MEDICAL MUTUAL®

MUTUAL NEWS

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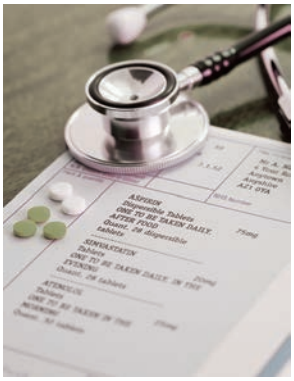
Drugs Added to Medical Mutual's Step Therapy Program



Effective July 1, 2015, additional drugs will require step therapy for Medical Mutual members whose pharmacy benefit manager is Express Scripts, Inc. (ESI).

Please note, members who previously have been prescribed a drug that will now require step therapy will be required to follow all coverage management rules related to the step therapy program unless otherwise indicated.

A letter has been sent to Medical Mutual members who have filled a prescription within the past 180 days for one or more of the medications affected by this change. The letter explains the change and what the member must do to have their medication covered.

Medical Mutual's coverage management programs, such as prior approval and step therapy, help ensure brand-name drugs are prescribed according to evidence-based outcomes and sound medical practices. Frequently, there are no clear clinical differences between these drugs and other preferred medications.

If special circumstances exist for a Medical Mutual member, request a coverage review by calling ESI at (800) 753-2851 or logging on to ESI's online prior authorization portal for providers, ExpressPath, at https://Provider.Express-Path.com/.

To learn more about the coverage management program and the coverage review process, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management.

Please see the next page for a list of drugs added to the step therapy program.

Provider Manual Updates

Designated sections of Medical Mutual's Provider Manual are scheduled for review each quarter and updated as needed. 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.

You can visit Provider.MedMutual.com and select Tools & Resources, Provider Manual to view the latest updates.

Additions to the step therapy program as of July 1, 2015, include:

Drug Classification – Step Therapy Program	Plan-Preferred First Line	Second Line
Androgens	Androgel, Axiron	Fortesta, Striant, Testim, Testosterone 1% Gel, Testosterone 2% Gel, Vogelxo
Angiotensin receptor blockers	Azor, Benicar, Benicar HCT, candesartan, candesartan/HCTZ, eprosartan, Exforge HCT, irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, telmisartan, telmisartan/amlodipine, telmisartan/HCTZ, Tribenzor, valsartan, valsartan/amlodipine, valsartan/HCTZ	Atacand, Atacand HCT, Avalide, Avapro, Cozaar, Diovan, Diovan HCT, Edarbi, Edarbyclor, Exforge, Hyzaar, Micardis, Micardis HCT, Teveten, Teveten HCT, Twynsta
Antidepressants[1]	bupropion, buspirone, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, venlafaxine	Aplenzin, Brintellix, Brisdelle Budeprion SR, Budeprion XL, Celexa, Cymbalta, Desvenlafaxine extended-release tablets (brand product), Desvenlafaxine fumarate extended-release tablets (brand product), Effexor XR, Fetzima, Fluoxetine 60mg tablets (brand product), Forfivo XL, Khedezla, Lexapro, Luvox CR, Paxil, Paxil CR, Pexeva, Pristiq ER, Prozac, Prozac Weekly, Remeron, Savella, Sarafem, Venlafaxine extended-release tablets (brand product), Viibryd, Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zoloft
Bisphosphonates (oral)[1]	alendronate, ibandronate, risedronate	Actonel, Atelvia, Binosto, Boniva, Fosamax, Fosamax Plus D
Diabetic test strips[2]	ABBOTT products, LIFESCAN products	BAYER products, NIPRO products, ROCHE products
DPP-4 inhibitors (oral)	Janumet/Janumet XR, Januvia, Kombyglyze XR, Onglyza	Jentadueto, Kazano, Nesina, Tradjenta
Epinephrine auto-injectors	Epipen, Epipen Jr.	Auvi-Q
Erectile dysfunction[3]	Cialis, Viagra	Levitra, Staxyn, Stendra
Erythroid stimulants[1]	Procrit	Aranesp, Epogen
Hepatitis C[1]	Pegasys	Peg-Intron
Infertility — follitropins[1, 4]	Gonal-F, Gonal-F RFF	Bravelle, Follistim AQ
Infertility — GnRH antagonists[1, 4]	Ganirelix	Cetrotide
Inhaled beta2-agonists (short-acting)	Proair HFA, Ventolin HFA	Maxair Autohaler, Proventil HFA, Xopenex HFA
Injectable non-insulin GLP-1 agonists	Bydureon, Byetta	Tanzeum, Trulicity, Victoza
Insulin	Humulin N, Humulin R, Humulin 70/30	Novolin N, Novolin R, Novolin 70/30
Insulin (rapid-acting)	Humalog all strengths and vials, pens and KwikPens	Apidra vials, Apidra SoloStar prefilled pen, NovoLog all strengths and vials, PenFill cartridges, FlexPens
Long-acting opioids	hydromorphone extended-release, morphine sulfate controlled-release tablets, morphine sulfate extended-release capsules (generics to Kadian, Avinza), Nucynta ER, oxymorphone extended-release tablets, Opana ER, OxyContin	Avinza, Embeda, Exalgo, Kadian, MS Contin, Oramorph SR, oxycodone extended-release tablets (brand products), Zohydro ER
Multiple sclerosis — injectables[1]	Avonex, Copaxone, Extavia, Plegridy, Rebif	Betaseron
Ophthalmic prostaglandins	Latanoprost, Lumigan, Travatan Z, Travoprost	Rescula, Xalatan, Zioptan
Otic antibiotics	Ciprodex, ciprofloxacin otic solution	Cetraxal
Pancreatic enzymes	Creon, Pancrelipase, Zenpep	Pancreaze, Pertzye, Ultresa
Triptans[1]	naratriptan, rizatriptan, sumatriptan, zolmitriptan	Alsuma, Amerge, Axert, Frova, Imitrex, Maxalt, Maxalt MLT, Relpax, Sumavel, Treximet, Zomig, Zomit-ZMT

