



PROVIDER NEWSLETTER

April - June 2011

Spring 2011

4/1/11 Provider Rate Reductions - Mercy Care

Article	Page
4/1/11 Provider Rate Reductions - Mercy Care	1
Electronic Fund Transfer	2
Fax Number Change for Prior Authorization Requests	3
Formulary First - Mercy Care Advantage	3
HIPAA 5010 Transaction Set and ICD-10 Code Set	5
Home Assessment Program - Mercy Care Advantage	5
Laboratory Services	6
MercyOneSource - Save Time - Go Online	6
Missed or Cancelled Appointments	7
Model of Care/ Individualized Care Plan - Mercy Care Advantage	7
Preferred Vendors	8
Reconsideration Process	9
Our Mission, Vision and Values	11

Effective April 1, 2011, Mercy Care Plan will be implementing a provider rate reduction in order to comply with AHCCCS' overall provider rate reduction of 5%.

For all Office Visits/Evaluation and Management procedure codes, Mercy Care Plan's fee schedule will now equate to the AHCCCS fee schedule. Reduction determinations for other procedure codes were based on careful review of historical changes previously made to Mercy Care's Fee Schedule and a realignment of fees where necessary. A copy of the Mercy Care Fee Schedule will be available on the Mercy Care web site at www.mercycareplan.com.

Additional information regarding the **AHCCCS April 1, 2011 Provider Rate Reduction** is available on the AHCCCS web site at www.azahcccs.gov, under **News and Updates**. Under the **Provider Rate Reduction Fact Sheet**, AHCCCS outlines the reasons for the provider rate reduction as follows:

In Fiscal Year 2012 (beginning July 1, 2011), the State of Arizona will need over \$1 billion in additional funding to support the Medicaid program (also known as the Arizona Health Care Cost Containment System or AHCCCS). Additional federal funding previously authorized by Congress to support state Medicaid programs will expire on July 1, 2011 and the General Fund will need to make up for the loss of these dollars. To date, budget policy decisions have reduced programmatic spending in excess of \$870 million. As depicted in the table, savings have been generated through several of the following changes:

Provider Rates – AHCCCS has previously reduced the majority of all non-institutional provider rates by 5-10%. Statutory changes have resulted in institutional rates freezes. These changes have generated the bulk of the budget savings.

Eligibility Changes - While federal maintenance of effort requirements established as part of stimulus funding and health care reform have limited the State's ability to make changes, some savings have been generated through the elimination of the KidsCare parents program and enrollment freeze in KidsCare.

Benefit Changes– Through legislation, several optional benefits were eliminated on October 1, 2010.

Cost Sharing – AHCCCS has increased cost sharing requirements to the maximum amount under federal law for the acute care population and some limited savings have been achieved through the imposition of mandatory copays for select populations.

Mercy Care 4/1/11 Provider Rate Reductions (cont'd.)

Administrative Reductions – Even though the AHCCCS population has increased by 30% since the start of the recession, staffing has decreased by over 30%.

HB2010 (the Health Budget Reconciliation Bill from the 2010 Legislative Session) gave AHCCCS the authority to reduce rates for all providers up to 5% for the rate year beginning October 1, 2010. On October 1st, AHCCCS was able to freeze provider reimbursement rates and still achieve the overall FY 2011 budget goal of maintaining per member per month costs at the same amount. This was due to decreased utilization and continued shifting from institutional settings to home and community based.

However, given the pending funding crisis for AHCCCS in FY 2012, all avenues must be pursued to generate budget savings. Given the current limitations, reducing provider rates is the only option available at this point to generate any significant savings. It is important to note that this significant action will generate less than \$300 million in total fund savings or less than \$100 million for the State General Fund.

The AHCCCS mandatory managed care model is one of the most successful Medicaid programs in the country. Providers have played a critical part of this success. Without sufficient provider participation, AHCCCS would not have the quality outcomes that members enjoy today. AHCCCS recognizes that these types of reductions are difficult but given overall state finances these actions must be taken.

Further developments will be posted at www.azahcccs.gov, either under the “News & Updates” or “New Topics” sections of the main page.

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](http://www.mercycareplan.com/PDF/Mercy_Care_Plan_EFT_Enrollment_Form.pdf) can be accessed at www.mercycareplan.com/PDF/Mercy_Care_Plan_EFT_Enrollment_Form.pdf. Your Provider Relations Representative can assist you with any questions you might have.

