

Provider Newsletter

CONTENTS

2012 MCA additional medical benefits	1
5010 status	1
AHCCCS eligibility verification – photo identification	2
Appeals – important reminders	2
Childhood obesity	3
Controlling high blood pressure	3
Dependable Medical Transport services	4
Electronic remittance advice submissions	5
Laboratory services network and CLIA waived in-office lab codes effective 10/1/11 - update	5
Penalty for missed appointments	5
Split surgical care	6
Mercy Care is proud to introduce...	7

2012 MCA additional medical benefits

We are excited to announce that our new enhanced benefits are now in place for the 2012 benefit year under the Mercy Care Advantage plan. Enhanced benefits are as follows:

Dental services – A \$1,500 limit for comprehensive dental benefits every year. This includes:

- Non-routine Services
- Restorative Services
- Endodontic/Periodontics/ Extractions

Van-Go Active Steps – Group health and wellness activities and learning events. Maximum two visits per month with up to 16 visits per calendar year.



Vision services – One routine eye exam/year and \$175 limit/year for eye wear.

Hearing aids – \$1,200 limit every three years for hearing aids.

Chiropractic services – 12 routine visits per year.

Routine podiatry – One routine visit every three months.

For additional information regarding benefit changes for 2012, please review the **Evidence of Coverage** on the Mercy Care Advantage website at:

www.MercyCarePlan.com/mca/members/downloads/EvidenceOfCoverage2012B.pdf

or the **Summary of benefits** on the Mercy Care Advantage website at:

www.MercyCarePlan.com/mca/members/downloads/SummaryOfBenefitsEnglish2012B.pdf

Additional information regarding the enhanced dental benefits is available on the Mercy Care Advantage website under the provider notification titled, “**2012 Dental Benefit Changes for MCA.**”

5010 status

UPDATE: The original deadline of January 1, 2012 that was imposed by the Department of Health and Human Services which released updated standards for electronic health and pharmacy transactions as part of the Administrative Simplification provision of Health Insurance Portability and Accountability Act (HIPAA). While the deadline remains, CMS’ Office of E-Health standards and Services (OESS)

won’t enforce compliance with the 5010 transaction set until March 31, 2012.

Mercy Care is happy to announce that we are currently ready for 5010! Mercy Care will convert any 4010

continued on page 2>

5010 status (continued from page 2)

transaction sets received by providers who may not be ready yet, to a 5010 format.

In addition, listed below are statuses of the Mercy Care clearinghouses we work with:

- **Emdeon, Gateway EDI and Office Ally** – Currently live with 5010. Emdeon will be working with its individual providers to submit claims in a 5010 format.
- **SSI** – Live with 5010 as of 1/3/12.
- **Relay Health/NDC** – Live with 5010 as of 12/30/11.

AHCCCS eligibility verification - photo identification

Beginning December 15, 2011, AHCCCS will be adding photos to its online verification tool, AHCCCS Online, which providers use to verify member eligibility. This new feature is one of many efforts to help protect members and prevent fraud. For all AHCCCS members who have an Arizona driver's license or a State Issued Identification (ID) Card, AHCCCS will get their picture from the Arizona Department of Transportation Motor Vehicle Division (MVD).

When providers use the online member verification system and enter a member's social security number, the member's picture, if available from MVD, will show on the AHCC eligibility verification screen

along with other AHCCCS coverage information. The picture will help AHCCCS providers to quickly validate the identity of a member.

Members will be informed about the addition of MVD photos on their AHCCCS ID card carriers as well as in the Welcome Back letters. In addition, current and future AHCCCS members will be notified of this change through the applicant and member portals on the AHCCCS internet website.

Arizona Laws ARS §§ 36-2905.04 and 2918.01 requires providers to cooperate with AHCCCS to prevent and discover eligibility fraud and to immediately notify AHCCCS of any cases of suspected fraud

or abuse. If a person presenting himself or herself in your office is not the person in the picture, it is your responsibility to determine if the person in your office is the AHCCCS member and you must report potential incidents of fraud to the AHCCCS Office of Inspector General. Providers can report suspected fraud at the following website:

<http://www.azahcccs.gov/fraud/reporting/onlineform.aspx>

Appeals – important reminders

Mercy Care would like to reiterate some important reminders concerning appeal submissions.

