

MERCY CARE ADVANTAGE PROVIDER MANUAL

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CHAPTER 1 - INTRODUCTION TO MERCY CARE ADVANTAGE HMO

1.0 - Welcome

Welcome to Mercy Care Advantage (herein MCA)! Our ability to provide excellent service to our enrollees is dependent on the quality of our provider network. By joining our network, you are helping us serve those Arizonans who need us the most.

1.1 - About Mercy Care

Mercy Care (herein MC) is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MC is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC, administers MC.

MC has an established, comprehensive model to accommodate service needs within the communities served. This manual contains specific information about MCA to which all Participating Healthcare Professionals (PHPs) must adhere. Please refer to MCA's website for a listing of [Provider Forms](#) and [Notices](#). You can print the **MCA Provider Manual** from our [Provider Manual](#) web page easily from your desktop.

Mercy Care includes the following lines of business:

- Mercy Care Complete Care
- Mercy Care Advantage
- Mercy Care Long Term Care
- Mercy Care RBHA
- Mercy Care DD
- KidsCare – Children's Health Insurance Program (CHIP)

Our Mercy Care Member Service phone numbers are: **602-263-3000** or **1-800-624-3879** (TTY/TDD **711**).

Our Mercy Care Advantage Member Service phone numbers are: **602-586-1730** or **1-877-436-5288** (TTY **711**),

Mercy Care Advantage Member benefits are effective January 1 through December 31.

1.2 - Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual, in addition to all federal and state regulations governing the plan and the provider. MCA may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS) and Centers for Medicare and Medicaid Services (CMS), providers are required to fully understand and apply AHCCCS and CMS requirements when administering covered services.

According to 42 CFR 438.3 - Standard Contract Requirements, it states:

AHCCCS, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of Mercy Care, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

For further information regarding [AHCCCS](#) and [CMS](#), please click on the respective link.

1.3 - MCA Overview

Mercy Care Advantage is an HMO Special Needs Plan with a Medicare contract and a contract with the Arizona Medicaid Program (AHCCCS). Mercy Care Advantage is a Medicare Dual Special Needs Plan, which means our plan benefits and services are designed for people with special health care needs and have both Medicare and Medicaid coverage. Our plan offers additional supplemental benefits and services not covered under Medicare.

1.4 - MCA Policies and Procedures

MCA has robust and comprehensive policies and procedures in place within the organization to help assure compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates made as needed.

1.5 - Eligibility

MCA is offered in select counties in Arizona and provides coverage for Medicare Part A and Part B benefits, (Part C) and Medicare Part D prescription drugs. Individuals who meet the following plan eligibility requirements may enroll:

- Entitled to Medicare Part A and enrolled in Part B.
- Receive Medicaid assistance from AHCCCS.
- For AHCCCS Complete Care (ACC) Medicaid programs our service area includes Gila, Maricopa and Pinal counties.
- For Arizona Long Term Care System (ALTCS) Medicaid programs our service area includes Gila, Pinal, Maricopa and Pima counties.
- For the Arizona Division of Developmental Disabilities our service area is all counties in the state of Arizona.

The Social Security Administration determines Medicare entitlement and eligibility. The Code of Federal Regulations (Title 42, Part 422) outlines the requirements for individuals to enroll in Medicare Advantage Plans. AHCCCS determines eligibility for Medicaid medical assistance. If an individual loses eligibility for either AHCCCS or Medicare, MCA is required to terminate their MCA plan coverage and provide appropriate enrollee notification.

1.6 - Annual Notice of Change

MCA plan benefits are subject to change annually. Enrollees are provided with advance written notice regarding the annual benefit changes by the date specified by CMS. The CMS Annual Election Period begins on October 15 each year for enrollees and ends on December 7. During this timeframe

Medicare beneficiaries can make a Medicare health plan change for a January 1 effective date. Providers can access the MCA website on or around October 15 for information about the MCA plan benefits that will be available for the following calendar year.

1.7 - Model of Care

The Model of Care for the MCA Special Needs Plan (SNP) offers an integrated care management program with enhanced assessment and management for enrolled dual eligible enrollees. The processes, oversight committees, provider management, care management, and coordination efforts applied to address enrollee needs result in a comprehensive and integrated model of care.

This program addresses the needs of enrollees who are often frail, elderly, and coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues. Within the MCA program, there are three eligible populations: the dual eligible enrollees that qualify for ALTCS program and dual eligible beneficiaries that qualify for the Arizona Complete Care (ACC) and Division of Developmental Disabilities programs (i.e. AHCCCS programs).

The program's combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the program include:

- Improving access to essential services such as medical, mental health, social services and preventive health services;
- To assist enrollees in accessing appropriate and timely care (including medical and preventive health services, mental health services, and social services);
- Improving access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve seamless transitions of care across healthcare settings and providers;
- Assure appropriate utilization of services and assure cost-effective service delivery.

MCA efforts to assure cost-effective health service delivery include, but are not limited to the following:

- Review of network adequacy
- Clinical reviews and proactive discharge planning activities.
- Implementation of an integrated Case Management Program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care/services.

Many components of an integrated care management program impact enrollee health. These include:

- Comprehensive enrollee assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow enrollees to reside in the least restrictive environment possible.

- Assessments and care plans that identify an enrollee's greatest needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Case manager referrals and predictive modeling software that identify beneficiaries at increased risk for nursing home placement, functional decline, hospitalization, emergency department visits, and death. This information is used to intervene with the most vulnerable enrollees in a timely fashion.

Overall program goals will be evaluated by measuring to include, but not limited to the following:

- The proportion of enrollees that show the minimum number of primary care provider visits during a calendar year as compared to others.
- Enrollee satisfaction with health services using the Consumer Assessment of Healthcare Providers and Systems.
- Enrollee self-rating of overall health.

Providers are required to review a power point presentation available on our website for the current year's Model of Care Provider Training available on our [Provider Information](#) web page. An attestation is built into this power point that enables you to e-mail directly to our Provider Relations department. It's very important to follow all instructions.

[1.8 - CMS Website Links](#)

MCA administers the plan in accordance with the contractual obligations, requirements and guidelines established by the Centers for Medicare & Medicaid Services (CMS). There are several manuals on the CMS website that may be referred to for additional information. Key CMS On-Line Manuals are listed below:

- [Medicare Managed Care Manual](#)
- [Medicare Prescription Drug Benefit Manual](#)
- [Medicare Claims Processing Manual](#)

[1.9 - Medicare Coverages](#)

- **Part A** – Hospital Insurance; pays for inpatient care, skilled nursing facility care, hospice and home health care.
- **Part B** – Medical Insurance; pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- **Part C** – Medicare Advantage Plans (MA): combines Part A and B health benefits through managed care organizations; most plans include Part D (MAPD plans).
- **Part D** – Medicare Prescription Drug Plan: helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin). Part D coverage is available as standalone Prescription Drug Plan (PDP) or integrated with medical benefit coverage (MAPD).

CHAPTER 2 – MCA CONTACT INFORMATION

2.0 - Health Plan Contacts

<u>Health Plan</u>	<u>Health Plan Telephone</u>	<u>Health Plan Web Address</u>
MCA	602-586-1730 1-877-436-5288	www.MercyCareAZ.org

MCA is available 8:00 a.m. to 8:00 p.m., seven days a week to assist providers with medical prior authorization requests.

A copy of the **Part D Coverage Determination Form** is available on our [Part D: Prescription Drug Benefits](#) web page and can be submitted electronically.

A copy of the Part D Redetermination (appeal) Form is available on our [Part D: Prescription Drug Benefits](#) web page and can be submitted electronically.

Providers may also initiate a request by calling Mercy Care Advantage at 877-436-5288, 8:00 a.m. to 8:00 p.m., 7 days a week. Select option #2 and follow the prompts to Pharmacy.

Provider Credentialing and Contracting (MCA)

MCA is committed to providing quality health care services to our members. And our credentialing and contracting processes help us achieve that goal.

To be eligible to join the MCA network, providers must have completed all required Arizona State licensure, certifications and AHCCCS registration. The Letter of Interest (LOI) or Letter of Contractual Changes (LOC) should be on the Provider's letterhead or in writing.

Once approved by the MCA Contract Committee; new providers will be sent a Participating Agreement (Contract). Providers making changes to an existing contract must also be approved in Contract Committee and sent a Contract Amendment.

Upon completion of credentialing and full execution of the Contract or Contract Amendment, the provider will receive notice from MCA's Contracting department with the effective date of participation, along with a copy of the fully executed agreement.

Providers should refrain from scheduling and seeing MCA members until notified of the participation effective date.

What to Submit to Contracting

- **Letters of Interest (LOI)** – Any request to participate in the Network – New Contract
- **Letter of Contractual Changes (LOC)** – Any change request to an Existing Agreement – Contract Amendments (A 90-day prior notification of effective date of changes is required)
- **Value Base Solution (VBS)** - VBS proposals or programs request

- **Contract Terminations** – Termination notification (includes loss of locations, programs and services no longer included in the contract)
- **Change of Ownership or Mergers** – All change of ownerships, mergers or stock purchases as contract are not assigned to new owners without prior approval (A 90-day prior notification of change of ownership or merger is required)

The LOI/LOC must include the following:

- AHCCCS ID number
- AZ Dept. of Health License number (if applicable)
- Medicare ID number (if applicable)
- National Provider ID (NPI) (if applicable)
- Geographic Location(s)
- Information outlining Facility, Specialty and Service Offerings
- Insurance Declaration Page(s)

Include applicable Credentialing Forms with the LOI/LOC. The Credentialing application must be submitted correctly and completely. Incomplete forms will not be accepted.