Fax Number Change For Prior Authorization Requests

Mercy Care Plan would like to inform you that effective February 28, 2011 a change will be made to the Prior Authorization fax number for Mercy Care Plan and Mercy Healthcare Group. The 800 number listed on the current Prior Authorization Request Form will remain the same, **1-800-217-9345**, however, the local fax number will be eliminated.

This change will also apply to the Schaller Anderson Family Planning Prior Authorization Request Form. The 800 number listed on the Schaller Anderson Family Planning Request Form will remain the same, **1-800-573-4165**, however, the local fax number will be eliminated.

Updated forms will be available on Mercy Care Plan's web site at www.mercycareplan.com prior to the February 28, 2011 effective date. Please take note of this change in order to avoid any unnecessary delays in getting your prior authorization requests reviewed.

Formulary First - Mercy Care Advantage

Prescribing from the Mercy Care Advantage formulary will provide:

- Reduced confusion for patients who are trying to fill non-covered prescriptions at the Pharmacy.
- Minimize the cost share burden on the patient by considering generic formulary medications first.
- Reduced administrative burden for your staff. Formulary requests generally do not require additional paperwork or information in order to be filled**.

***Some covered drugs may have additional requirements or limits on coverage. Please consult the formulary before you prescribe.*

The Mercy Care Advantage (MCA) formulary contains all of the Part D drugs needed for most clinical situations. Medicare requires that all of the plans cover at least 2 drugs in each of the Medicare Model Guidelines (1) 37 Categories, and 170 Classes of medications. In addition, CMS reviews each formulary in a 13 step review process, which looks for drugs to treat rare diseases, drugs used in national guidelines, drugs used in vulnerable populations and more. The formulary contains many generic medicines to reduce the copay for your members, and also has special formulations for fragile patients, such as liquids, transdermal patches, etc. IV formulations of many medicines are available for home health administration.

The **MCA Formulary** is a list of covered drugs selected by the plan for the annual contract year and approved by the Centers for Medicare and Medicaid Services (CMS). The plan will generally cover formulary drugs as long as these basic rules are followed:

- A network provider writes the prescription
- A network pharmacy fills the prescription
- The drug is on the plan's formulary

The drug and quantity are considered "medically necessary," meaning reasonable and necessary for treatment of the injury or illness and is an accepted indication for the medical condition.

Prior Authorization Requirement (PAR): For certain formulary drugs, a prior authorization from the plan is needed before covering the requested drug. Drugs that require Prior Authorization are identified on the formulary with "PAR".

Formulary First - Mercy Care Advantage (cont'd.)

Quantity Limits (QLL): For certain formulary drugs, there is a limit to the amount of drug that a patient can have, identified on the formulary with “QLL”. For example, the plan might limit how many refills, or how much of a drug a patient can get each time they fill their prescription. Drugs prescribed outside the QLL require prior authorization.

Step Therapy (ST): This requires safer, more effective or less expensive medicines to be tried before the plan covers this formulary drug. Drugs with step therapy requirements are identified on the formulary with “ST”.

How do you reference the formulary?

Current formulary information is available on the plan’s web site at www.mercycareadvantage.com. In addition, calls can be made to the MCA Pharmacy Department at 602-263-3000 or 800-624-3879 (Option #2 for providers) to verify if the drug is on the formulary.

How do you search for a drug within the online formulary:

Medical Condition: The drugs on the formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”.

Alphabetical Listing: The Index, located at the end of the formulary, provides an alphabetical listing of all the drugs included on the formulary. Both brand-name drugs and generic drugs are listed in the Index.

Prior Authorization Guidelines for MCA formulary drugs can be viewed online at www.mercycareadvantage.com.

If you have identified a situation where the formulary medicines are not adequate for your patient’s needs, you may request a formulary exception in advance of prescribing the drug to the patient.

Requesting a Formulary Exception on behalf of your MCA patient:

The Prescriber can ask the plan to make an exception to the formulary and cover a drug in the way requested. Federal Medicare Part D regulations require the Prescriber to justify the medical reasoning when asking for an exception. This is called the “Physician’s Supporting Statement”. The MCA form is available at www.mercycareadvantage.com or you can use the CMS form at http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf.

IMPORTANT: To ensure timely and appropriate processing, please submit your Supporting Statement with the initial request. This statement needs to be from the prescriber, not from the office staff.