1 Covered members currently taking these medications will not be required to fulfill step therapy requirements. Authorizations will be automatically placed to allow for uninterrupted therapy.

2 Certain diabetes testing supplies are available at no cost to members who actively participate in Medical Mutual's Disease Management Program for diabetes, if the group offers this program.

3 Quantity limits also apply.

4 Coverage of fertility drugs varies by plan.

Coverage of New Oral Hepatitis C Medications

In the past several months, the landscape of hepatitis C therapies has changed dramatically. New, all-oral treatment regimens have entered the market with significant media attention. These new therapies include AbbVie's Viekira Pak and Gilead's Harvoni. These drugs join Sovaldi and Olysio, which were approved by the U.S. Food and Drug Administration (FDA) in late 2013. Both of these newer agents offer cure rates greater than 95 percent and eliminate the need for injectable peginterferon.

While Viekira Pak and Harvoni offer an important treatment option, they entered the market bearing unprecedented costs, carrying a price tag greater than $80,000 for a typical 12-week course of therapy. After a thorough review of the currently available oral therapies, Medical Mutual has developed step therapy criteria while updating our prior authorization criteria for these agents. The criteria are intended to ensure these high-cost therapies are used appropriately while saving our members money. The following changes are effective immediately.

Step Therapy

Viekira Pak is the preferred product for hepatitis C, genotype 1 and genotype 4 (chronic HCV only). Viekira Pak does not require step therapy for these indications and is covered first line as long as the Viekira Pak prior authorization criteria are met.

Harvoni, Sovaldi and Olysio are non-preferred for hepatitis C, genotype 1 and genotype 4 (chronic HCV only). Patients must first try the preferred brand product(s). Exceptions may be granted if the patient has certain documented contraindications, adverse reactions or potential drug interactions.

Preference Hierarchy for Hepatitis C, Genotypes 1 & 4 (chronic HCV only)

Status	Order of Preference	Drug Name	Step Requirement
Preferred	First Line	Viekira Pak	No Step Requirement
Non-Preferred	Second Line	Harvoni	Step Requirement
Non-Preferred	Third Line	Sovaldi, Olysio	Step Requirement

Please note these step therapy requirements are independent of the prior authorization requirements. All four of these drugs still require prior authorization as they have in the past.

