the next page.

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

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

*Article continued on next page.*
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
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<tbody>
<tr>
<td>94041</td>
<td>Obstetrical Policy</td>
</tr>
<tr>
<td>200117</td>
<td>Continuous Glucose Monitoring</td>
</tr>
<tr>
<td>200135</td>
<td>Surgical Treatment of Migraine</td>
</tr>
<tr>
<td>200139</td>
<td>Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions</td>
</tr>
<tr>
<td>200224</td>
<td>Sublingual Immunotherapy</td>
</tr>
<tr>
<td>200229</td>
<td>Whole Body CT Scan Screening</td>
</tr>
<tr>
<td>200310</td>
<td>Endoscopic and Laproscopic Therapies for Tx of GERD</td>
</tr>
<tr>
<td>200312</td>
<td>Vertebroplasty</td>
</tr>
<tr>
<td>2003-C</td>
<td>Electrical Stimulation for Treatment of Dysphagia</td>
</tr>
<tr>
<td>2005-D</td>
<td>Percutaneous Neuromodulation Therapy</td>
</tr>
<tr>
<td>2005-E</td>
<td>Pulsed Electrical Stimulation - Osteoarthritis of Knee</td>
</tr>
<tr>
<td>2007-E</td>
<td>Uterine-Sparing Fibroid Treatments</td>
</tr>
<tr>
<td>200815</td>
<td>Kyphoplasty</td>
</tr>
<tr>
<td>2009-C</td>
<td>Anal Fistula Plug</td>
</tr>
<tr>
<td>201015</td>
<td>Prolotherapy - Musculoskeletal Conditions</td>
</tr>
<tr>
<td>2011-C</td>
<td>Wireless Gastrointestinal Motility Monitoring System</td>
</tr>
<tr>
<td>2011-E</td>
<td>Suit Therapy</td>
</tr>
<tr>
<td>2011-F</td>
<td>Ovarian Adnexal Mass Assessment Score Test System</td>
</tr>
<tr>
<td>2012-B</td>
<td>Bronchial Thermoplasty for Treatment of Severe Asthma</td>
</tr>
<tr>
<td>2013-B</td>
<td>Bulking Agents for Fecal Incontinence - Solesta</td>
</tr>
<tr>
<td>2014-A</td>
<td>Nonsurgical Treatment of Obstructive Sleep Apnea - Oral Pressure Therapy</td>
</tr>
<tr>
<td>201503-IQ</td>
<td>Subcutaneous Implantable Cardioverter Defibrillator (SICD)</td>
</tr>
<tr>
<td>201506</td>
<td>Drug Testing</td>
</tr>
<tr>
<td>201520-IQ</td>
<td>Fetal Biophysical Profile</td>
</tr>
<tr>
<td>201525</td>
<td>Thermal Intradiscal Procedures for Chronic Low Back</td>
</tr>
<tr>
<td>201526</td>
<td>Low Level Laser (Light) Therapy</td>
</tr>
<tr>
<td>201527</td>
<td>Electrothermal Therapy</td>
</tr>
<tr>
<td>201530</td>
<td>Breath Testing for Detection of Heart Transplant Rejection (Heartsbreath)</td>
</tr>
<tr>
<td>201531</td>
<td>Salivary Hormone Testing</td>
</tr>
<tr>
<td>201532</td>
<td>Gait Analysis</td>
</tr>
<tr>
<td>201533</td>
<td>Disc Decompression Procedures</td>
</tr>
<tr>
<td>201535</td>
<td>AmniSure® ROM (Rupture of Membrane) Test</td>
</tr>
<tr>
<td>2015-A</td>
<td>Prostatic Urethral Lift</td>
</tr>
<tr>
<td>2015-B</td>
<td>Sacroiliac Joint Fusion (iFuse System)</td>
</tr>
<tr>
<td>2015-C</td>
<td>Computer-Aided Detection of Breast MRI</td>
</tr>
</tbody>
</table>
Medical Mutual to Expand CMS Multiple Procedure Payment Reduction Processing

Medical Mutual uses the Centers for Medicare & Medicaid Services (CMS) Relative Value File for multiple procedure payment reduction.