The written supporting statement must indicate that the requested drug is required and **all** other applicable formulary drugs and dosage limits would NOT be as effective because:

- All covered drugs on the formulary have been tried and failed, or caused or would have caused adverse effects; or
- The number of doses available under a QLL has either been ineffective or based on sound clinical evidence and medical/scientific evidence is likely to be ineffective, or would adversely affect patient compliance due to known physical or mental characteristics of the member; or
- The formulary alternatives on the formulary or required under STEP therapy requirements has either been ineffective or based on sound clinical evidence and medical/scientific evidence is likely to be ineffective, or would adversely affect patient compliance due to known physical or mental characteristics of the member; or would likely cause harm.

Formulary First - Mercy Care Advantage (cont'd.)

How to Appeal a Denial:

If the request for medication has been denied, the Prescriber has the right to file an appeal on behalf of their patient. Written, signed appeals must be received by the plan within 60 days of the denial notice by fax (602) 351-2300 or mail. For additional information please contact the Appeals Department directly at (602) 453-6098.

Questions, Comments or Concerns? Please contact your Mercy Care Plan Provider Relations Representative.

HIPAA 5010 Transaction Set and ICD-10 Code Set Upgrades

On Jan. 15, 2009, the United States Department of Health and Human Services (HHS) released two final rules for electronic data as part of the Administrative Simplification Provision of HIPAA.

The following federal provisions will facilitate a nationwide conversion to an electronic health care environment:

- Updated standards for electronic health care and pharmacy transactions (Electronic Data Interchange [EDI] HIPAA 5010) – effective Jan. 1, 2012.
- New diagnosis and procedure coding standards (ICD-10-Clinical Modification [CM] and ICD-10-Procedure Coding System [PCS]) – effective Oct. 1, 2013.

Providers must prepare for upcoming changes

Mercy Care encourages providers to prepare for these upgrades. For more information, visit the provider's section of www.mercycareplan.com, www.mercycareadvantage.com, or www.mercyhealthcaregroup.com.

Mercy Care is currently assessing and planning for all aspects of transaction and code-set conversions. We plan to meet all required dates and specifications of these upgrades.

Home Assessment Program - Mercy Care Advantage

Mercy Care Advantage (HMO SNP) has partnered with INSPIRIS, a care and care management company headquartered in Nashville, Tennessee, to conduct in-home assessments on selected Mercy Care Advantage (MCA) enrollees. INSPIRIS has been conducting in-home assessments for Mercy Care Advantage since 2009, and in 2010, completed over 1,500 assessments in Phoenix and Tucson.

MCA is a Special Needs Plan (SNP) that only serves Medicare beneficiaries with Medicaid medical assistance (AHCCCS). Enrollees may be chosen to have an in-home assessment through our arrangement with Inspiris based on their hospitalization history, the presence of multiple chronic conditions or because their claims history suggests they have not been routinely accessing their Primary Care Provider (PCP).

Enrollees selected for the program will receive a letter on MCA letterhead describing the in-home assessment program and how it can be of benefit to them. INSPIRIS' outreach specialists will then contact targeted enrollees to describe the program in detail and gain their consent. Enrollees are told that the in-home assessment does not replace care from their PCP, but is provided by MCA as an added benefit at no additional cost to them. In 2010, 80% of MCA enrollees INSPIRIS was able to reach accepted the appointment.

In-home assessments are provided either by a nurse practitioner or physician and generally require 60-90 minutes. Assessment providers review available information before their visit, including information about past chronic conditions. As part of the assessment, a comprehensive written evaluation is completed by the provider and made available to MCA and the enrollee's PCP. Goals of the program include:

Home Assessment Program - Mercy Care Advantage (cont'd.)

- Providing an additional touch point for enrollees who have difficulty accessing their PCP
- Assessing an enrollee's home environment and how it impacts their health care
- Determining if recommended testing related to chronic conditions (e.g. A1C for members with diabetes) should be considered, and encouraging enrollees to discuss any recommendations with their PCP
- Escalating any urgent or emergent clinical or social issues found at the time of the in-home assessment by working with the enrollee's PCP and/or the MCA case management staff
- Documenting all chronic conditions to help ensure that the Centers for Medicare and Medicaid Services (CMS) allocates appropriate funding for enrollees with complex medical needs
- Helping MCA achieve certain quality indicators, such as HEDIS measures, as required by CMS

This program is voluntary and does not affect an enrollee's health care coverage in any way. If you have additional questions about this program please contact your Provider Relations Representative.