- Corrected claims should not be sent to the Appeals Department. These should be submitted to the Claims Department. They should be clearly labeled as "Resubmission" or "Reconsideration" at the top of the claim in black ink. The Re-submission Form should be used to assist in identifying the claim adjustment issue. For further information regarding claim re-submissions, please refer to the appropriate plan's Provider Manual under the section titled, "**Claim Resubmission or Reconsideration.**"
- Appeals should contain appropriate documentation. An appeal may be denied if it does not include the following information:
 - An appeal letter stating the reason why an appeal is being requested.
 - A copy of the original claim that was submitted to the claims department.
 - Any medical documentation, etc., that may support their request.
- Timely filing must be adhered to whether submitting an initial claim, a resubmission or an appeal. Timely filing rules are as follows:
 - Initial claim submissions must be filed on a valid claim form within 180 days (6 months) from the date services were performed or from the date of eligibility posting, whichever is later, unless there is a contractual exception. For hospital inpatient claims, date of

continued on page 3>

Appeals – important reminders (continued from page 2)

service means the date of discharge of the patient.

- o Appeal submissions or claim resubmissions/re-considerations 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.

For additional information regarding timely filing, please refer to the appropriate plan's Provider Manual under the section titled,

“Timely Filing of Claim Submissions.”

Further information regarding Appeals can be found in the **MCP/ MCLTC Provider Manuals**, chapter titled **Grievances, Provider Claim Disputes and Appeals** or in the **MCA Provider Manual**, chapter titled **MCA Enrollee Grievances and Appeals**.

Childhood obesity

Mercy Care is committed to working on ways to help prevent childhood obesity. Childhood obesity is affecting children throughout the nation. Overweight children are at higher risk for serious health problems such as Type 2 diabetes, high blood pressure and high cholesterol. Mercy Care believes a joint effort between our physician network and continued education to our members will enable us to work toward a healthier future for our members' children. Mercy Care is developing a holistic approach by providing the links to community, member and provider to take steps to increase childhood obesity awareness and take preventative measures.



What can our provider network do to help?

- Educate members about the risk associated with obesity in general.
- Point members to low cost resources to increase individual activity and healthy eating.
- Look at member family history as a risk of overweight.
- Go to **AZ Way to Go** for easy interactive tools to use with members and resources to increase quality care delivered. Go to: www.AzWayToGo.org.

Controlling high blood pressure

The following comes from an article titled, **“The Importance of Accurate Blood Pressure Measurement.”**

Extracted from the **Permanente Journal/ summer 2009/ Volume 13 No. 3**, and reprinted here with their permission from the Permanente Press.

What is wrong with the blood pressure measurement technique in this picture? Can you list all 10 errors?

continued on page 4>



Controlling high blood pressure (continued from page 3)

1. Patient's arm is unsupported;
2. Patient's back is unsupported;
3. Patient is talking;
4. Patient is engaged in active listening;
5. Wrong size cuff in use ("mis-cuffing");
6. Blood pressure cuff is positioned too low on the upper arm; appears to be over the elbow; the artery marker on the cuff is probably mal-positioned as well;
7. Cuff is over clothing;

8. Observer is not at eye level with the monitor (where is the monitor?);
9. Patient's legs are crossed;
10. End of stethoscope is in clinician's coat pocket.

Obtaining proper blood pressure (BP) measurements are important for the following reasons:

- Identify follow-up needs for patients if their BP is not adequately [**<140/90 mmHg**] controlled. A list of Mercy Care Advantage members was distributed by mail in mid-November to assist you.

- Measure and document accurate BP in order to quickly identify if a change occurs in the future.
- Recheck BP at later date if any medical therapy is initiated or altered.

Mercy Care recommends you review the article in its entirety with your staff in order to assure accurate blood pressure readings are taken every time. The article can be accessed at the following website:

<http://www.thepermanentejournal.org/issues/2009/summer/390-blood-pressure.html>

Dependable Medical Transport services

When a Mercy Care patient requires self-regulated oxygen during transport or has an IV that can be capped at a Hospital, Skilled Nursing Facility or Assisted Living Facility, they often require non-emergent transportation. Transportation scenarios can include:

Hospital	➡	Hospital
Hospital	➡	Skilled Nursing Facility (SNF)
Hospital	➡	Assisted Living Facility (ALF)
Hospital	➡	Doctor's Office
Skilled Nursing Facility (SNF)	➡	Hospital
Skilled Nursing Facility (SNF)	➡	Doctor's Office
Assisted Living Facility (ALF)	➡	Hospital
Assisted Living Facility (ALF)	➡	Doctor's Office

Since most transportation vendors are not equipped to facilitate patients who require this care, your discharge planners were

previously required to contact an Emergency Medical Transport (EMT) to provide the non-emergent transportation.