- W-9 Form
- AzAHP Facility Application
- AzAHP Practitioner Credentialing Form
- AzAHP Organizational Credentialing Form

Community Service Agencies must be credentialed and sign a letter of Intent to contract with MCA prior to submitting the application for AHCCCS Registration.

Contact information for the Mercy Care Contracting Department is as follows:

Email: contractingdepartment@MercyCareAZ.Org

Fax: 860-975-3201

Phone: 602-453-6148

If you have questions about the contracting process or to check the status of a contract, please call or email MCA's Contracting Department.

[2.1 - Health Plan Authorization Services](#)

Department

Medical

Services

Prior Authorization Department

Medical Fax: 800-217-9345

You may also call our main Member Services number.

Department

eviCore – delegated entity

Services

Complex Radiology and Pain Management Authorization

Phone: 888-693-3211

Fax: 844-822-3862

Log onto the eviCore healthcare Online Web Portal via the following web portal:

<https://www.evicore.com/pages/providerlogin.aspx>

Utilizing the web portal is the quickest, most efficient way to initiate a request.

MCA Claim Disputes

Phone: 602-263-3000

Toll-Free: 800-264-3879

Express Service Code: 626

**Part D Coverage
Determination and Exceptions
and Part D Appeal Requests**

Mercy Care Advantage

Phone: 800-624-3879, 8:00 a.m. to 8:00 p.m., 7 days a week.

Select option #2 and follow the prompts to Pharmacy.

Fax: Mercy Care Advantage

Part D Coverage Determinations and Appeals

1-855-230-5544

***NOTE: If you are requesting a formulary exception, please include a statement supporting your request. A copy of the Part D Coverage Determination Form and Part D Redetermination (appeal) Form are available on our MCA website and can be submitted electronically.**

**Behavioral Health, including
Behavioral Health Crisis Line**

Phone: 800-876-5835

Fax: 800-873-4570

2.2 - Community Resources Contact Information

Community Resource

**Arizona’s Smokers Helpline
(Ashline)**

Contact Information

Address: P.O. Box 210482
Tucson, AZ 85721

Phone: 800-556-6222

Fax: 520-318-7222

Website: www.ashline.org

**Community Information and
Referral**

Address: 2200 N. Central Avenue, Suite 601
Phoenix, AZ 85004

Community Resource

Contact Information

Phone: 602-263-8856

800-352-3792 (area codes 520 & 928)

Website: <http://www.cir.org/>

CHAPTER 3 – NETWORK MANAGEMENT

3.0 – Network Management Overview

The Network Management department serves as a liaison between MCA and the provider community. They are responsible for training, maintaining and strengthening the provider network in accordance with regulations.

Network Management staff conducts onsite provider training, problem identification and resolution, site visits, accessibility audits and assist in the development of provider communication materials.

A Network Management Specialist/Consultant is assigned to each provider's office. You may reach your Network Management Specialist/Consultant directly by calling 602-263-3000 or 800-624-3879. Please review our [Mercy Care Advantage](#) web page to find a listing of your assigned Network Management Specialist/Consultant along with their detailed contact information.

To meet Regulatory Compliance Standards, all provider inquiries, communications and provider complaints received via telephone call/e-mail must be responded to by Network Management within 48-72 hours. All issues brought to the attention of the Network Management department must be addressed within 30 days. According to our contract, MCA will provide prompt responses and assistance to providers.

Contact Network Management for:

- Recent practice or provider updates
- Forms
- To find a participating provider or specialist
- Termination from practice
- Notifying the plan of changes to your practice
- Tax ID change
- Obtaining a website Login ID
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice

CHAPTER 4 - PROVIDER RESPONSIBILITIES

4.0 - Provider Responsibilities Overview

These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the plan, provider contract and requirements in this manual. MCA may or may not specifically communicate such terms in forms other than the contract and this manual. This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual.

Providing Enrollee Care

4.1 - Medicare/AHCCCS Registration

Each provider must be registered with an active National Provider Identification (NPI) number as well as an active AHCCCS provider ID number to coordinate benefits and process claims.

Referring, ordering, prescribing and attending providers are required to register with AHCCCS in order to be reimbursed. Please reference the AHCCCS website, [ROPA section](#) for more information about this new requirement.

4.2 - Medicare Opt Out Providers

As specified by Medicare laws, rules and regulations, physicians may “opt out” of participating in the Medicare program and enter into private contracts with Medicare beneficiaries. If a physician chooses to opt out of Medicare due to private contracting, no payment can be made to that physician directly or on a capitated basis for Medicare-covered services. The physician cannot choose to opt out of Medicare for some Medicare beneficiaries but not others, or for some services but not others. MCA is not allowed to make payment for services rendered to MCA enrollees to any physician or health care professional that has opted out of Medicare due to private contracting unless the beneficiary was provided with urgent or emergent care.

Providers are listed on the [Opt Out List](#), which is published by Noridian.

4.3 - Appointment Availability Standards

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards below. MCA will routinely monitor compliance and seek corrective action plans, such as panel or referral restrictions, from providers that do not meet accessibility standards.

4.3 – Appointment Availability Standards

<u>Provider Type</u>	<u>Emergency Services</u>	<u>Urgent Care</u>	<u>Preventative & Routine Care</u>	<u>High Risk</u>	<u>Wait Time in Office Standard</u>
PCP	Same Day	Within 24 hours	Within 21 days		Less than 45 minutes
Specialty Referrals	Within 24 hours	Within 3 days of request	Within 45 days		Less than 45 minutes
Dental Care	Within 24 hours	Within 3 days of request	Within 45 days		Less than 45 minutes

4.4 - Telephone Accessibility Standards

Providers are responsible to be available during regular business hours and have appropriate after-hours coverage. Providers must have coverage 24 hours per day, seven days per week, including on-call coverage. Call coverage does not include referrals to the emergency department.

Examples of after-hours coverage that will result in follow up from MCA:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the provider to retrieve the message).
- An answering machine that directs the caller to go to the emergency department.
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above.
- An answering machine that directs the caller to page a beeper number.
- No answering machine or service.
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e., enrollees should not receive a telephone bill for contacting their physician in an emergency).
- Telephones should be answered within five rings and hold time should not exceed five minutes. Callers should not get a busy signal.

4.5 - Covering Physicians

Provider Relations must be notified if a covering physician is not contracted or affiliated with MCA. This notification must occur in advance of providing coverage and MCA must provide authorization. Reimbursement to covering physicians is based on the MCA Fee Schedule. Failure to notify MCA of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering physician.

4.6 - Verifying Enrollee Eligibility

All providers, regardless of contract status, must verify an enrollee's enrollment status prior to the delivery of non-emergent, covered services. An enrollee's assigned provider must also be verified prior to rendering primary care services. MCA will not reimburse providers for services rendered to enrollees that lost eligibility or were not assigned to the primary care provider's panel (unless s/he is physician covering for a provider).

Enrollee eligibility may be verified through one of the following ways:

Website*: www.MercyCareAZ.org - Link available on homepage or you can login to the secure website portal. *You must have a confidential password to access. To register, contact your Network Management Specialist/Consultant. More information is available in this Provider Manual under section **4.7 – Mercy Care Web Portal**.

MCA Telephone Verification: Use as a last resort. Call Member Services to verify eligibility at 877-436-5288 and use Express Service Code 629. To protect enrollee confidentiality, providers are asked for at least three pieces of identifying information such as enrollee identification number, date of birth and address, before any eligibility information can be released. When calling MCA, use the prompt for the providers.

Monthly Roster: Monthly rosters are found on the secure website portal. Contact your Network Management Specialist/Consultant for more information. Note that rosters are only updated once a month. More information is available in this Provider Manual under section **4.7 – Mercy Care Web Portal** regarding provider rosters.

4.7 – Mercy Care Web Portal

MCA 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 enrollee healthcare information. The following information can be attained from the Mercy Care Web Portal platform:

- **Enrollee Eligibility Search** – Verify current eligibility of one or more enrollees. Please note that eligibility may also be verified through the AHCCCS website.
- **Panel Roster** – View the list of enrollees 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 enrollee, 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 enrollee, 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
- Durable Medical Equipment – Rental
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Check the status of the enrollee’s compliance with any of the HEDIS measures. A “Yes” means the enrollee has measures that they are not compliant with; a “No” means that the enrollee has met the requirements.

4.8 - Enrollee Temporary Move Out of MCA Approved Service Area

CMS defines a temporary move as:

- An absence from the MCA approved service area of six months or less, and
- Maintaining a permanent address/residence within the MCA plan approved service area.

An MCA plan enrollee is covered while temporarily out of the MCA approved service area for emergent, urgent, post-stabilization and out-of-area dialysis services. If an enrollee permanently moves out of the MCA plan service area or is absent for more than six months, the enrollee will be dis-enrolled from MCA.

4.9 - Coverage of Renal Dialysis – Out of Area

MCA pays for renal dialysis services obtained by an MCA plan enrollee from a contracted or non-contracted Medicare-certified physician or health care professional while the enrollee is temporarily out of MCA’s service area (up to six months).

4.10 - Health Risk Assessment (HRA)

As a contracted Special Needs Plan, MCA is required to conduct a health risk assessment for each new enrollee within 90 days of his/her enrollment in the MCA plan and annually thereafter. MCA attempts to complete the health risk assessment by telephone or in person but will mail to enrollees when the plan is unable to reach enrollees by phone. The information obtained through the health risk assessment is used to develop an individualized care plan for enrollees and is shared with enrollees and their PCP.

4.11 - Preventive or Screening Services

Providers are responsible for providing appropriate preventive care for eligible enrollees. These preventive services include, but are not limited to:

- Welcome to Medicare exam, which is covered during the first 12 months of enrollment in Part B.
- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female enrollees may go to a contracted obstetrician/gynecologist for a well woman exam once a year without a referral).
- Age and risk appropriate health screenings.