Prior Authorization

The prior authorization criteria for Viekira Pak and Harvoni (chronic hepatitis C, genotype 1) have been updated. Treatment is no longer prioritized based on liver disease staging, risk of transmission or severe extrahepatic complications.

Patients must continue to meet certain other criteria including:

- Be at least 18 years old
- Be prescribed the drug by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician or a liver transplant physician affiliated with a liver transplant center
- Use the drug for the appropriate duration of therapy according to the labeling approved by the FDA

Criteria for coverage in patients with chronic hepatitis C, genotype 4 have also been added where applicable based on guidelines from the American Association for the Study of Liver Diseases and the Infectious Disease Society of America.

Medical Mutual's prior authorization and step therapy policies are regularly reviewed and updated. They are subject to change as new information, guidelines and other clinical data become available.

For more information, including updated versions of our prior approval policies, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Rx Management.

Prior Approval Update for Drugs Under the Medical Benefit

Effective April 30, 2015, the following prescription medications require prior approval when requested under the member's medical benefit through Medical Mutual:*

- Cosentyx (secukinumab)
- Firazyr (icatibant)
- Ruconest (recombinant c1 esterase inhibitor)
- Mircera (methoxy polyethylene glycol-epoetin beta)
- Plegridy (interferon beta-1a)

Effective July 30, 2015, the following prescription medications will require prior approval when requested under the member's medical benefit through Medical Mutual:*

- Adcetris (brentuximab vedotin)
- Sandostatin (octreotide acetate)
- Zaltrap (ziv-aflibercept)

These lists are subject to change. For more information on prescription medications requiring prior approval or that are considered investigational, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies, Prior Approval & Investigational Services.

*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.

Correction

The Q1 2015 Mutual News article Prescription Drug Prior Approval Update incorrectly identified ado-trastuzumab as generic Perjeta. The article should have stated pertuzumab (Perjeta) requires prior approval when requested under the member's medical benefit through Medical Mutual as of January 31, 2015. Please note ado-trastuzumab (Kadcyla) also requires prior approval.

National Drug Codes Must Be Included on Claims for Medications Requiring Prior Approval

National Drug Code (NDC) identifiers must be included for select medications on professional and outpatient claims.

Starting July 1, 2015, claims submitted to Medical Mutual without appropriate Healthcare Common Procedure Coding System (HCPCS) codes and NDC identifiers for medications that require prior approval will be denied and returned to the provider. NDC identifiers must include the 11-digit drug code, quantity of medication dispensed and unit of measure.

In order to prevent payment delays, include HCPCS codes and NDC identifiers on the claim when billing specialty medications under the medical benefit. To be processed for payment, claims rejected for missing NDC identifiers will need to be submitted as new claims with the correct NDC identifier.

A list of medications that require prior approval is available by visiting Provider.MedMutual.com and selecting Tools & Resources, Care Management, Corporate Medical Policies, Prior Approval & Investigational Services.

For a list of HCPCS codes that require NDC identifiers, and for information on where to submit codes on the CMS-1500 and UB-04 form, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Medical Drug Management.

FDA Recommendations Regarding the Use of Laparoscopic Power Morcellators

In 2014, the FDA issued a warning about the potential for spreading cancerous tissue when using laparoscopic power morcellators during hysterectomies and myomectomies.

Medical Mutual continues to cover the use of laparoscopic power morcellators according to the member's benefits. However, providers should review current FDA recommendations before advising patients regarding optimal treatment approaches. The FDA recommendations are available by visiting FDA.gov and selecting Medical Devices, Medical Device Safety, Safety Communications, UPDATED Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Safety Communication (11/24/14).

More information is available by visiting Provider.MedMutual.com and selecting In the News.

Employer Groups May Elect Coverage Maximum* for Specific Lab Services Starting in 2016

Employer groups may elect to move to a defined benefit for specific lab services for plan years beginning January 1, 2016. This means that some services will only be covered up to a coverage maximum—the reference price—for patients who are members of groups that elect the coverage maximum defined benefit.