Effective 11/1/11, hospitals, skilled nursing facilities and assisted living facilities now have the ability to contact Dependable Medical Transport Services (DMTS) for this type of non-emergent transportation. DMTS will provide a stretcher van or wheelchair accessible vehicle with oxygen. DMTS' contact information is as follows:

Dependable Medical Transport Services

In Maricopa: 602-235-2255

Toll-Free: 866-216-3687

Fax: 602-275-1914

Website: www.dmtstransport.com

Advantages of using DMTS:

- No prior authorization required
- Improved discharge or triage coordination and planning
- Door through door service
- Pharmacy pick-up

- One simple phone call
- It's more cost effective
- It should alleviate scheduling difficulties when emergencies take precedence

Who qualifies for DMTS transport?

Mercy Care patients who require:

- Rapid delivery of DME
- Re-direct to lower level of care
- Coordination of oxygen

Who continues to qualify for EMT transport?

The following qualifies as basic life support transport through an EMT:

- Requires the use of a ventilator
- Receives dialysis
- Requires medical supervision according to attending physician
- Requires IV (includes heparin lock and PICC)
- Uses a drainage tube
- Is in traction
- Is morbidly obese
- Has a Foley catheter
- Has monitoring device or equipment (e.g. heart monitor or insulin pump)
- Has bone fracture
- Requires transport from ICU

Electronic remittance advice submissions

The benefits of Electronic Remittance Advice (ERA) include:

- Receipt of electronic file of processed claims from Mercy Care.
- Ability to electronically post payments to your Practice Management System.
- Faster reconciliation of account receivables.
- Simplified reconciliation process.
- Received day after electronic funds transfer.

To receive ERA you need the following:

- Submit your claims electronically (preferred)
- Receive electronic funds transfer (preferred)

- Ability to accept HIPAA standard 835 electronic remit transactions

In order for providers to be able to access the Emdeon 835 electronic remit, the **Mercy Care Electronic Remit Request Form** must be fully filled out and submitted to the **MercyCareProviderRelations@AETNA.com** email box. Please refer to the Provider Notification titled **Electronic Tools** available on our website to assist you with filling out the form.

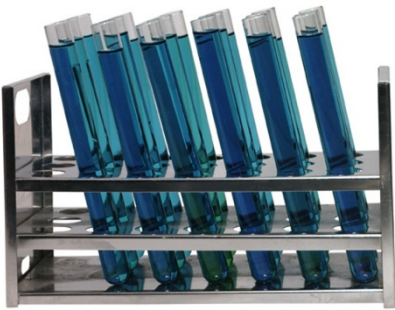
You may request ERA without having EFT, however, we strongly encourage you have EFT to take full advantage of all electronic processes.

You have the option of having your vendor pick up the file for you or you may pick up the file yourself through Payment Manager.

Process Outline

- Provider submits fully completed form to Mercy Care Provider Relations email box.
- The form is forwarded to Emdeon for them to load in their system.
- Emdeon notifies Mercy Care that the form has been loaded into their system.
- Mercy Care then gives the OK to Emdeon to turn on the 835 to start receiving ERA.
- Emdeon then sends an email to you providing your login information in order to pick up the file. You will need to contact Emdeon after you get their login in order to set up a secure password.

Laboratory services network and CLIA waived in-office lab codes effective 10/1/11 – update



In the **Fall 2011** edition of the **Mercy Care Provider Newsletter** we provided an update regarding our CLIA Waived List. We have made one more change this quarter. CPT code **85610-QW** (*Prothrombin time*) has been added to the list as a CLIA Waived Lab. To review the

entire list of CLIA Waived Labs, please refer to the Provider Notification titled **Laboratory Services Network and CLIA Waived In Office Lab Codes Effective 10/1/11** that is available on our websites.