4.12 - Educating Enrollees on their own Health Care

MCA does not restrict or prohibit providers, acting within the lawful scope of their practice, from advising or advocating on behalf of an enrollee who is a patient for:

- the enrollee’s health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- any information the enrollee needs to decide among all relevant treatment options;
- the risks, benefits, and consequences of treatment or non-treatment; and,
- The enrollee’s right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

4.13 - Emergency Services

Prior authorization is not required for emergency services. In an emergency, enrollees should call 911 or go to the nearest emergency department.

For immediate assistance and intervention, if an enrollee is having a behavioral health emergency, please call MCA’s 24–hour Crisis Line at 800-876-5835.

MCA educates its enrollees regarding the appropriate use of Emergency Services. An emergency is a medical condition that could cause serious health problems or even death if not treated immediately. Examples of this may include:

- Poisoning
- Sudden chest pains - heart attack
- Car accident
- Convulsions
- Very bad bleeding, especially if you are pregnant
- Broken bones
- Serious burns
- Trouble breathing
- Overdose

4.14 - Urgent Care Services

While providers serve as the medical home to enrollees and are required to adhere to the AHCCCS and MCA appointment availability standards, in some cases, it may be necessary to refer enrollees to one of MCA’s contracted urgent care centers (after hours in most cases). Please reference [Find A Provider](#) on MCA’s website and select Urgent Care Facility in the specialty drop down list to view a list of contracted urgent care centers.

MCA reviews urgent care and emergency room utilization for each provider panel. Unusual trends will be shared and may result in increased monitoring of appointment availability.

MCA educates its enrollees regarding the appropriate use of Urgent Care Services. Urgent Care Services are to be used when an enrollee needs care right away but is not in danger of lasting harm or of loss of life. Examples of this may include medical care for:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Health conditions that you have had for a long time
- Back strain
- Migraine headaches

4.15 - Primary Care Physicians (PCPs)

The primary role and responsibilities of primary care physicians participating in Mercy Care Advantage network include, but are not limited to:

- Providing initial and primary care services to assigned enrollees;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services and maintaining continuity of enrollee care;
- Maintaining the enrollee's medical record.

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the enrollee. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services and maternity services, if applicable.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to Mercy Care Advantage enrollees assigned to them and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring enrollees to specialty providers or hospitals within the Mercy Care Advantage network, as appropriate, and if necessary, referring enrollees to out-of-network specialty providers;
- Coordinating with Mercy Care Advantage's Prior Authorization Department about prior authorization procedures for enrollees;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned enrollees by other providers, specialty providers and/or hospitals;
- Coordinating the medical care for the Mercy Care Advantage enrollees assigned to them, including at a minimum:
 - Oversight of drug regimens to prevent negative interactive effects
 - Follow-up for all emergency services
 - Coordination of inpatient care
 - Coordination of services provided on a referral basis, and
 - Assurance that care rendered by specialty providers is appropriate and consistent with each enrollee's health care needs.

- The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.

4.16 - Specialist Providers

Specialist providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should only provide services to enrollees upon receipt of a written referral form from the enrollee's primary care provider or from another MCA participating specialist. Specialists are required to coordinate with the primary care provider when enrollees need a referral to another specialist. The specialist is responsible for verifying enrollee eligibility prior to providing services.

When a specialist refers the enrollee to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the enrollee, other specialists or other providers.

Primary Care Providers (PCPs) should only refer enrollees to MCA network specialists. If the enrollee requires specialized care from a provider outside of the MCA network, a prior authorization is required.

The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.

4.17 - Women's Health Specialists

MCA enrollees have direct access to mammography screening services at a contracted radiology facility without a referral, as well as direct access to in-network women's health specialists for routine and preventive services.

4.18 - Direct-Access Immunizations

MCA enrollees may receive influenza and pneumococcal vaccines from any network provider or participating retail pharmacy without a referral, and there is no cost to the enrollee if it is the only service provided at that visit. A PCP copayment will apply for all other immunizations that are medically necessary.

4.19 - Second Opinions

An enrollee may request a second opinion from a provider within the MCA contracted network. The provider should refer the enrollee to another network provider within an applicable specialty for the second opinion. Enrollee requests for a second opinion from a non-contracted provider requires prior authorization.

4.20 - Provider Assistance Program for Non-Compliant Enrollees

The provider is responsible for providing appropriate services so that enrollees understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage enrollees and ensure compliance with treatment plans and with scheduled

appointments. If you need assistance helping noncompliant enrollees, MCA's Provider Assistance Program is available to you. The purpose of the program is to help coordinate and/or manage the medical care for enrollees at risk. You may complete the **Provider Assistance Program Form** available under our [Forms](#) web page and submit it to Member Services for possible intervention.

If you elect to remove the enrollee from your panel rather than continue to serve as the medical home, you must provide the enrollee at least 30 days written notice prior to removal and ask the enrollee to contact Member Services to change their provider. The enrollee will NOT be removed from a provider's panel unless the provider's efforts and those of the Health Plan do not result in the enrollee's compliance with medical instructions. If you need more information about the Provider Assistance Program, please contact your Network Management Specialist/Consultant.

Documenting Enrollee Care

4.21 - Enrollee's Medical Record

The provider serves as the member's "medical home" and is responsible for providing quality health care, coordinating all other medically necessary services and documenting such services in the enrollee's medical record. The enrollee's medical record must be kept in a legible, detailed, organized and comprehensive manner and must remain confidential and accessible and in accordance with applicable law to authorized persons only. The medical record will comply with all customary medical practice, Government Sponsor directives, applicable Federal and state laws and accreditation standards.

- a) **Access to Information and Records** - All medical records, data and information obtained, created or collected by the provider related to enrollee, including confidential information must be made available electronically to MCA or any government agency upon request. Medical records necessary for the payment of claims must be made available to MCA within fourteen (14) days of request. Clinical documentation related to payment incentives and outcomes, including all pay for performance data will be made available to MCA or any government entity upon request. MCA may request medical records for transitioning an enrollee to a new health plan or provider. The medical record will be made available free of charge to MCA for these purposes.

Each enrollee is entitled to one copy of his or her medical record free of charge. Enrollees have the right to amend or correct medical records. The record must be supplied to the enrollee within fourteen (14) days of the receipt of the request.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements.

Enrollee identification information on each page of the medical record (i.e., name or AHCCCS identification number and CMS identification number)

- Documentation of identifying demographics including the enrollee's name, address, telephone number, AHCCCS identification number and CMS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Initial history for the enrollee that includes family medical history, social history and preventive laboratory screenings (the initial history for enrollees under age 21 should also include prenatal care and birth history of the enrollee's mother while pregnant with the enrollee)
- Past medical history for all enrollees that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (required for children; recommended for adult enrollees if available)
- Dental history if available, and current dental needs and/or services
- Current problem list
- Current medications
- Documentation, initialed by the enrollee's PCP, to signify review of:
 - Diagnostic information including:
 - Laboratory tests and screenings
 - Radiology reports
 - Physical examination notes, and
 - Other pertinent data.
 - Reports from referrals, consultations and specialists
 - Emergency/urgent care reports
 - Hospital discharge summaries
 - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when an enrollee's health status changes or new medications are prescribed
 - Behavioral health history
 - Documentation as to whether an adult enrollee has completed advance directives and location of the document
 - Documentation related to requests for release of information and subsequent releases, and
 - Documentation that reflects that diagnostic, treatment and disposition information related to a specific enrollee was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the enrollee's health care.

b) **Medical Record Maintenance** – The provider must maintain enrollee information and records for the longer of six (6) years after the last date provider services were provided to enrollee, or the period required by applicable law or Government Sponsor directions.

The maintenance and access to the enrollee medical record shall survive the termination of a Provider's contract with MCA, regardless of the cause of the termination.

- c) **PCP Medication Management and Care Coordination with Behavioral Health Providers -**
When a PCP has initiated medical management services for an enrollee to treat a behavioral health disorder, and it is subsequently determined by the PCP or MCA that the enrollee should receive care through the behavioral health system for evaluation and/or continued medication management services, MCA will require and assist the PCP with the coordination of the referral and transfer of care through the behavioral health case management team at MCA. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

4.22 - Access to Facilities and Records

Medicare laws, rules and regulations require that contracted providers retain and make available all records pertaining to any aspect of services furnished to MCA plan enrollees or their contract with the MCA for inspection, evaluation and audit for the longer of:

- A period of 10 years from the end of the contract period of MCA contract;
- The date the Department of Health and Human Services, the Comptroller General or their designees complete an audit; or
- The period required under applicable laws, rules and regulations.

4.23 - Confidentiality and Accuracy of Enrollee Records

Contracted providers must safeguard the privacy and confidentiality of and ensure the accuracy of any information that identifies an MCA plan enrollee. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.

Specifically, MCA's contracted providers must:

- Maintain accurate medical records and other health information.
- Help ensure timely access by enrollees to their medical records and other health information.
- Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and enrollee information.

4.24 - Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult enrollees. The advance directive must be prominently displayed in the adult enrollee's medical record. Requirements include:

- Providing written information to adult enrollees regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the enrollee's medical record whether the adult enrollee has been provided the information and whether an advance directive has been executed.

- Not discriminating against an enrollee because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

4.25 - Medical Record Audits

MCA will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when MCA is responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available free of charge. Medical records must be made available to AHCCCS for quality review upon request. MCA shall have access to medical records for assessing quality of care, conducting medical evaluations and regulatory audits, and performing utilization management functions.

4.26 - Documenting Enrollee Appointments

When scheduling an appointment with an enrollee over the telephone or in person (i.e. when an enrollee appears at your office without an appointment), providers must verify eligibility and document the enrollee's information in the enrollee's medical record.