For dates of service on or after February 1, 2016, Medical Mutual will expand its current CMS Multiple Procedure Payment Reduction processing to include the following values found on the CMS Physician Relative Value file:

- 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.

The content of this article is effective as described above, but will be reflected in the fourth quarter 2015, Provider Manual.

Updates to Provider Manual

Designated sections of Medical Mutual’s Provider Manual are scheduled for review each quarter and updated as needed. Sections that have been reviewed are announced in the corresponding quarterly issue of Mutual News. When topics are added or updated within a section, an annotation of New or Revised appears next to the topics in the section’s Table of Contents.

During fourth quarter 2015, the following sections of the Provider Manual were reviewed: Introduction, Claims Submission, Care Management, Forms and Publications, and Plan Guidelines. To view the current updates, visit Provider.MedMutual.com and select Tools & Resources, Provider Manual.
Help Your Patients Stay on Track with Their Important Well-Woman Screenings

Changes over the past several years in the recommended frequency of well-woman screenings have led to patient uncertainty and confusion about when and what types of screenings women need to receive.

The U.S. Preventive Services Task Force recommends:

- A Pap test every three years for women ages 21 to 65 or a Pap test with HPV screening every five years for women ages 30 to 65
- A screening mammography for women, with or without clinical breast examination, every two years for women ages 50 to 74

The American College of Obstetricians and Gynecologists (ACOG) continues to recommend an annual well-woman visit that may include screenings as needed, immunizations, discussion of relevant health topics and counseling.

In addition, both ACOG and the American Academy of Family Physicians (AAFP) agree that a pelvic exam or screening for cervical cancer is not needed to safely prescribe oral contraceptive medications.

Medical Mutual recently sent letters to remind members who are due for mammograms and/or cervical cancer screenings. You may also need to work with your female patients during their annual well-woman visits to determine if and when screenings are needed.

These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.

3-D Mammography Not a Covered Benefit for Screening Services

Medical Mutual does not reimburse for Digital Breast Tomosynthesis (DBT) or 3-D mammography for screening services. Claims received for DBT for breast cancer screening (CPT code* 77063) will deny as not medically necessary. DBT may be considered medically necessary when utilized for diagnostic imaging of a suspected lesion.

In April 2015, the U.S. Preventive Services Task Force (USPSTF) released a Draft Recommendation Statement indicating a lack of adequate evidence on the use of DBT for breast cancer screening. The recommendations point to a lack of studies that look at clinical outcomes associated with DBT, including mortality and quality of life. USPSTF also notes that DBT appears to expose women to approximately twice the radiation of 2-D digital mammography.

To view the full medical policy, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies, Digital Breast Tomosynthesis for Breast Cancer Screening.

*CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
Medical Mutual Re-Entering Medicare Advantage in 2016

Medical Mutual is re-entering the Medicare Advantage market effective January 1, 2016. Medical Mutual’s Medicare Advantage (MedAdvantage) plans include various options that may offer extras such as wellness, dental, vision and SilverSneakers:

- MedAdvantage Classic and Choice HMOs
  - 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 the Medicare Advantage Network.

- MedAdvantage Select, Preferred and Premium PPOs
  - Members can access services from non-Medicare Advantage Network providers.
  - Payment for services provided by a non-Medicare Advantage Network provider is reduced in accordance with the member’s policy.

To be a participating provider in the network and receive payment directly at the highest level of benefits, you will need to have a current Medicare Advantage Addendum with us. Please contact the appropriate Provider Contracting office if you are interested in joining this network.

Medicare Advantage Section of Provider Manual and Medicare Advantage Fee Schedule Available Online


Welcome to Medicare and Annual Wellness Visits

Medicare Advantage members are entitled to receive a Welcome to Medicare Visit within the first 12 months of Medicare Part B coverage for a $0 copayment. Only one initial visit is eligible per lifetime and should not be coded as a physical exam. All Medicare Advantage members are eligible for an Annual Wellness Visit (AWV) as long as they have been Medicare beneficiaries for at least 12 months.

