



March 26, 2007

**IMPORTANT UPDATE REGARDING
PRIOR AUTHORIZATION REQUIREMENTS
EFFECTIVE APRIL 23, 2007**

Re: Prior Authorization Requests

Dear Provider:

In an effort to improve service, Mercy Care Plan (MCP), Mercy Healthcare Group (MHG) and Mercy Care Advantage (MCA) have redesigned its Prior authorization (PA) process. The new PA process will become almost exclusively telephonic or Web site submittals.

Beginning April 23, 2007, MCP/MCA/MHG will only accept faxed PA requests for:

- Total OB authorization
- Family Planning requests
- DME
- Orthotics and Prosthetics
- Dialysis
- Gastric Bypass
- Transplants
- Or, any other documentation that may be requested by MCP/MCA/MHG PA clinical staff to make a coverage determination

All other requests for PA must be phoned in or submitted through the Web site. To register for a secure login, go to www.mercycareplan.com. Using the MCP/MCA/MHG Web site you will be able to:

- Verify member eligibility
- Find a participating doctor or specialist
- Submit prior authorizations
- Look up claims status

If you choose to use the telephonic process beginning April 23, 2007, you will need to call our Prior Authorization department at (602) 263-3000 or (800) 624-3879 (listen for the PA prompt) to request a prior authorization. Please note that all urgent requests will only be accepted over the PA phone line. The telephonic process and use of Web site PA requests facilitate a more rapid determination for you and your patient.

To help expedite the processing of your authorization, please have the following information available when you call:

- Member Name
- Member ID number



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- CPT Code/HCPC Code of the intended service(s)
 - ICD9 code(s)
 - Referring Physician
 - Facility Name or Place of Service
 - Date of Service (if applicable)
 - Pertinent information to support request for service. MCP/MCA/MHG utilizes Milliman Care Guidelines to determine medical necessity. Your office should be prepared to respond to any relevant questions regarding the response to the success or failure of prior treatment. In addition, the PA staff may request physical findings supporting need for the service, outcome of prior treatment (success or failure), and results of any prior diagnostic procedures or consultations. For example, a request for shoulder MRI would need abnormal findings of shoulder exam, outcome of conservative treatment (NSAID, PT, shoulder injections, x-ray)

Please remember the PA staff can not process your request if you do not have the necessary information at the time of the phone request; the Web site will prompt you for the required information as well. If medical necessity cannot be documented at the time of your phone call or Web site request, it will be electronically forwarded to a medical director for determination. The medical director will make a determination within 24 hours of your phone or Web site request. If the medical director makes an adverse determination (denies your request), you may request a peer to peer phone conversation with the medical director by calling and asking to speak with that medical director. These peer to peer conversations should occur within 3 days of the adverse determination. After that period you may submit a written appeal of the adverse determination as outlined in the letter of denial that you and your patient will receive.

For a peer to peer review, please call 602-798-2507.

While this process may be new for your MCP/MCA/MHG membership it is not substantially different than other payors in the Arizona market. We are confident that you and your office staff will welcome this one call telephonic or use of the Web site PA process. If you have any questions or concerns, please do not hesitate to contact your provider services representative.

Sincerely,

R Sanchez, MD

Chief Medical Officer