4.27 - 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 MCA's [Forms](#) web page for an enrollee who continually misses appointments.

MCA encourages providers to use a recall system. MCA reserves the right to request documentation supporting follow up with enrollees related to missed appointments.

4.28 - Documenting Referrals

The provider is responsible for initiating, coordinating and documenting referrals to specialists, including dentists and behavioral health specialists within the MCA organization. The provider must follow the respective practices for emergency room care, second opinion and noncompliant enrollees.

4.29 - Respecting Enrollee Rights

MCA is always committed to treating enrollees with respect and dignity. [Rights and Responsibilities](#) are shared with staff, providers and enrollees each year. Rights and Responsibilities are incorporated herein and may be reviewed on the MCA Member website and in the MCA Evidence of Coverage.

4.30 - Provider Marketing

MCA and their contracted providers must adhere to all applicable Medicare laws, rules and regulations relating to marketing. Per Medicare regulations, "marketing materials" include, but are not limited to, promoting MCA, informing Medicare beneficiaries that they may enroll or

remain enrolled in MCA, explaining the benefits of enrollment in MCA or rules that apply to enrollees, or explaining how Medicare services are covered under MCA.

Regulations prevent MCA from conducting sales activities in healthcare settings except in common areas. MCA is prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. MCA is permitted to schedule appointments with beneficiaries residing in long-term care facilities, only if the beneficiary requests it.

Physicians and other health care professionals may discuss, in response to an individual patient's inquiry, the various benefits of Medicare Advantage plans. Physicians are encouraged to display plan materials for all plans with which they participate. Physicians and health care professionals can also refer their patients to 1-800-MEDICARE, the State Health Insurance Assistance Program; the specific Medicare Advantage Organization's marketing representatives; or the [CMS](#) website for additional information. Physicians and health care professionals cannot accept MCA plan enrollment forms. MCA follows the federal anti-kickback statute and CMS marketing requirements associated with Medicare marketing activities conducted by providers and related to Medicare plans. Payments that MCA makes to providers for covered items and/or services will be fair market value, consistent with an arm's length transaction, for bona fide and necessary services, and otherwise will comply with relevant laws and requirements, including the federal anti-kickback statute.

For a complete description of laws, rules, regulations, guidelines and other requirements applicable to Medicare marketing activities conducted by providers, please refer to the Code of Federal Regulations, Requirements for Medicare Communications and Marketing (§§ 422.2260–422.2274; 423.2260– 423.2274) which can be found at <https://www.govinfo.gov/help/cfr>.

4.31 – Consent to Treat Minors or Disabled Members under Guardianship

Health care professionals and organizational providers who treat or provide services for MCA members must comply with federal and state laws requiring consent for the treatment of minors or disabled members under guardianship to be HIPAA compliant.

Both participating and nonparticipating practitioners and providers are responsible for determining whether consent is needed for a service being provided to a member and must obtain appropriate consent as required. Since this involves Protected Health Information (PHI) and needs to be shared with the member's guardian or Durable Power of Attorney, providers are required to meet all HIPAA regulations.

If during a review or audit it is discovered that appropriate consent was not attained, it will be reported to our Quality Management Department or Chief Medical Officer.

4.32 - Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All PHPs are required to adhere to **HIPAA Regulations**. In accordance with HIPAA guidelines, providers may not interview enrollees about medical or financial issues within hearing range of other patients.

If a PHP discovers an event that resulted in impermissible use or disclosure of protected health information for Mercy Care Advantage and/or Mercy Care enrollees, please immediately notify your Network Management representative. Timely notification is required because Mercy Care, Mercy Care Advantage, and contracted PHPs must comply with the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, which requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information.

4.33 - Cultural Competency, Health Literacy and Linguistic Services

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter.

Mercy Care (herein MC) members must receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. PHPs are required to treat all enrollees with dignity and respect, in accordance with federal law.

Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Members with physical and mental disabilities.

Studies show that people who understand health instructions make fewer mistakes when they take their medicine or prepare for a medical procedure. They may get well sooner or better manage chronic health conditions. Mercy Care's health literacy and cultural competency program is designed to help providers and members work together and communicate effectively to achieve the best health outcomes. The PCP is responsible for providing appropriate services so that members understand their health care needs and the member is compliant with their health care.

Actions for providers and provider organizations to improve health outcomes:

- Responding to cultural and linguistic needs of our members
- Applying health literacy techniques to enhance their communication skills during patient/provider interactions

Cultural and linguistic competence is defined as:

- “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (*Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards a Culturally Competent System of Care Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center*)
- “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (*Ratzan and Parker, 2000*)

Responding to cultural and linguistic needs of our members

The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, comorbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access.

Mercy Care’s members are diverse, with their own set of values and beliefs. Providers and office staff can have a positive effect on patient care (encounters) by:

- Delivering understandable and respectful care that is provided in a manner compatible with the member’s cultural health beliefs and practices and in their preferred language. Once the baseline understanding of cultural differences is understood, this serves as a context for future communication.
- Develop communication skills to deliver cross-culturally competent care. Examples of culturally competent care include:
 - Striving to overcome cultural, language, and communications barriers;

- Providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
- Using community workers as a check on the effectiveness of communication and care;
- Encouraging patients/consumers to express their spiritual beliefs and cultural practices; and
- Being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.

When members need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.

- Use Language Services for Mercy Care members. Providers must deliver information in a manner that is understood by the member. MC complies with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. MC strongly recommends the use of professional interpreters, rather than family or friends.
 - The 711 TTY line is available for members who are hearing impaired.
 - [Language Line](#) is the service provider contracted with Mercy Care. They provide telephonic interpretation services in over 200 languages. This service is available at no cost to you or the member. To access telephone interpretation services to assist members who speak a language other than English or who use sign language, please call Language Line directly at the following phone number/pin:
 - Clinical Services (CL): (855) 380-5345, pin 1204;
 - or Non-Clinical Services (NC): (855) 380-5345, pin 5345

Applying health literacy techniques to enhance communication skills during patient/provider interactions

If health literacy techniques are applied, then members would have the capacity to obtain, process and understand the basic health information and services needed to make appropriate health decisions.

What does this mean to the member? They would know their benefits and services and where to go for services and as a result:

- They would be able to read and comprehend prescription bottles, appointment slips, and other essential health-related materials required to successfully function as a patient;
- Have fewer ER visits;
- Have fewer illnesses related to mistakes in taking medication;
- Show up for appointments; and

- Follow up on their treatment plan as prescribed by their provider.

It is important not only to the member, but also the responsibility of all providers and health care service delivery organizations to create a health literacy environment and ensure the patient/provider relationship supports all components of health literacy. Components of Health Literacy include:

- Reading and writing
- Listening and verbal communication
- Numeracy (representation of numbers for everyday life)
 - Computation skills
 - Interpreting/evaluating risk (%)
 - Empowerment

To create this type of environment, consider the other areas that provide context into the success of communication and health empowerment:

- Values, beliefs, culture
- Languages spoken
- Family belief systems
- Community support

In addition, there may be other considerations or roadblocks to learning, communicating, and comprehending at the member level:

- Cognitive impairment
- Hearing/visual impairment
- Medications
- Stress
- Shame associated with lack of literacy skills

While providers and their office staff would not be able to know everything about a patient, there are general practices, tools and techniques to empower patients, communicate effectively, and create an open dialogue. Here are some quick communication strategies:

1. Keep language simple - no jargon; define terms.
2. Be aware of the member considerations or “roadblocks” to learning.
3. Create an open environment based on respect for the member and allowing them to communicate their cultural beliefs regarding what you are saying.
4. Use the “teach back” method – teach to goal.
5. Get rid of phrase, “Do you have any questions?” and replace with “What questions do you have?”

The teach back method and communication tips are included in the **Provider and Patient Communication Guide** available on our [Reference Material and Guides](#) web page. There are

specific tools and techniques that providers can reference to help create awareness and learn new skills in the health literacy field.

Additional Provider Resources available for your use include:

- <http://www.nih.gov/clearcommunication/culturalcompetency.htm>
- www.healthliteracymissouri.org
- <https://community.lincs.ed.gov/group/health-literacy> (Health Literacy Discussion Group)
- <http://www.ama-assn.org/ama> (Foundation/Health Literacy)
- http://www.acponline.org/about_acp
- <http://www.healthypeople.gov/2020/leading-health-indicators/Leading-Health-Indicators-Development-and-Framework>

4.34 - Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician’s office, be accessible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

4.35 - PCP Assignments

MCA enrollees may select their PCP or if no choice is made at the time of enrollment, MCA will automatically assign a PCP. Enrollees have the right to change their provider at any time. Enrollee eligibility changes frequently, as a result, providers must verify eligibility prior to delivering services.

4.36 - Plan Changes

Medicare beneficiaries who qualify for Medicare and Medicaid are considered “dual eligible” and are entitled to a CMS defined Special Election Period (SEP). Dual eligible beneficiaries can use the Dual/LIS SEP once per quarter (certain exceptions apply) to change Medicare plans. The Dual/LIS SEP cannot be used in the 4th quarter of the year (October – December), during this timeframe the beneficiary can use the CMS Annual Enrollment Period to make a plan change for a January 1 effective date. Other Special Election periods may apply depending on the enrollee’s situation. Enrollment elections are effective the first of the month following receipt of the election request. Dis-enrollments are effective the last day of the month upon receipt of the enrollees’ written request or upon notification from CMS that the enrollee has enrolled in a new plan. To maintain eligibility for Medicare Part D, it is recommended that an enrollee select another MAPD plan or if they elect to return to Original Medicare, they must elect a standalone Part D prescription drug plan, which will automatically dis-enroll them from

MCA. Dis-enrolling from MCA does not affect an enrollee's AHCCCS Medicaid coverage or plan assignment.

