



Provider Newsletter

January—March 2011

2010 Benefit Updates

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As a reminder, finalized benefits went into effect on October 1, 2010 by AHCCCS. Primarily, the benefit changes affect members greater than 21 years of age and address specific types of services.

Mercy Care has experienced issues with regard to the copay set-up for TWG and TMG members. Claims are no longer being held for this reason. The following information regarding copays is important to note:

When Claims Were Released:

The copay information will not be included on the remit.

All applicable interest will be paid on each claim.

The provider is still entitled to collect applicable copays, as they normally would.

When The System is Corrected:

Applicable copays will be reflected on the provider's remits.

Mercy Care will not adjust claims on a retrospective basis for recoupment after the system has been corrected.

Copay information will be automatically applied to claims processed on a go forward basis from the date the system is corrected. This also applies to resubmissions/adjustments as well.

For additional detailed information regarding these benefit changes, please refer to Mercy Care's web site at www.MercyCarePlan.com under the **Provider** tab. The **Provider Claim References** are available under the link titled **2010 Benefit Updates**. Specific **Provider Claim References** are listed as follows:

- Well Exams
- Behavioral Health
- Bone-Anchored Hearing Aids
- Cochlear Implants
- Emergency Dental Services
- Insulin Pumps
- Non-Experimental Transplants
- Orthotics
- Percussive Vests
- Physical Therapy
- Prosthetics Notification
- Services by Podiatrist

2010-2011 Flu Vaccines

Mercy Care Plan would like to inform you that on October 12, 2010, The Centers for Medicare and Medicaid Services (CMS) published a MLN Matters specifying the appropriate codes providers should be using to bill for the influenza vaccine/administration this year. AHCCCS has determined that they will be consistent with the CMS billing requirements related to influenza vaccine this year, as will Mercy Care Plan.

The codes providers should use for the influenza vaccine are listed as follows:

90655 – *Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use*

90656 - *Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use*

90657 - *Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use*

90658 - *Influenza virus vaccine, split virus, when administered to individuals 3 years and older, for intramuscular use*

90660 - *Influenza virus vaccine, live, for intranasal use*

Administration codes should be billed using one of the CPT codes from the range **90465 – 90474**. Providers should determine from the documentation of the services rendered which is the appropriate code to use for the administration of the vaccine that has been given.

Medicare is also requiring that **G0008** be used when billing with **90660**.

This year's influenza vaccines include a combination of the influenza vaccine and the H1N1 vaccine.

2010 TWG and TMA Copays

Effective **October 1, 2010**, Transitional Medical Assistance (TMA) members over the age of 19 will have **mandatory copays** for services as follows:

Transitional Medical Assistance (TMA)	
Service	Co-pay
Visit	\$4.00
All Pharmacy	\$2.30
Surgeries (In-office, Outpatient, non-emergent, Ambulatory Surgery Centers)	\$3.00
Out Patient Professional Therapies	\$3.00

Effective **November 1, 2010**, Transitional Waiver Group (TWG) members over the age of 19 will have **mandatory copays** for services as follows:

Title 19 Waiver Group (TWG)	
Service	Co-pay
Office Visit	\$5.00
Generic Pharmacy	\$4.00
Brand Pharmacy	\$10.00
Non-Emergency Use of the ER	\$30.00

An injunction was in placed from October 1, 2010 – October 31, 2010 for TWG members, but was lifted effective November 1, 2010, at which point these copays became mandatory.

Copays for both TMA and TWG may never be collected for the following services:

- Emergency services
- Children under the age of 19
- Services related to pregnancy or any other medical condition which might complicate pregnancy
- Family planning services and supplies

For both TWG and TMA members, a provider **can enforce** collection of these copays and a member can be refused service if the member is not able to pay the copay.

“Nominal” copays may be collected per the Arizona Administrative Code R9-22-711(D). This applies to **all other** AHCCCS eligible persons (other than certain persons eligible for Transitional Medical Assistance (TMA) and Title 19 Waiver Group (TWG)). These “nominal” or “soft” copayments are voluntary (not mandatory) and are for the following services in the following amounts:

Nominal Copays*	
Service	Co-pay
Prescription Drugs	\$2.30
Certain Evaluation & Management Services	\$3.40
Certain Physical, Occupational, or Speech Therapy	\$2.30

****Health care providers may not refuse to provide service if a patient states that they are unable to make these copayments.***

If a member is a Qualified Medicare Beneficiary (QMB), the Medicare deductible and coinsurance for eligible Medicare services will continue to be paid.

Providers also have the ability to view the AHCCCS Eligibility Verification System at www.AZAHCCCS.gov to determine AHCCCS adult payment requirements. The member copay level means the following:

- 00 – Exempt from Copay
- 20 – Nominal Copay
- 21 – Nominal Copay
- 40 – TWG Copay
- 50 – TMA Copay

A **Provider Claims Reference** is also available on Mercy Care's Web Site at www.MercyCarePlan.com, on the **Provider** tab under **What's New at Mercy Care Plan**, titled **TMA and TWG Copay – System Configuration Update**. Please reference for additional information regarding these copays.