Providers are encouraged to review the coverage maximum fee schedule to determine if their reimbursements are within the coverage maximum. While participating members will have continued network access to all network providers, this may influence where they choose to receive services.

- If a provider's contracted rate with Medical Mutual is below the coverage maximum for a specific service, reimbursement will be the lesser of the contractual reimbursement or coverage maximum.
  - The patient will not incur additional cost share or financial liability beyond their normal benefit plan out-of-pocket responsibility (e.g., network deductibles and coinsurance payments).
- If a provider's contracted rate is above the coverage maximum, reimbursement will be capped at the coverage maximum less any benefit cost-sharing owed by the patient.
  - The patient will pay the difference between the coverage maximum and the provider's contractual reimbursement amount.

Lab services rendered in an emergency setting or inpatient hospital/facility, and those resulting from outpatient procedures, will not be subject to the coverage maximum.

More than ever, our customers are looking to implement cost savings initiatives that provide Medical Mutual members the quality care they need in the right setting at the right price. We are committed to working with providers to deliver both high-quality care and value to our members.

For more information and to view the coverage maximum fee schedule, visit Provider.MedMutual.com and select Tools & Resources, Provider eServices, ePortal Resources. You must be logged into the secure Provider ePortal to view the coverage maximum fee schedule.

*Previously referred to as reference-based pricing.

Public Exchange Members Get Nurse Line

Beginning in July 2015, Medical Mutual members who purchased their health plan on the Health Insurance Marketplace, also known as the public exchange, will have access to Nurse Line, a confidential email and telephone health service.

Through Nurse Line, registered nurses are available to answer members' healthcare questions and give guidance any time, day or night. When a member calls or emails, they get immediate support for health issues and questions that might otherwise lead to unnecessary visits to the emergency room.

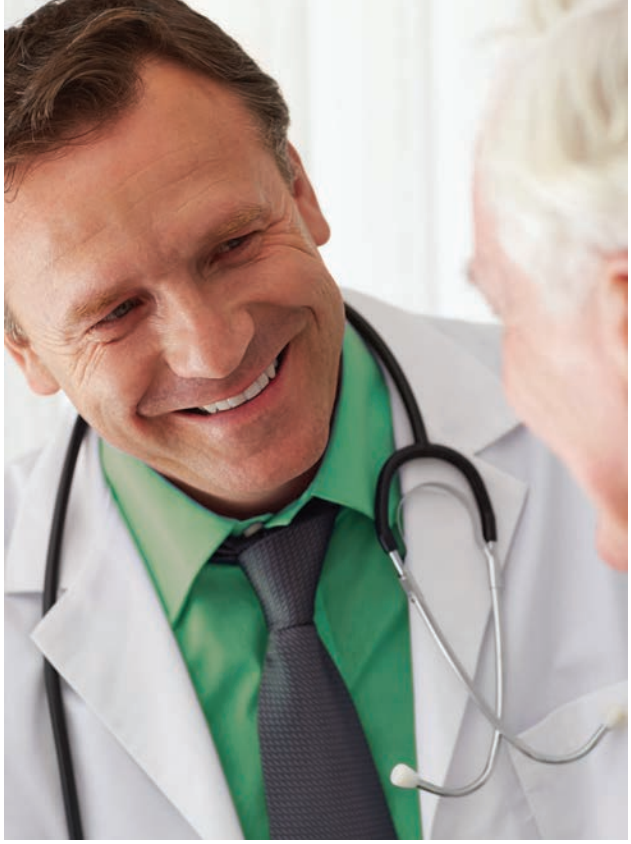
Members with access to the service will receive a new member identification (ID) card with the toll-free 24/7 Nurse Line phone number, (888) 912-0636, appearing on the front.

ID Cards Now Identify Public Exchange Members

The new ID cards will also feature an indicator that the member signed up for their health plan on the public exchange. This indicator will be the letters EXCH, located on the back side of the card, in the upper right hand corner.

Front

Back



State Innovation Model Performance Reports Distributed

In March 2015, Medical Mutual informed providers and healthcare systems which qualified that they would receive a performance report related to the Ohio State Innovation Model (SIM) initiative.