Provider Guidelines and Plan Details

4.37 - Cost Sharing and Coordination of Benefits

Providers must adhere to all contract and regulatory cost sharing guidelines. When an enrollee has other health insurance, such as a commercial carrier, MCA will coordinate payment of benefits in accordance with the terms of the PHP's contract and federal and state requirements.

4.38 - Clinical Guidelines

To help provide MCA members with consistent, high-quality care that utilizes services and resources effectively, we have chosen certain clinical guidelines to help our providers. These are treatment protocols for specific conditions as well as preventive health guidelines.

Please note that these guidelines are intended to clarify standards and expectations. They should not:

- Come before a provider's responsibility to provide treatment based on the member's individual needs.
- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

4.39 - Office Administration Changes and Training Requirements

Providers are responsible to notify MCA's Provider Relations of changes in professional staff at their offices (physicians, physician assistants or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact your Network Management Specialist/Consultant to schedule any needed staff training.

The following trainings are required for participation in the MCA network:

- Medical records standards
- Model of Care training
- Fraud and abuse training
- Compliance training
- Behavioral health step therapy for members with depression, post-partum depression, anxiety and attentive deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals (appendices E and F)
- PCP training regarding behavioral health referral and consultation services

All providers and facilities must remain in good standing with any licensure or regulatory agency and adhere to all training requirements. This includes clinical supervision, orientation and training requirements.

4.40 - Contract Additions or Physician Terminations

To meet contractual obligations and state and federal regulations, providers **must** report any terminations or additions to their contract at least 90 calendar days prior to the termination or change for MCA to comply with CMS' member notification requirements. Providers are required to continue providing covered services to enrollees until the effective date of their contract termination.

CMS requires that MCA make a good faith effort to provide written notice of a termination of a contracted physician at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the physician whose contract is terminating. However, please note that when a contract termination involves a PCP, all enrollees who are patients of that PCP must be notified.

4.41 - Continuity of Care

Providers terminating their contracts without cause are required to continue to treat MCA enrollees until the treatment course has been completed or care is transitioned. Authorization may be necessary for these services. Enrollees who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. MCA is not responsible for payment of services rendered to enrollees who are not eligible.

4.42 - Contract Changes or Updates

CMS expects Medicare Advantage Organizations (MAO) to have processes in place to have regular, ongoing communications/contacts (at least quarterly) with providers to ascertain their availability and, specifically, whether they are accepting new patients, in addition to requiring contracted providers to inform the plan of any changes to street address, phone number, and other changes that affect availability. MAOs must include in their online provider directories all active contracted providers, with specific notations to highlight those providers who are closed or not accepting new patients. CMS monitors and audits MAO online provider directories for compliance with this - requirement.

Providers **must** report any changes to demographic information to MCA at least 90 calendar days prior to the change to be in compliance with contractual obligations and state and federal regulations. When a provider has elected to terminate their contract, they are still required to continue providing services to enrollees until their termination effective date. For information on where to send change information, refer to the Table 8, Provider Record Updates (below).

4.42.1 – Provider Record Updates

<u>Type of Change</u>	<u>Notification Requirements</u>	<u>Send To</u>	<u>Notice Requirement</u>
Individual or group name	Must mail updated W-9 and letter describing change and effective date	Network Management	90 days

Tax ID number	Must mail updated W-9 and letter describing change and effective date	Network Management	90 days
Address, phone and office hours, not accepting new patients	Must fax 860-975-3201 or mail	Network Management	90 days
Staffing changes including physicians leaving the practice	Must fax 860-975-3201 or mail letter describing change and effective date	Network Management	90 days
Adding new office locations	Must fax 860-975-3201 or mail letter describing change and effective date	Network Management	90 days
Adding new physicians to current contract	Must fax 860-975-3201 or mail letter describing change and effective date	Network Management	90 days

4.43 - Credentialing/Re-Credentialing

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses and DEA certificates are also required. Please note that providers may not treat MCA enrollees until they are credentialed.

Temporary/Provisional Credentialing Process

Mercy Care Plan shall have 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into Mercy Care's information system to allow payment to the provider effective the date the provisional credentialing is approved.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

For additional details regarding credentialing/re-credentialing, please refer to our **Credentialing/Re-Credentialing Process**, available on our [Reference Material and Guides](#) web page.

4.44 - Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated in their contract.

4.45 - Provider Policies and Procedures - Health Care Acquired Conditions and Abuse

As a prerequisite to contracting with an organizational provider, MCA must ensure that the organizational provider has established policies and procedures that meet state and federal requirements. The requirements must be met for all organizational providers (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis centers, transportation companies, dental and medical schools, and free-standing surgi-centers): and the process by which the subcontractor reports at a minimum incidences of Health Care Acquired Conditions, abuse, neglect, exploitation, injuries, suicide attempts and unexpected death to MCA.

4.46 - Receipt of Federal Funds, Compliance with Federal Laws and Prohibition on Discrimination

Payments received by contracted providers from MCA for services rendered to plan enrollees include federal funds; therefore, MCA's contracted providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law;
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.);
- The anti-kickback statute (section 1128B(b) of the Social Security Act); and
- HIPAA administrative simplification rules at 45 CFR parts 160, 162 and 164.

In addition, our contracted providers must comply with all applicable Medicare laws, rules and regulations, and as provided in applicable laws, rules and regulations, contracted providers are prohibited from discriminating against any MCA plan enrollee based on health status.

4.47 - Financial Liability for Payment of Services

In no event should MCA contracted providers bill an MCA plan enrollee (or a person acting on behalf of an MCA plan enrollee) for payment of fees that are the legal obligation of MCA. However, a contracted provider may collect deductibles, coinsurance or copayments from MCA plan enrollees in accordance with the terms of the enrollee's Evidence of Coverage.

Note: CMS issued a memo to MCA dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this

CMS Guidance states that providers are prohibited from balance billing Dual Eligible beneficiaries who are classified as Qualified Medicare Beneficiaries (QMB) for Medicare Parts A and B cost sharing amounts. The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or Medicare Advantage plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as “private pay patient” to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment. Providers participating in Medicare networks are required to comply with all the requirements set forth in this CMS Guidance.

CHAPTER 5 - COVERED AND NON-COVERED SERVICES

5.0 - Coverage Criteria

All Medicare-covered services must be medically necessary, and except for emergency or urgently needed care, or otherwise authorized by MCA, must be provided by a participating PCP or other qualified participating providers. Benefit limits apply.

Participating providers are required to administer covered services to MCA enrollees in accordance with the terms of their contract and enrollee's benefit package.

5.1 - Covered Services

MCA has specific covered and non-covered services. To review MCA covered benefits and services, please refer to our Mercy Care Advantage Member website. The page titled [Member Materials](#) contains a copy of the current MCA Summary of Benefits and Evidence of Coverage.

5.2 - Non-Covered Services - MCA

- Services not reasonable or necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by MCA as a covered service.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or under a Medicare-approved clinical research study or by our plan. Detailed information regarding Medicare Clinical Trial policies can be found on the CMS website. Experimental procedures and items are those items and procedures determined by MCA and the Original Medicare Plan to not be generally accepted by the medical community.
- Private room in a hospital, unless medically necessary.
- Charges for personal convenience items, such as a telephone or television in a room in a hospital or skilled nursing facility.
- Nursing care on a full-time basis in the enrollee's home.
- Custodial care provided in a nursing home, hospice or other facility setting when the enrollee does not require skilled medical care or skilled nursing care. "Custodial care" is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered. These services may be covered for some enrollees under their Medicaid health plan benefits.
- Homemaker services. These services may be covered for some enrollees under their Medicaid health plan benefits. Charges imposed by immediate relatives of the household. These services may be covered for some enrollees under their Medicaid health plan benefits.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.

- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
- Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet, with one exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
- Dentures.
- Non-routine dental care. Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under MCA, we will reimburse veterans for the difference. Enrollees are still responsible for our Plan cost-sharing amount.

CHAPTER 6 - BEHAVIORAL HEALTH

6.0 - Behavioral Health Overview

MCA covers behavioral health services under certain conditions that include:

- Partial hospital program and intensive outpatient programs.
- Medication monitoring.
- Counseling by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. (First ten visits are covered without Prior Authorization for contracted providers).
- Inpatient psychiatric services with a limitation on freestanding psychiatric hospitals. There is a 190-day limit for free standing psychiatric hospitals. If the enrollee goes to a behavioral health unit contained in the hospital this limit does not apply.
- Substance Abuse Treatment - Substance abuse mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other Medicare-qualified mental health care professional as allowed under applicable state laws.

6.1 - MCA Behavioral Health Emergency Services

If an enrollee is in a behavioral health crisis, call the MCA Behavioral Health Hotline at: 800-876-5835. Medicare covers medically necessary services. MCA enrollees are eligible for behavioral health services through contracted behavioral health providers.

6.2 - PCP Responsibilities for MCA Care Behavioral Health Services

Enrollees should be screened by their PCP for behavioral health needs during routine or preventive visits. If a provider feels that an enrollee needs behavioral health services, referrals for these services should be coordinated through the enrollee's case manager for long term care enrollees and the behavioral health coordinator for acute plan enrollees.

Behavioral health forms are available on our [Forms](#) web page and include:

- **ECT Prior Authorization Request Form**
- **Request for Psychological Testing**

6.3 - Coordination of Care

The PCP will be informed of the enrollee's behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, current behavioral health diagnosis and treatment within 10 business days of receiving the request.

Where there has been a change in an enrollee's health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document, and initial signifying review receipt of information received from a behavioral health provider who is treating the enrollee.