Assisted Living Facility Rate Change (ALTCS Only)

Effective November 1, 2010, the reimbursement rate for Assisted Living Facilities will increase. This will affect the ALTCS line of business only.

The purpose of the rate change is to align the Assisted Living Facility's payment to more accurately reflect current market values.

There will be no increase for Assisted Living Centers at this time. A market study was completed for this group of providers, and the study indicates rates currently being paid are in line with current market values.

Electronic Fund Transfer

Mercy Care Plan strives to continually improve service to our participating network. One way to help improve service is to offer electronic tools to expedite service to our network.

Mercy Care offers multiple tools to allow the participating network to submit and receive electronic transactions and reports. Electronic transactions and reports reduce the volume of paper and costs associated with such transactions. As a state and federally funded program, Mercy Care and contracted providers have the fiduciary responsibility to reduce costs. We are working closely with providers to encourage utilization of electronic tools. We are currently focused on increasing our network participation in Electronic Fund Transfer.

The benefits of Electronic Funds Transfer include:

- Automatic deposit of payment for covered services
- Faster receipt of payment
- No paper checks to deposit
- Easier verification of payment

In order to receive Electronic Funds Transfer you need the following:

- Submit your claims electronically (preferred)
- Bank account number
- A voided check or savings account deposit slip
- Signed Electronic Funds Transfer Enrollment Form.

The **Electronic Funds Transfer Enrollment Form** can be accessed at www.MercyCarePlan.com under the **Provider** tab. Click on **Register for Electronic Funds Transfer** listed on the left side of the screen. Your Provider Relations Representative can assist you with any questions you might have.

Encounter Issues

Recent encounter issues have been identified as follows:

Duplicate Billing – RBHA and Mercy Care

An issue has been identified through our encounter process where claims are being billed to RBHA and to Mercy Care Plan and being paid by both payers. This involves behavioral health services. Claims should not be billed to both RBHA and Mercy Care Plan, but only to the plan responsible for payment.

Incorrect Place of Service Billed

An issue has been identified through our encounter process where claims are being billed with an incorrect place of service, CPT/HCPCS code combination. Letters educating providers have been sent. It is an important reminder that providers need to make sure they are billing claims in accordance with AHCCCS billing regulations.

HEDIS Initiative – MercyOneSource - Mercy Care Advantage

Mercy Care provides a web-based platform enabling health plans to communicate healthcare information directly with providers. Users can perform transactions, download information, and work interactively with member healthcare information. One of the key communications involving healthcare information involves **HEDIS** measures.

Under **MercyOneSource**, a provider can check the status of the member's compliance with any of the HEDIS measures. **MercyOneSource** is a tool for you to keep track of the services that your patients are actually receiving. The information here is based on recommended services by such organizations as NCQA for specific illnesses or within certain age groups and genders. A "Yes" means the member has measures that they are not compliant with; a "No" means that member has met the requirements.

Additional information available at the **MercyOneSource** platform include:

- ✦ **Member Eligibility Search** – Verify current eligibility on one or more members.
- ✦ **Panel Roster** – View the list of members currently assigned to the provider as the PCP.
- ✦ **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- ✦ **Claim Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- ✦ **Remittance Advice Search** – Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- ✦ **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed.
- ✦ **Submit Authorizations** – Submit an authorization request on-line. Three types of authorization types are available:
 - Medical Inpatient
 - Outpatient
 - DME – Rental

Additional information on how to register for our secure web site can be found on Mercy Care's web site at www.MercyCarePlan.com or www.MercyCareAdvantage.com. You may click on the **Provider** tab either under the **Mercy Care Plan** or **Mercy Care Advantage** section. Click on **Register for Secure Site** in the left hand side listing. You may register for the secure site if you do not have a Login ID or feel free to login if you already have your Login ID.

Prior Authorization Clarifications

Recent changes were made to Mercy Care's prior authorization requirements as follows:

Evaluation and Management Services

Effective December 1, 2010, Mercy Care will no longer require authorization for Evaluation and Management services for all participating providers, regardless of specialty.

Procedures will, however, require prior authorization and detail is specified in each health plan's Prior Authorization Grid posted on Mercy Care's web site.

Pain Management

A previous notification was posted that **effective December 1, 2010** prior authorization will be required for ALL Pain Management Procedures. The only services not requiring prior authorization will be the evaluation and management services in a physician's office for pain management.