Medical Mutual previously shared information about the SIM initiative's goal to improve overall health system performance by paying providers and health systems for value rather than volume (for more information, see the Mutual News, Volume 7, Issue 4 [4th Quarter 2014] article State Innovation Model Performance Reports Delayed Until 2015). The state plans to achieve its goal through statewide expansion of patient-centered medical homes and episode-based, or bundled, payment and care delivery.

The episodes of care chosen by Medical Mutual for the initial rollout of the SIM initiative include: percutaneous coronary intervention (PCI); perinatal; and total joint replacement (hip and knee). Providers and systems qualified to receive the initial performance reports based on the number of valid episodes attributed to them for Medical Mutual's members.

Those who qualified received instructions on how to obtain their report(s), which allow recipients to monitor their performance compared to other providers and make improvements.

Qualified recipients will receive notifications throughout 2015, informing them that additional episode-of-care reports are available.

For more information, visit Provider.MedMutual.com and select Tools & Resources, Healthcare Reform Information.

Medical Mutual Re-Entering Medicare Advantage in 2016

Having made a significant corporate investment, Medical Mutual is re-entering the Medicare Advantage market effective January 1, 2016. We are dedicated to serving this population and pleased with the opportunity to provide benefits to this market.

We will be offering plans through our contracted Medicare Advantage PPO and HMO networks. To be a participating provider in these networks and receive payment directly at the highest level of benefits, you will need to have executed a current Medicare Advantage Addendum with us. If you would like to be included in our aggressively expanding Medicare Advantage Network, please contact the appropriate regional Provider Contracting office.

In addition, Medical Mutual is interested in further collaborating with its contracted Medicare Advantage providers to promote and educate prospective members about its Medicare plans, products and services in accordance with CMS guidelines. Please contact your regional Provider Contracting office if your health system, facility or provider practice is interested in joining Medical Mutual in these opportunities.

If you need assistance determining which regional office to contact, please visit Provider.MedMutual.com, Contact Us and reference the Provider Contracting regional office map.

Care Coordination and Documentation Missing Between Behavioral Health Providers and PCPs

Results of a recent Medical Mutual study indicate summary communication between behavioral health practitioners and primary care physicians (PCPs) often does not occur or is not documented in the patient's medical record. In fact, the study showed this is the case following 70 percent of initial patient visits to a behavioral health practitioner. And, in instances where summary communication is documented, it is often incomplete or does not include pertinent information.

The study evaluated the frequency and quality of summary communications from behavioral health practitioners to PCPs by examining a sample of medical records for members who completed an initial visit to a behavioral health practitioner in 2014. The results are summarized in the table below.

Measure	2014
Documentation of Summary Communication Present	28.75%
Summary Communication Occurred Within 30 Days	65.21%
Summary Communication Includes:	
Treatment Plan	73.91%
Test Results (When Applicable)	37.50%
Detailed Plan for Follow-up	69.76%

Collaboration between behavioral health practitioners and PCPs can improve follow-up care and promote compliance with the prescribed treatment plan. Comprehensive summary communications between providers are essential to successful collaboration and can be accomplished through various avenues, including a phone call, email or letter. Regardless of the form, it is crucial that communications are documented in the medical record.

Medical Mutual recognizes that a major barrier to summary communications is the need for a release of information from the member. Some members may be reluctant to share their information, but this can be an opportunity to educate them about the importance and benefits of open communication between providers.

To download or request copies of the Patient Summary Behavioral Health Communication Form, which includes an area to record signed patient consent for communication, visit Provider.MedMutual.com and select Tools & Resources, Forms, Clinical Supply Form, Behavioral Health.

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed or revised between January 1 and March 31, 2015, are outlined in the chart below.

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.