The behavioral health providers should supply the PCP with information regarding services that they are providing so that they may be included in the enrollee's permanent medical record.

CHAPTER 7 – MCA COVERED SERVICES AND SUPPLEMENTAL BENEFITS

To review MCA covered benefits and services; please refer to our Mercy Care Advantage Member website available at [MercyCareAZ.org](https://www.mercycareaz.org). The page titled [Member Materials](#) contains a copy of the current MCA Summary of Benefits and Evidence of Coverage. Chapter 4 of the MCA Evidence of Coverage contains a complete description of covered benefits and exclusions.

7.0 - Dental Services Overview

Medicare covers limited non-routine dental care – surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor.

MCA provides additional supplemental dental benefits, which include the following preventative and diagnostic dental services for a \$0 copay:

- One (1) cleaning every six months.
- One (1) fluoride treatment every six months.
- One (1) exam every six months.
- One (a) X-ray per year.
- One (a) full mouth/Panorex X-ray every three years from the date of last Panorex X-ray.

MCA provides a **\$5,000** annual allowance for comprehensive dental services, which includes:

- Extractions
- Endodontic – Root Canals
- Periodontics – Gum Treatment
- Restorative Services including Fillings, Replacement of Defective Fillings, Removal of Decay, Single Unit Crowns
- Prosthodontic services including removable dentures, relines, rebase, repairs, adjustments and Oral/Maxillofacial surgery
- Anesthesia Services, when appropriate with a covered dental service
- No prior authorization required.

Excluded: Services related to emergency dental treatment; certain prosthodontic procedures such as bridges and dental implants and the surgical preparation for these types of procedures and/or their repair; orthodontics; and services related to the treatment of chronic TMJ. NOTE: These services may be covered under your AHCCCS (Medicaid) benefits.

MCA dental benefits are administered by DentaQuest. Members must use dental providers participating in the DentaQuest network.

7.1 - Vision Services Overview

Medicare covers the following services:

- Exams to diagnose and treat diseases and conditions of the eye.
- Preventive and diagnostic eye exams for diabetic retinopathy, glaucoma and macular degeneration that result from illness or injury. A glaucoma test once every 12 months

for people at high risk for glaucoma. The screening must be done or supervised by an eye doctor who's legally allowed to do this test. This includes members with diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic American and 65 or older.

- Cataract Surgery: Medicare covers conventional Intraocular Lenses (IOLs) when it is implanted as a part of cataract surgery.
- Eye Prostheses: Medicare covered when there is an absence or shrinkage of an eye due to birth defect, trauma, or surgical removal. Medicare generally covers replacement every 5 years. Medicare covers polishing and resurfacing.
- One (1) pair of Medicare covered eyeglasses or contact lenses after each cataract surgery.
- Eye Exams: Medicare doesn't cover routine eye exam (sometimes called a "refraction test") to obtain a prescription for eyeglasses or contact lenses. But MCA offers coverage for a routine eye exam.

MCA provides additional supplemental vision services and an eyewear benefit:

- One (1) supplemental routine eye exam per year at \$0 copay.
- Eyewear - \$300 allowance for lenses, eyeglass frames and contacts every year.

7.2 – Hearing Services Overview

Medicare covers the following services:

- Diagnostic hearing and balance exams

MCA provides an additional supplemental hearing aid benefit:

- \$1,900 allowance for hearing aids every two years

7.3 - Podiatry Services Overview

Medicare covers the following services:

- Diagnosis and the medical or surgical treatment of injuries and diseases of the feet.
- Routine foot care for enrollees with certain medical conditions affecting the lower limbs.

MCA provides additional supplemental podiatry services:

- One (1) supplemental routine visit every three months for \$0 copay.

7.4 - Chiropractic Services Overview

Medicare covers the following services:

- Manual manipulation of the spine to correct subluxation

MCA provides additional supplemental chiropractic services:

- 12 supplemental routine visits every year at \$0 copay.

7.5 – Over the Counter Benefit (OTC)

Mercy Care Advantage members have \$100 a month to purchase generic over the counter (OTC) drugs and personal health and wellness products. Our partner for this service is OTC

Health Solutions. Orders can be placed by phone or online and will be shipped at no cost. Effective 1/1/2020, over the counter (OTC) drugs and personal health and wellness products are available for purchase at select CVS pharmacy retail locations.

7.6 – Transportation

Mercy Care Advantage covers routine transportation services to access the supplemental benefits covered by Mercy Care Advantage. Our plan will cover up to 42 one-way trips or 21 roundtrips every calendar year. Members may have additional transportation services available under their Medicaid plan coverage.

7.7 – Meals-Post Discharge

Mercy Care Advantage provides an additional supplemental meal benefit. This benefit will provide 28 meals upon each discharge from a hospital stay. Members may have additional meal benefit available under their Medicaid plan coverage.

7.8 – Telehealth

Mercy Care Advantage will provide members with access to board-certified doctors using a smartphone or computer via the Internet to have a consult about non-emergency conditions. This service is available 24 hours a day, seven days a week.

CHAPTER 8 - CASE MANAGEMENT AND CONDITION MANAGEMENT

8.0 - Case Management and Condition Management Overview

MCA has a comprehensive case management program. The Medical Case Management team considers the medical, social and cultural needs of enrollees by targeting, assessing, monitoring and implementing services for enrollees identified as "at risk." Case Management and Condition Management services are available for all eligible enrollees, however, enrollees who are identified as "at risk," as described below are assigned a high-risk case manager.

A wide spectrum of services is available for enrollees, providers and families who need assistance in finding and using appropriate health care and community resources. The MCA case management staff:

- Considers the medical, social and cultural needs of enrollees in targeting, assessing, monitoring and implementing services for enrollees.
- Helps enrollees and families in navigating through the complex medical and behavioral health systems.
- Provides education on chronic conditions and assists enrollees to appropriately manage these conditions by coordinating services needed to achieve optimal outcomes.

This site contains the treatment protocol related to:

- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)
- Major Depressive Disorder in Adults
- HIV
- Attention Deficit/Hyperactivity Disorder (ADHD)

8.1 - Referrals

Referrals for case management are accepted from any source. Please leave a message at **602-586-1870** to make a referral. A registered nurse at Mercy Care Plan will review the case and determine whether to assign a High-Risk Case Manager or a less intensive level of care coordination. Case managers will contact the enrollee either by telephone or by letter. The case management staff communicates with enrollees, family and the PCP on an ongoing basis while the enrollee's case is open.

8.2 - Case Management

Case management services are provided to medically complex enrollees. The enrollees are assigned to a case manager who works closely with the PCP and enrollee to coordinate care and services. The case manager also collaborates with community resources, home health services and PCPs to coordinate medical care and assure appropriate access to medical and social services.

Enrollees who meet any of the following criteria and do not fall under other identified categories of case management will also be considered for case management services:

- High utilizers of services
- Frequent inpatient readmissions
- Overuse of the emergency department
- Have a poorly controlled chronic condition, such as asthma, CHF, COPD, diabetes or depression
- Chronic controlled substance use
- Poor compliance with prescribed medical treatment
- Experiencing social problems that are impacting medical care
- Multiple, complex care needs

A health risk assessment and any other information available on the enrollee will be used to develop a care plan, which the case manager shares with the enrollee and the assigned PCP. The case manager interacts routinely with the PCP, the enrollee and the enrollee's care giver/family to monitor progress toward meeting the care plan goals.

8.3 - HIV/AIDS

Early identification and intervention of enrollees with HIV allows the case manager to assist in developing basic services and information to support the enrollee during the disease process. The case manager links the enrollee to community resources that offer various services, including housing, food, counseling, dental services and support groups. The enrollee's cultural needs are continually considered throughout the care coordination process.

The MCA case manager works closely with the PCP, the MCA corporate director of pharmacy, and an MCA medical director to assist in the coordination of the multiple services necessary to manage the enrollee's care. PCPs wishing to provide care to enrollees with HIV/AIDS must provide documentation of training and experience and be approved by the MCA credentialing process. These PCPs must agree to comply with specific treatment protocols and AHCCCS requirements. PCPs may elect to refer the enrollee to an AHCCCS approved HIV specialist for the enrollee's HIV treatment.

8.4 – Chronic Condition Management

The Case Management team administers condition management programs intended to enhance the health outcomes of enrollees. Condition management targets enrollees who have illnesses that have been slow to respond to coordinated management strategies for the following conditions: asthma, COPD, CHF, diabetes or depression. The primary goal of condition management is to positively affect the outcome of care for these enrollees through education and support and to prevent exacerbation of the disease, which may lead to unnecessary hospitalization.

The objectives of condition management programs are to:

- Identify enrollees who would benefit from the specific condition management program
- Educate enrollees on their disease, symptoms and effective tools for self-management

- Monitor enrollees to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care
- Provide evidence-based, nationally recognized expert resources for both the enrollee and the provider;
- Monitor effectiveness of interventions.
- Refer enrollees for tobacco cessation assistance as needed

The following conditions are specifically included in MCA’s Condition Management programs and have associated Practice Guidelines that are reviewed annually.

8.5 - Asthma

The Asthma Condition Management program offers coordination of care for identified enrollees with primary care physicians, specialists, community agencies, the enrollees’ caregivers and/or family. Enrollee education and intervention is targeted to empower and enable compliance with the physician’s treatment plan.