Anesthesiology

Services provided by an anesthesiologist in an inpatient or outpatient facility setting are covered under the prior authorization for the surgical procedure. Anesthesiology services provided in an office setting do require authorization for the anesthesia service and may be obtained by the physician when the authorization for the procedure is requested. Anesthesia provided in an office setting is approved by Mercy Care based on medical necessity. If a procedure does not require authorization but physician is requesting anesthesia for that procedure in an office setting, then the physician will need to request prior authorization for the anesthesia. Anesthesia services in an in office setting that are not prior authorized will be denied for payment.

Outpatient Blood Transfusions

Outpatient blood transfusions do not require an authorization.

Durable Medical Equipment/Prosthetic Devices/Orthotics

All durable medical equipment with a purchase or rental price greater than \$270.00 currently requires an authorization for each item. **Effective January 1, 2011**, this will be raised to \$300.00 per item.

Non-OB Observation

Effective January 1, 2011, prior authorization will no longer be required for Non-OB Observation.

Special Report Procedures/Unlisted Procedures

Prior authorization is always required for all special report procedures or unlisted procedures regardless of place of service.

Additional Information

Please refer to the plan specific Prior Authorization Grid for important details regarding prior authorizations.

Exceptions for specific codes are listed at the end of the Prior Authorization Grids. These listed codes do not require prior authorization.

Limitations may apply depending on the benefit plan. The Benefit Grid should be reviewed in conjunction with the Prior Authorization Grid for complete coverage determination.

The Prior Authorization Grid will be reviewed on a quarterly basis for clarification and changing needs.

Please refer to Mercy Care Plan's web site at www.MercyCarePlan.com to review information regarding the **Provider Claims Reference** titled **Prior Authorization Requirements Change**. The information is located by clicking the **Provider** tab and then looking under **What's New at Mercy Care Plan**.

Additional prior authorization information is also available by clicking on the **Provider** tab and then clicking on **Medical Management Prior Authorization** on the left hand side of the web site. Prior authorization requirements are listed by plan and are available for your further review.

Please review this site periodically as prior authorization requirements are reviewed and may be revised on a quarterly basis.

Mercy Care also encourages providers to use MercyOneSource to make prior authorization requests rather than calling or faxing them in. This is the most efficient way for prior authorization to be requested and worked and will assist in expediting requests.

Radiology Fee Schedule Reduction Notification

Effective October 1, 2010 Mercy Care Plan, Mercy Care Advantage and Mercy Healthcare Group will be changing the reimbursement rate for most radiology services performed by physicians, for all places of service, whether in-office or in an outpatient/inpatient setting. This applies to services billed on a CMS-1500 form, not on a UB04 CMS-1450 form.

The changes to the Mercy Care Fee Schedule will affect all physicians administering radiology services in the following manner:

Radiology Services by Physicians - For dates of service beginning October 1, 2010 reimbursement for radiology services under the Mercy Care Fee Schedule will be the equivalent of **sixty-five percent (65%)** of the AHCCCS Fee Schedule*. PET Scans are not affected by this change and will remain a flat rate. ***The reimbursement for all other non-radiology services provided by same physicians will not be affected by this change.***

Physician Specialty Exceptions – The following specialties are exceptions to the above payment methodology:

- Hematology/Oncology
- Obstetrics/Gynecology
- Cardiology
- Radiologists

For dates of service beginning October 1, 2010 reimbursement for radiology services by the above specialties under the Mercy Care Fee Schedule will be the equivalent of **eighty percent (80%)** of the AHCCCS Fee Schedule*. PET Scans are not affected by this change and will remain a flat rate. ***The reimbursement for all other non-radiology services provided by same physicians will not be affected by this change.***

* ***The percentages indicated apply against the July, 1, 2010 AHCCCS Fee Schedule.***

Physicians contracted at the Mercy Care Fee Schedule –If a physician is contracted at a percentage of the Mercy Care Fee Schedule, the above percents will apply to the contract rate.

Example 1: Physician is contracted at 80% of the Mercy Care Fee Schedule and is not Hematology/Oncology, Obstetrics/Gynecology, Cardiology or Radiology. The physician will be paid 65% of the 80% contracted rate.

Example 2: Physician is contracted at 80% of the Mercy Care Fee Schedule and has a specialty of Hematology/Oncology, Obstetrics/Gynecology, Cardiology or Radiology. The physician will be paid at 80% of the 80% contracted rate.

Please refer to Mercy Care Plan's web site at www.MercyCarePlan.com to review information regarding the **Provider Claims Reference** titled **Radiology Fee Schedule Update**. The information is located by clicking the **Provider** tab and then looking under **What's New at Mercy Care Plan**.

Sonora Quest Laboratories

Effective February 1, 2010, Mercy Care contracted with Sonora Quest Laboratories to provide all laboratory services for our network. Participating providers must refer all laboratory services to Sonora Quest Laboratories. Services referred to a non-participating laboratory must be prior authorized or they will be denied. If Sonora Quest is unable to perform a specific test, prior authorization would still be required. **Any services referred to a non-contracted provider without prior authorization will become your financial responsibility per the terms of your contract with Mercy Care.**