Laboratory Services

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.**

MercyOneSource - Save Time - Go Online

The Mercy Care web site is available to help expedite services for you. Mercy Care offers the following services on our secure web portal, MercyOneSource. Some of the services we currently offer are:

- Find a participating doctor or specialist
- Access Clear Claim Connection (ClaimCheck Bundling Software Assistance)
- Searchable Formulary - Preferred Drug List
- Verify Member eligibility
- Authorization List
- Submit Prior Authorization Requests
- Check Claim Status

MercyOneSource - Save Time - Go Online (cont'd.)

- Remittance Advice Search
- HEDIS Measures

If you have not obtained a login ID yet, please call your Provider Services Representative to get started.

Missed or Cancelled Appointments

In regard to missed or cancelled appointments, providers must:

- Document and follow-up on missed or canceled appointments.
- Notify Member Services by completing a [Provider Assistance Program Form](#) located on MCP's web site at www.mercycareplan.com/MCP/ProviderForms.aspx for any member who continually misses appointments. Mercy Care is required to track this information.

Model Of Care/Individualized Care Plan - Mercy Care Advantage

Beginning January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) require Special Needs Plans (SNP) such as Mercy Care Advantage (HMO SNP) to develop and implement a Model of Care (MOC) each year.

The Model of Care is defined by high quality, compassionate medical care delivered in a multi-disciplinary Team model. The primary focus is meeting the needs of the patient through a multi-specialty style. We treat the member as a whole person rather than isolated disease entity.

Nurse Practitioners and Care Managers work with Primary Care Physicians, facilities, social support service providers and families to provide intensive primary and preventive services to people who have long-term or advanced illness, are older or have disabilities.

The Model of Care for MCA offers an integrated care management program that is supported by MCA policy, procedures and operational systems by combining benefit design, the development of the provider network, and clinical management programs.

We understand that many members want to play an active role in their diagnosis and treatment and we offer them the opportunity to be involved, in part through the administration of the Health Risk Assessment Tool and development of the Individualized Care Plan (ICP).

Health Risk Assessment (HRA) Tool & Individualized Care Plan (ICP)

MCA developed two HRA tools to assist with the identification of enrollee needs and risks. The tools are designed to assess enrollees in both the institutional or residential setting, including those who qualify for long-term care.

The assessment tools evaluate medical history, functional status, and cognitive changes, along with medical and mental health needs. The responses are incorporated into a stratification process that also uses administrative and other surveillance data developed and reviewed by both healthcare economics and clinical staff. The ICP is generated based upon the enrollee's case management status and risk status and then mailed to the enrollee and the PCP of record.

Model Of Care/Individualized Care Plan - Mercy Care Advantage (cont'd.)

The Role of a PCP: The ICP is a means of communicating information from the Plan to the PCP to support the coordination of care and avoid gaps or duplications in services. The ICP provides an opportunity for the Plan to encourage enrollees to follow their treatment plans, promotes communication between the enrollee and the PCP, educates enrollees about their conditions, provides community resources and supports enrollees in achieving their healthcare goals. Please take a few minutes to review the ICP for each MCA patient and store it in the enrollee's office medical record.

If you have questions or concerns about any data elements contained in your MCA patient's ICP please feel free to contact one of our Nurse Case Managers at 602-586-1870.

Preferred Vendors

Mercy Care Plan, Mercy Healthcare Group and Mercy Care Advantage have several preferred vendors in place for key specialty services. Referrals must be made to these providers for these specialty types, unless otherwise specified.

If a service cannot be provided by one of the below strategic partners, prior authorization will be required in order to refer to another specialty group. Below is a list of our preferred vendors:

Preferred Vendors	Specialty Type	Comments
Sonora Quest Laboratories	Laboratory	Referral Needed
Nationwide Vision Center	Vision	Member May Self-Refer
Dependable Medical Equipment, Inc.	Durable Medical Equipment	Referral Needed - Preferred Vendor for Southern Arizona
Preferred Homecare	Durable Medical Equipment	Referral Needed - Preferred Vendor for Maricopa County
United Seating and Mobility	Durable Medical Equipment	Referral Needed - Wheel-chairs and Custom Wheel-chairs
SimonMed Imaging, Inc.	Radiology	Referral Needed
Insight Imaging	Radiology	Referral Needed
AZTech Radiology Open MRI	Radiology	Referral Needed
Radiology, Ltd.	Radiology	Referral Needed
Southwest Diagnostic Imaging, Ltd.	Radiology	Referral Needed
United Surgical Partners Surgery Centers	Ambulatory Surgical Centers	Referral Needed