Providers play an important role in helping enrollees manage this chronic condition by promoting program goals and strategies, including:

- Preventing chronic symptoms
- Maintaining “normal” pulmonary function
- Maintaining normal activity levels
- Maintaining appropriate medication ratios
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations
- Providing optimal pharmacotherapy without adverse effects
- Providing education to help enrollees and their families better understand the disease and its prevention/treatment

8.6 - Chronic Obstructive Pulmonary Disease (COPD)

The COPD Condition Management program is designed to decrease the morbidity and mortality of enrollees with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to enrollees with COPD, decrease complication rates and utilization costs, and improve the enrollees’ health. The objectives of the COPD Condition Management program are to:

- Identify and stratify enrollees
- Provide outreach and condition management interventions
- Provide education through program information and community resources
- Provide provider education through the COPD guidelines, newsletters and provider profiling

8.7 - Congestive Heart Failure (CHF)

The CHF Condition Management program is designed to develop a partnership between MCA, the primary care provider and the enrollee to improve self-management of the disease. The

program involves identification of enrollees with CHF and subsequent targeted education and interventions. The CHF Condition Management Program educates enrollees with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

8.8 – Depression

The Depression Condition Management program aims to provide enrollees with education and support surrounding this condition and to assist them with any care coordination needs as a result. Depression screening is available to care management staff and can be used to inform the enrollee’s provider(s) regarding the severity of the condition. Case management can educate and assist enrollees with the following:

- Identifying signs and symptoms of depression
- Finding appropriate behavioral health care
- Providing education and reinforcement regarding the various treatment modalities available

8.9 - Diabetes

The Diabetes Condition Management program involves identification of enrollees with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance with increasing enrollee compliance with diabetes care and self-management regimens. Providers play an important role in helping enrollees manage this chronic condition. MCA appreciates providers’ efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in MCA’s Diabetes Management Practice Guidelines
- Laboratory exams that include:
 - Glycohemoglobins at least twice annually
 - Micro albumin
 - Fasting lipid profile annually
 - Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

8.10 - Active Health

MCA has contracted with Active Health Management to administer a patient health-tracking program that was implemented in October of 2008 with providers. Effective March of 2010, enrollees will be receiving letters concerning their “Care Considerations” as well.

Active Health will expand MCA’s opportunities to identify enrollees at risk for poor health outcomes and to communicate directly with the providers who are responsible for their care, in a time-critical mode. It also enables the enrollee to work closely with their physician to choose treatments and tests that are right for them, Active Health utilizes data received through claim, lab and pharmacy submissions to identify potential opportunities to meet evidence-based guidelines, such as through the addition of new therapies, avoidance of contraindications or prevention of drug interactions. When an opportunity is identified for our enrollee, a formal

patient-specific communication will be sent to the provider to assist in offering health care to the patient based upon the physician's independent medical judgment. A "Care Consideration" letter will be sent to the enrollee as well, encouraging them to discuss the "Care Consideration" with their physician.

It is important to note that this program is not a utilization review mechanism and does not constitute consultation. MCA's goal is to offer timely, accurate and patient-specific information to facilitate patient care and improve outcomes.

Examples of "Care Consideration" are:

- If the enrollee is a diabetic and there are no records that the patient has had their eyes checked or an HgA1c lab has been done.
- If the patient has a heart condition and there are no records to show that the enrollee is on any type of drug to lower cholesterol.

CHAPTER 9 - CONCURRENT REVIEW

9.0 - Concurrent Review Overview

MCA conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines® and the AHCCCS NICU/Nursery/Step-Down Utilization Guidelines. Admission certification is conducted within one business day of receiving notification. It is the responsibility of the facility to notify MCA of all enrollee admissions and emergency department visits to assure that a service medical necessity review is conducted so that claims are not delayed. Services rendered without notification will result in the claim being held for retrospective review. Failure to notify MCA of an admission or emergency department visit within ten (10) days of the encounter may result in denial of the claim.

Continued stay reviews are conducted by MCA concurrent review nurses before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. The nurses work with the medical directors in reviewing medical record documentation for hospitalized enrollees. MCA medical directors may make rounds on site as necessary. MCA concurrent review staff will notify the facility case management department and business office at the end of the enrollee's hospitalization stay, by fax, of the days approved and at what level of care.

9.1 - Milliman Care Guidelines®

MCP uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific case is available for review upon request.

9.2 - Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the enrollee and for involving the enrollee and family in implementing the plan.

The MCA concurrent review Nurse (CRN) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for enrollees with complex and/or multiple discharge needs.

- Providing hospital staff and attending physician with names of contracted MCA providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers). The CRN is critical in assisting with discharge planning and may authorize services required for a safe discharge such as pharmacy, home health and DME. MCA CRN staff work to make sure there is a safe discharge even when the primary payer is not MCP, so it is important that the facilities notify MCA of all members.
- Informing hospital staff and attending physician of covered benefits as indicated.

9.3 - Physician Medical Review

MCA medical directors conduct medical review for each case with the potential for denial of medical necessity. The CRN (Inpatient) or the prior authorization nurse (Outpatient) reviews the documentation for evidence of medical necessity according to established criteria. When the criteria are not met, the case is referred to an MCA medical director. The medical director reviews the documentation, discusses the case with the nurse and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Utilization management decisions are based only upon appropriateness of care and service. MCA does not reward practitioners, or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by a physician.

For inpatient denials, hospital staff is verbally notified when MCA is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal claim dispute may be filed according to the established MCA claim dispute process.

CHAPTER 10 - PHARMACY MANAGEMENT

10.0 - Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized prescriber, such as a PCP, specialist, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible for the prescription to be dispensed. The formulary identifies all the Part D prescription drugs covered by MCA. The formulary and utilization management criteria have been developed and approved by the Pharmacy and Therapeutics Committee (P&T Committee) to ensure that they are clinically appropriate to meet the therapeutic needs of our enrollees in a cost-effective manner. CMS reviews and approves the MCA formulary and utilization management criteria annually.

10.1 - Updating the Formulary

MCA's formulary is continuously reviewed by the P&T Committee and prescription drugs are added or removed based on objective, clinical and scientific data and market changes. All updates to the formulary must be approved by CMS and adhere to CMS formulary guidance on changes. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change drugs listed in the formulary. Market share shifts, price increases, generic availability and varied dosage regimens may affect the actual cost of therapy.
- MCA formulary must adhere to CMS formulary guidance and requirements.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the formulary, other drugs in the same category may be removed.

10.2 - Notification of Formulary Updates

MCA must follow CMS policy regarding formulary changes. MCA may add drugs to the formulary or delete utilization management requirements at any time during the year. Generally, if a member is taking a drug on our formulary that was covered at the beginning of the year, MCA will not discontinue or reduce coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available, when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. CMS approval is required for certain types of formulary changes. MCA will provide notice to affected enrollees at least 60 days prior to removing a covered Part D drug from the formulary. If the FDA deems a drug unsafe or it is removed from the market by its manufacturer, MCA will provide a retrospective notice as soon as possible. A copy of the MCA formulary and utilization management criteria is available on the MCA website.

Federal Part D regulations require MCA to have a formulary that contains at least two Part D prescription drugs in each approved category, and all drugs (but not necessarily all dosage forms) in the six special classes listed below:

- Antidepressants
- Antipsychotic
- Anticonvulsants
- Antiretroviral
- Antineoplastics
- Immunosuppressant

Both generic and brand name drugs are covered by MCA, but some drugs are statutorily excluded from coverage under Medicare Part D or are excluded for certain indications.

Excluded drugs include, but are not limited to:

- Drugs for anorexia, weight loss or weight gain;
- Fertility drugs;
- Erectile Dysfunction drugs;
- Drugs for cosmetic purposes or hair growth;
- Drugs for symptomatic relief of cough and cold (exceptions may apply);
- Prescription vitamins and mineral products (except pre-natal vitamins and fluoride preparations);
- Electrolytes/Replenishers;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale;
- Non-prescription drugs (also called over-the-counter drugs);
- Drugs covered under Medicare Part A or Part B (exceptions may apply);
- Drugs purchased outside the United States and its territories;
- Off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use”.

Barbiturates and benzodiazepines are therapeutic classes that are covered by Medicare Part D and are represented on the formulary. As with other therapeutic classes, not all drugs in these categories are covered under the MCA Formulary. Phenobarbital is only covered by Medicare Part D for the indications of cancer, epilepsy and chronic mental health disorders.

In August 2017, CMS announced the injectable drug Parsabiv® (etelcalcetide) that falls within the bone and mineral metabolism functional category has been approved for renal dialysis services by the United States Food and Drug Administration (FDA). Beginning January 1, 2018,

the injectable drug Parsabiv® (etelcalcetide) will be included in the ESRD Prospective Payment System (PPS). With the inclusion of Parsabiv® in the ESRD PPS, Sensipar® (cinacalcet) will also now be included in the ESRD PPS and therefore no longer payable under Part D benefit when used for the provision of renal dialysis services. The 2018 Mercy Care Advantage formulary will require a Part B versus Part D prior authorization when Sensipar® (cinacalcet) is prescribed for Mercy Care Advantage members.

Home Infusion Drugs covered under Medicare Part D are covered under the MCA formulary and claims are submitted to the PBM. Claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by a provider to an enrollee are covered under the enrollee's medical benefits and would be billed to MCA.

10.3 - Pharmacy Transition of Care Process

New enrollees (within their first 90 days) taking prescription drugs that are not on the MCA formulary, or formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy, will receive a temporary transitional fill of up to a 31-day supply of a non-formulary drug, or a formulary drug requiring prior authorization at a retail pharmacy.

Enrollees and their prescribing physician will receive a letter instructing them to consult with their prescribing physician to decide if they should switch to an equivalent drug that is on the MCA formulary or to request a formulary exception to get coverage for the drug. Only drugs that are covered under Medicare Part D are eligible for Transition Fills. Part B medications are not eligible for a Transition Fill.

MCA will not pay for additional fills for the drug(s) unless the prescriber submits a request for a coverage determination or formulary exception and MCA approves. If a formulary exception is approved, the approval will be valid through the remainder of the calendar year, unless prescribed for a lesser period.