Policy Number	Title
200204-IQ	Transplantation, Cardiac
200218	Carpal Tunnel, Tendon Sheath or Ligament, Tendon and Trigger Point Injection
200233	Skin Substitutes
200408	Radiofrequency Thermal Ablation for Chronic Spinal Pain
200416	Uterine Artery Embolization — Uterine Fibroids
200509	Rhinoplasty
200606	Radiofrequency Ablation — Trigeminal Neuralgia
200608-IQ	Proton Beam Radiotherapy (PBRT)
200614	Gene Expression Assays for Management of Breast Cancer
200703-IQ	Cardiac Computed Tomography and Angiography of the Coronary Arteries
200801	Smooth Pursuit Neck Torsion Testing
2009-H	Transcranial Magnetic Stimulation
201007	Light Therapies for Treatment of Vitiligo
201010	Repository Corticotropin Injection (H.P. Acthar Gel)
2011-B	Bioimpedance Spectroscopy
201102	Pancreatic Islet Cell Transplantation
201103	Orthoptic Therapy
2012-B	Bronchial Thermoplasty for Treatment of Severe Asthma

Policy Number	Title
201302	Transcatheter Aortic Valve Replacement
201308	Chromosomal Microarray Analysis
201309	Implantable Microscopic Telescope (IMT)
201318	Percutaneous Tibial Nerve Stimulation
2014-A	Non-Surgical Treatment of Obstructive Sleep Apnea: Oral Pressure Therapy
201402	Bone Growth Stimulation (invasive and semi-invasive)
201430-CC	Keytruda (pembrolizumab)
201501	Real-Time Intra-Fraction Target Tracking Systems *New*
201502	Lemtrada (alemtuzumab) *New*
201504	Vectra DA Blood Test *New*
201505-CC	Perjeta (pertuzumab) *New*
201507	Compounded Drugs *New*
94002	Breast Reconstruction and Related Procedures
94007	Evaluation of Vestibular Disorders — Vestibular Function Test — Computerized Dynamic Posturography — Vestibular Autorotation
94056-IQ	Treatment of Varicose Veins of the Lower Extremities
94057	Light Therapy for Dermatological Conditions — Phototherapy — Photochemotherapy — Laser Therapy

Quick Tips: Documentation and Coding for Risk Adjustment

The following documentation and coding tips can help ensure accurate medical coding and billing compliance for U.S. Department of Health and Human Services risk adjustment. The tips are based on Official ICD-9-CM Guidelines for coding and reporting as well as Centers for Medicare & Medicaid Services (CMS) requirements. Coding to the highest specificity for services provided not only reflects the severity of the population that is being treated, but also justifies the claim submitted and the medical necessity of the visit. When documenting and coding, keep the following tips in mind:

Be specific.

- Diagnosis codes provide justification for the services and procedures billed. The more precise the documented diagnosis is, the better medical necessity will be supported.
- CMS does not recognize probable, suspected, ruled out, working or questionable diagnosis codes in outpatient records. If there is not an established definitive diagnosis, code the signs and symptoms with which the patient is presenting.

Use only standard abbreviations.

Do not document "history of" for diseases that the patient currently has.

- Use terms such as "controlled," "asymptomatic" or "managed" to describe an existing condition (for example, CHF controlled on beta blocker).

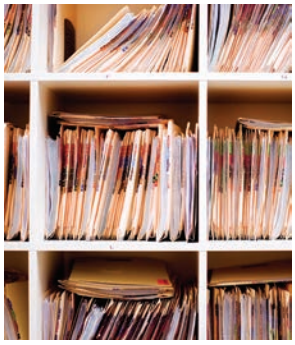
Include a legible signature with credential.

Include all conditions related to health status.

- Show causal relationships by using statements such as "due to," "because of" or "related to."
- Always document and report comorbidities that affect the treatment of the primary diagnosis that you are reporting.
- Evaluate chronic conditions at least annually. Document the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment (M.E.A.T.) for each of the patient's acute and chronic conditions.
- Frequently overlooked conditions/status factors when documenting include transplant status, quadriplegia, dialysis status, current ostomies, amputations and HIV status.

Authenticate the electronic health record (i.e., ensure it is electronically signed).

Quick Tips: Understanding the Difference between Revenue Codes 0250 and 0636



To avoid possible payment delays when billing hospital outpatient claims for medications billed under revenue codes (RCs) 0250 and 0636, please consider the tips on this and the following page.

Revenue Code 0250

RC 0250 is used to report take-home drugs given to an inpatient to permit or facilitate the patient's discharge from the hospital. The drugs, which are covered as inpatient services, must be medically necessary and given in limited supply (i.e., enough supply to last until the patient can obtain a supply of their own).