Penalty for missed appointments

As part of Arizona's Medicaid Reform Plan and in an effort to increase member accountability and provider satisfaction during a period of decreased funding in Arizona's Medicaid program, effective January 1, 2012, healthcare providers will be able to impose a fee to Adults Eligible

for AHCCCS for Families with Children under Section 1931 of the Social Security Act and individuals eligible for AHCCCS Care (childless adults) who reside outside of Maricopa and Pima counties for missed appointments if certain conditions are met.

For additional information regarding this, please refer to the AHCCCS website at:

<http://www.azahcccs.gov/commercial/ProviderBilling/PenaltyMissedAppointments.aspx>

Split surgical care

The following article was compiled by iHealth Technologies, one of Mercy Care's coding vendors, and is printed here with their permission.

Overview

Split surgical care occurs when different physicians furnish either the preoperative, intra-operative or post-operative portions of the global surgical package. Split surgical care is only applicable to providers of different Tax ID groups or providers within the same Tax ID group but with different specialties. Providers within the same Tax ID group and same specialty are treated as a single entity and may not bill split surgical care.

When split surgical care occurs, each provider is reimbursed according to the portion of surgical care they provided. The three portions of surgical care are:

- Pre-operative;
- Intra-operative- surgical care only including hospital post-operative care; and
- Post-operative

CMS has established percentages for each of the three portions of surgical care for all 10-day and 90-day procedure codes. These percentages are located on the National Physician Fee Schedule Relative Value file (NPFSSRV), which is updated quarterly by CMS. The sum of these portions represents the total global surgical package.

Split Surgical Care - Modifiers

According to the AMA CPT Manual, the following modifiers should be used by the billing provider to indicate which portion of the global surgical practice was provided.

Modifier 54 – Surgical Care Only

Modifier 55 – Post Op Management Only

Modifier 56 – Pre Op Management Only



Split Surgical Care - Things to Know

- According to AMA CPT, description for modifiers 54 (Surgical care only), 55 (Post-op management only), and 56 (Pre-op management only) indicate that they are surgical in nature and therefore should not be appended to a non-surgical procedure code. (A non-surgical procedure code is defined as any service with a zero-day global period or when the global concept does not apply).
- Split surgical care can only occur when the physicians involved have formally (i.e. in writing) transferred the care of the patient from one physician to another. The transfer of care may be in the form of a letter or an annotation in the hospital or ASC record. If a formal transfer of care has not occurred, then it is appropriate for the physician, other than the surgeon, providing the post-operative care to bill with Evaluation and Management services.
- The provider that rendered the surgical care only should append

modifier 54 (Surgical Care Only) to the surgical procedure code. Unless another provider has billed separately for the pre-operative care (modifier 56), it is assumed that the provider billing modifier 54 has rendered the pre-operative care, the intra-operative care and the post-operative hospital care and will thus be reimbursed at the pre-operative and intraoperative percentages.

- Providers billing modifiers 55 (Post-Operative Care Only) or modifier 56 (Pre-Operative Care Only) should:
 - Use the same procedure code that was billed by the surgeon (modifier 54).
 - Use the actual surgery date, even though they may not have seen the patient for a period of time after the surgery.

Appropriate use of split surgical care modifiers help to clarify what services were performed and aid in proper adjudication.



Mercy Care is proud to introduce...



Chuck Sowers
chief financial officer
Mercy Care Plan

As chief financial officer for Mercy Care Plan, Mr. Sowers is responsible for overseeing the plan's financial planning and financial management. Mr. Sowers

has more than 20 years' experience in the health care industry. His background includes contract negotiation, financial and strategic planning, contract analysis, provider reimbursement, health plan operations and hospital management.

Prior to joining Mercy Care Plan, Mr. Sowers was president and chief executive officer of Health Net of Arizona, formerly serving as its chief financial officer. In addition, he worked for PacifiCare of Arizona and Chandler Regional Hospital. Mr. Sowers holds a bachelor's degree in accounting from Arizona State University.

MERCY CARE PLAN MERCY CARE ADVANTAGE MERCY HEALTHCARE GROUP

Address:

4350 E. Cotton Center Blvd.,
Building D
Phoenix, AZ 85040

Phone Numbers:

602-263-3000 or
800-624-3879

Web Site Addresses:

www.MercyCarePlan.com
www.MercyCareAdvantage.com
www.MercyHealthcareGroup.com

Our mission

Southwest Catholic Health Network Corporation (SCHN) d/b/a Mercy Care Plan is a not-for-profit corporation founded 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 of 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.
 - Seeking 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 learning 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.