Reconsideration Process

Mercy Care routinely reviews trends associated with claims disputes. A claims dispute is defined as “a dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.” Below is a summary of key trends identified and guidance on how to resolve these issues outside the claims dispute process:

Denial Reasons	Guidance
Time limit for filing has expired	The general provisions of your contract detail timely filing requirements. If a claim has not been submitted and accepted by Mercy Care within either: one hundred eighty (180) days from the date of provision of the covered service, or within sixty (60) days of the date of the explanation of benefits from the primary carrier, your claim will be denied for untimely filing.
Duplicate Claim/Service	Resubmitting a claim without properly identifying the claim as a resubmission will likely result in a denial for a duplicate claim. Be sure to mark all resubmissions or claims with additional supporting documentation as a resubmission so that the claim is not denied as a duplicate.
Payment denied/reduced for absence of, or exceeded, pre-certification/authorization	Please make sure that you have obtained appropriate authorization before rendering services. If your claim is denied for no prior authorization and you have additional supporting documentation, you should contact the Prior Authorization department to update your authorization.
Procedure code incidental to primary procedure	The payment for the code being billed is already included in the payment for the primary procedure. If this code is separate and distinct, please resubmit the claim with appropriate modifiers or any other appropriate documentation, such as operative report
Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	The payment for the code being billed is already included in the payment for the primary procedure. If this code is separate and distinct, please resubmit the claim with appropriate modifiers or any other appropriate documentation, such as operative report or office notes.
Pre/postoperative care payment is included in the allowance for the surgery/procedure	The payment for the code being billed is already included in the payment for the primary procedure. If this code is separate and distinct, please resubmit the claim with appropriate modifiers or any other appropriate documentation, such as operative report
Procedure code billed is not correct/valid for the services billed or the date of service billed	This code is no longer a valid code. Resubmit claim with the proper replacement code.

Reconsideration Process (cont'd)

Denial Reasons	Guidance
Payment adjusted because the payor deems the information submitted does not support this many services.	The maximum amount of units have been exceeded for this service for this day.
This claim has been denied without review. The claim was not received timely.	All claims must be clean and submitted within 180 days of the date of service. Claims not received within this time frame will not be paid.

Resubmissions must be clearly identified as a resubmission, using black ink, and submitted to the appropriate claims addresses.

Mercy Care Plan, Mercy Care Advantage or Mercy Healthcare Group
 Attention: Claim Resubmissions
 P.O. Box 52089
 Phoenix, AZ 85072-2089

Resubmissions and reconsiderations may not be submitted electronically. Failure to mail and accurately label the resubmission or reconsideration to the correct address will cause the claim to deny as a duplicate.

Claim resubmissions must be filed within 365 days (1 year) from the date of provision of the covered service. If a provider disagrees with resubmission outcome or recoupment of a claim, the provider must submit the claim for resubmission within 60 days of the decision to pay, deny or recoup the claim. Please submit any additional documentation that may effectuate a different outcome or decision.

When filing resubmissions or reconsiderations, please include the following information:

- Use the Resubmission Form available on our web site at www.mercycareplan.com/Forms/Resubmission_Form.pdf.
- An updated copy of the claim. All lines **must** be rebilled or a copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.



Mercy Care Plan
Mercy Care Advantage
Mercy Healthcare Group
4350 E. Cotton Center Boulevard,
Building D
Phoenix, AZ 85040

Phone: 602-263-3000 or
800-624-3879

Web Site Addresses
www.mercycareplan.com
www.mercycareadvantage.com
www.merchhealthcaregroup.com

Our Mission, Vision and Values

Our Mission

Southwest Catholic Health Network (SCHN) is a not-for-profit partnership sponsored by Carondelet Health Network and St. Joseph's Hospital & Medical Center, a Catholic Healthcare West facility. SCHN is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, especially the preferential option for the poor and for persons with special needs.

Our Vision

SCHN will lead the transformation of the care delivery model by:

- Enhancing care coordination and collaboration across the continuum (Sponsors, SCHN, provider network).
- Enhancing health literacy and patients' accountability in their health.
- Seeks a long-term partnership with our provider network by offering effective and personalized services.
- Impacting the care and outcome of high risk/complex patients.
- Applying learnings and capabilities to other patient populations to improve community health outcomes.

Our Values

Passion: SCHN will pursue its mission with enthusiasm, optimism and diligence.

Stewardship: SCHN will act prudently, focusing on the interests of those we serve.

Teamwork: SCHN will collaborate with others to create exceptional results.

Advocacy: SCHN will work on behalf of the underserved to improve health outcomes.