AWVs can be conducted once per year.

Article continued on next page.
Only the following CPT codes* are included in the $0 copayment for wellness visits. If other services are billed with the visit, and those services are normally subject to a copayment or coinsurance, that copayment or coinsurance will still apply even if the primary reason was a wellness visit.

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Medicare</td>
<td>G0402</td>
<td>Initial preventive physical examination; face-to-face visit, services limited to a new patient during the first 12 months of Medicare enrollment.</td>
</tr>
<tr>
<td>AWV First Visit</td>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.</td>
</tr>
<tr>
<td>AWV Subsequent Visit</td>
<td>G0439</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit.</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>99495</td>
<td>Communication (direct contact, telephone, electronic) with a patient and/or caregiver within two business days of discharge from hospital, SNF or CMHC stay, observation or partial hospitalization; medical decision-making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge.</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>99496</td>
<td>Communication (direct contact, telephone, electronic) with a patient and/or caregiver within two business days of discharge from hospital, SNF or CMHC stay, observation or partial hospitalization; medical decision-making of high complexity during the service period; face-to-face visit within seven calendar days of discharge.</td>
</tr>
<tr>
<td>Chronic Care Management</td>
<td>99490</td>
<td>Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements: (a) multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; (b) chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline; and (c) comprehensive care plan established, implemented, revised or monitored.</td>
</tr>
</tbody>
</table>

* CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
Medical Mutual conducts random provider audits to ensure all required elements of the AWV are documented in the medical record.

All codes are subject to change. Please review coding prior to claims submission at CMS.gov. Please remember to contact Medical Mutual’s Customer Care to confirm benefits.

**MedMutual Advantage Member ID Cards**

Distinctive ID cards make identifying members participating in a Medical Mutual Medicare Advantage plan simple. Please review the below ID card images. The MedAdvantage logo appearing in the top right corner of the ID card’s front panel identifies the member as a Medicare Advantage participant.

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**Member Copayments**

- Preventive Office Visit: $0
- Urgent Care: $0
- Emergency Room: $0
- PCP Office Visit: $0
- Specialist: $0

---

**For Providers**

- Information: Provider.MedMutual.com
- Medical: (800) 362-1279
- Dental: (877) 823-3682
- Vision: (877) 226-1115
- Prior Approval: (855) 887-2275
- Claims submission: P.O. Box 6018
  Cleveland, OH 44101-1018
- Electronic payer ID: 29076

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**For Pharmacists**

- Rx Bin: 003858
- Rx Group: MMOMDRX
- Rx PCN: MD
- Rx Helpline: (800) 922-1557

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**Possession of this card does not guarantee coverage.**

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**Medical Mutual Advantage Select PPO**

**John W Smith**

Member Name: 001234567890

ID Number: (800) 982-3117

Rx Member Service: 711

TTY: (844) 404-7947

MedMutual.com/Medicare

**Member Copayments**

- Preventive Office Visit: $0
- Urgent Care: $0
- Emergency Room: $0
- PCP Office Visit: $0
- Specialist: $0

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**Medical Mutual Advantage HMO Plan**

**John W Smith**

Member Name: 001234567890

ID Number: (800) 982-3117

Rx Member Service: 711

TTY: (844) 404-7947

MedMutual.com/Medicare

**Member Copayments**

- Preventive Office Visit: $0
- Urgent Care: $0
- Emergency Room: $0
- PCP Office Visit: $0
- Specialist: $0

---

**For Providers**

- Information: Provider.MedMutual.com
- Medical: (800) 362-1279
- Dental: (877) 823-3682
- Vision: (877) 226-1115
- Prior Approval: (855) 887-2275
- Claims submission: P.O. Box 6018
  Cleveland, OH 44101-1018
- Electronic payer ID: 29076

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**For Pharmacists**

- Rx Bin: 003858
- Rx Group: MMOMDRX
- Rx PCN: MD
- Rx Helpline: (800) 922-1557

---

**Possession of this card does not guarantee coverage.**