Please be sure to include a HCPCS code and the appropriate NDC identifiers when billing for RC 0250.

Examples of over-the-counter medications that may be billed with RC 0250 include Tylenol, aspirin, vitamin supplements and non-injectable prescription drugs.

Outpatient chemotherapy drug codes J8520-J9600 and certain Q codes and C codes should not be reported under the pharmacy RC 0250. Report these medications and their respective HCPCS codes under RC 0636, which is used for drugs requiring detailed coding. Claims for immunosuppressants, oral anticancer, oral antiemetics and inhalation drugs should also use RC 0636.

Article continues on next page

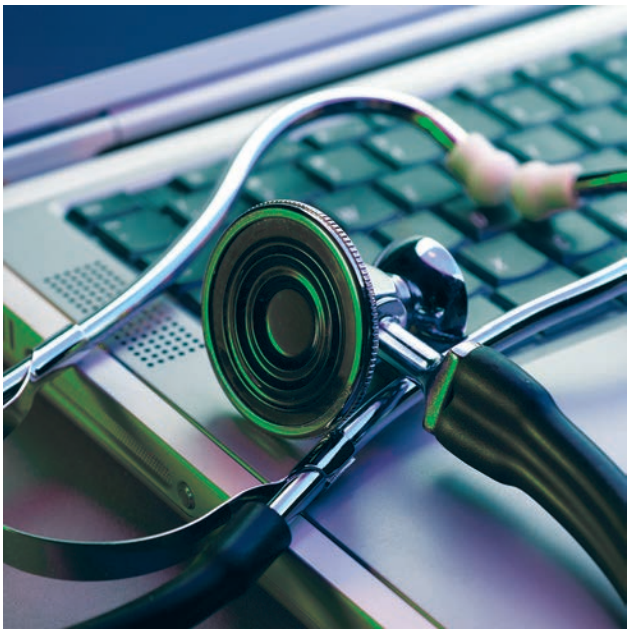
Continued from previous page

Revenue Code 0636

RC 0636 is used to report charges for drugs and biologics (except radiopharmaceuticals, which may be reported under RC 0343 or 0344) requiring detailed coding (i.e., HCPCS code). HCPCS codes are required for services billed under RC 0636. Please also include the appropriate NDC identifiers and be sure that the correct number of units administered to the patient is billed on the claim.

Examples of medications that must be billed under RC 0636 include oral and intravenously infused chemotherapy medications that are administered to outpatients, immunosuppressants, biologicals and hemophilia clotting factors. Skin substitutes, such as Apligraf, are also required to be billed under RC 0636 with the correct HCPCS code and the amount used.

Please be sure to check if the medication being administered requires prior approval. Skin grafts may require prior approval or may be considered investigational. For more information on prescription medications requiring prior approval or for services considered investigational, visit Provider.MedMutual.com and select Tools & Resources, Care Management, Corporate Medical Policies.



Source: Optum. (2014, August). Uniform Billing Editor: The ultimate guide to accurate facility claim submission.

Clinical Practice Guidelines

Medical Mutual is committed to partnering with our network providers to provide 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.

Clinical practice guidelines that can be accessed on our website include:

- Alcohol Screening
- Asthma
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Cholesterol
- Continuity and Coordination of Care
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Depression *(Behavioral Health & Primary Care Providers)*
- Diabetes
- Heart Failure
- Hypertension
- Musculoskeletal and Chronic Pain
- Preventive Care
- Tobacco Dependence

Chrysler Group, LLC Renamed FCA US, LLC

Chrysler Group, LLC has been renamed. It is now FCA US, LLC. Medical Mutual members with insurance through FCA US, LLC who do not yet have a member identification (ID) card with the FCA name located at the top right corner of the card will receive a new card with an issue date of June 2015. Please update patient records and materials to reflect this change. For more information, call (800) 892-6200.

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MUTUAL NEWS

In This Issue

This material is considered part of the Provider Manual for Medical Mutual of Ohio and its subsidiaries | Mutual News is published for network providers serving Medical Mutual
To contact us or for more information, visit Provider.MedMutual.com