10.4 - LTC/ Nursing Facility

If a new enrollee is a resident of a Long Term Care facility, and are entitled to a transition fill, MCA will allow a refill of the prescription until we have provided up to a 31-day supply (unless the prescription is written for less) during the transition period. If your prescription is written for less than a 31-day supply, we will allow multiple fills to provide up to a maximum of 31-days of medication.

If an enrollee has unplanned level of care changes, (e.g., discharged from a hospital to a home, or ending a stay at a long-term care facility and returning home), MCA will provide a transition fill of a currently prescribed drug to transition the enrollee to their new level of care setting. The enrollee and the enrollee's physician will receive a letter notifying them that they will need to transition to a prescription drug on our formulary or request a coverage determination.

Please note that the MCA transition policy applies only to Part D drugs filled at a network pharmacy.

10.5 - Part D Co-Payments

Co-payments for covered Part D prescription drugs are mandatory per federal regulations. Because MCA enrollees are dual eligible and qualify for Low Income Subsidy (LIS) assistance with their Part D prescription drug coverage they are only required to pay small co-pays for each prescription drug they receive. The maximum co-pay an enrollee must pay for drugs is based on the federal Low-Income Subsidy (LIS) thresholds which are published annually. Certain enrollees qualify for a \$0 co-pay **for covered Part D drugs.**

The 2023 Part D LIS cost sharing amounts are:

- \$0/\$1.45/\$4.15 (each prescription for generic/preferred multisource drugs)
- \$0/\$4.30/\$10.35 (each prescription for all other drugs)

The following are Medicare Part D cost sharing changes resulting from the Inflation Reduction Act (IRA) issued in August 2022, which become effective January 1, 2023. These new requirements apply to our Mercy Care Advantage (MCA) membership.

Part D Vaccines

Beginning January 1, 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), will be available to Medicare beneficiaries **at no cost**. This change applies to Medicare beneficiaries 19 years of age and older. Below are the most commonly used ACIP recommended Part D vaccines that are eligible for the **\$0 cost share** requirement. The list is subject to change as new vaccines are recommended by ACIP.

- Hepatitis A
- Hepatitis A and hepatitis B
- Hepatitis B1
- Human papillomavirus (HPV)2
- Measles, mumps, and rubella (MMR)
- Meningococcal
- Tetanus and diphtheria toxoids1
- Tetanus and diphtheria toxoids and acellular pertussis
- Varicella (chickenpox)
- Zoster (shingles)

Insulin Products

Beginning January 1, 2023, Medicare beneficiaries enrolled in a Medicare health plan that includes Medicare Part D prescription drug coverage will not pay more than \$35 for a month's supply of insulin products covered by their Medicare Part D plan when dispensed at a pharmacy or through a mail-order pharmacy. The Medicare Part D deductible will not apply to covered insulin products.

Important MCA Plan Information:

The Mercy Care Advantage Part D drug benefit approved by CMS does not include a Part D deductible. MCA enrollees qualify for Medicare Part D Low Income Subsidy (LIS) “extra help” assistance to pay for covered Part D drugs including covered insulin products. Based on this information, MCA members will continue to be charged the applicable Part D LIS copay amounts for insulin products covered under the Mercy Care Advantage formulary.

10.6 - Pharmacy Benefits Manager

CVS Caremark is the Pharmacy Benefit Manager (PBM) that Mercy Care Advantage has contracted to administer the Part D prescription drug benefits. MCA enrollees have access to pharmacies participating in the CVS pharmacy network.

10.7 Medicare Part D Opioid Policies

The Centers for Medicare and Medicaid Services (CMS) finalized new opioid policies for Medicare drug plans starting on January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy and drug management programs for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

To comply with the new Medicare opioid policies, Mercy Care Advantage (MCA) implemented point of sale safety edits and a Drug Management Program (DMP) on January 1, 2019. This program includes system generated safety edits and a safety review at the point of sale when members are at the pharmacy filling opioid or benzodiazepines prescriptions and will include the following types of reviews:

- Potentially unsafe opioid amounts.
- Taking opioids with benzodiazepines like Xanax®, Valium®, and Klonopin®.
- New opioid use (opioid naïve) will be limited to a 7-day supply or less. This edit is not applicable to individuals already taking opioids.

These reviews are especially important if a member has more than one doctor who prescribes these drugs. In some cases, the pharmacist may need to first talk to the member’s doctor about the need for the medication and that they are being used safely before dispensing the medication.

Note: *The Drug Management Program requirements do not apply to members who have cancer, get hospice, palliative, or end-of-life care, or that live in a long-term care facility. The safety edits for members in these situations can be overridden by the pharmacist.*

In some instances, the pharmacist will be able to determine if the safety edit should be overridden and can contact the Pharmacy Helpdesk for assistance. In other instances, the Pharmacist will need to consult with the members prescriber. When an opioid safety edit is triggered and the issue cannot be resolved at point of sale by the pharmacist, they will give members a copy of the notice “Medicare Prescription Drug Coverage and Your Rights”. This

notice explains the member's right to ask for a coverage determination from MCA for the following situations:

- When the beneficiary does not receive a covered fill of the full days' supply as written on the prescription due to the opioid naïve 7-day supply limit edit,
- When the hard MME edit or care coordination edit is triggered and cannot be resolved by the pharmacist (e.g., prescriber cannot be reached for care coordination edit consultation, prescriber consulted due to care coordination edit but does not confirm the medical necessity of the prescription, pharmacist does not fill the prescription based on clinical judgment or other reasons, or due to hard edit reject).

Case Management & Limiting Access to Certain Part D Drugs

Under the new Drug Management Program (DMP) policies, CMS will provide Plans with quarterly Overutilization Monitoring System (OMS) reports of potential at-risk beneficiaries (PARBs). CMS will also let Plans know if a new member was flagged as potentially at-risk by their prior Health Plan. Plans may also identify PARBs by applying the minimum or supplemental OMS criteria on their own; and Plans will engage in case management for identified members. Case management serves the purpose of engaging in clinical contact with the prescribers of frequently abused drugs (FADs), verifying whether the member is at-risk for abuse or misuse of FADs, and obtaining agreement to a coverage limitation on FADs, if a limitation is deemed necessary and agreement is required. The goal of case management under a DMP is to achieve a consensus among multiple prescribers as to the appropriate, medically necessary, and safe dosage of FADs, and if there is no consensus, to facilitate one.

Once completed if it's determined that a member's use of prescription opioids and benzodiazepines isn't safe, MCA will be able to limit coverage for these drugs (commonly called lock-in). Under the Drug Management Program MCA can implement the following limitations:

- A point-of-sale claim edit for FADs that is specific to an at-risk beneficiary (ARB)
- Require member to get their medications from only certain doctors or pharmacies to help better coordinate care

If MCA determines a member requires lock-in to limit access to frequently abused drugs, the Plan is required to provide 30-day advance written notice to the member. CMS has issued (3) notices to be used to notify members.

Important Lock-In Information

- MCA may implement more than one coverage limitation for a single at-risk beneficiary (ARB)
- Lock-in for at risk beneficiary (ARB) lasts for 12 months unless extenuating circumstances apply and can be extended for an additional 12 months if needed.
- An at-risk beneficiary (ARB) placed in lock-in can only change Medicare plans in limited situations, such as when moving out of the plan's service area or if they lose or have a change in the Extra Help received for prescription drug costs. They can change plans

during the Medicare Annual Enrollment Period which occurs every year from October 15 - December 7.

- If an at-risk beneficiary (ARB) can make a Medicare plan change, MCA will give their new plan information about their case and the limits placed to access frequently abused drugs (FADs).

MCA has contracted with CVS Caremark to assist in the case management and member notification requirements for this new Opioid Drug Management Program. For more information about the new Opioid Drug Management Program, please visit our MCA website.

CHAPTER 11 - QUALITY MANAGEMENT

11.0 - Quality Management Overview

MCA works in partnership with providers to continuously improve the care given to our enrollees. The MCA Quality Management (QM) Department is comprised of the following areas:

- The Quality of Care Review Unit monitors the quality of care provided by the PHP network, as well as the review and resolution of issues related to the quality of health care services provided to enrollees.
- The Prevention and Wellness Unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters.
- The Credentialing Unit is responsible for provider credentialing/recredentialing activities.

11.1 - Measurement Tools

MCA must measure performance using measurement tools specified by CMS and report its performance to CMS. MCA is required to make available to CMS information from these measures to provide enrollees with a means to assess the value they receive for their health care dollar and to hold health plans responsible for their performance. As a contracting medical provider, you may be required to assist in medical record data collection.

11.2 - Chronic Care Improvement Program

MCA is required to have a Chronic Care Improvement Program (CCIP). This program must identify enrollees with multiple or sufficiently severe chronic conditions who meet criteria for participation in the program and must have a mechanism for monitoring enrollee participation in the program. As a contracting medical provider, you may be required to assist in medical record data collection or verification to confirm eligibility or participation in the CCIP.

CHAPTER 12 - REFERRALS AND AUTHORIZATIONS

12.0 - MCA Organization Determination Process

Medicare beneficiaries enrolled in MCA are entitled to request an Organization Determination (OD), which is a decision/determination concerning the rights of the enrollee about services covered by Medicare and/or MCA, and any decision/determination concerning the following items:

- Reimbursement for coverage of emergency, urgently needed services or post-stabilization care.
- Payment for any other health services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered or, if not covered by Original Medicare, should have been furnished, arranged for or reimbursed by the organization.
- The provider' or organization's refusal to provide coverage of an item or service the enrollee has not received but believes should be covered.
- Discontinuation of coverage of a service, if the enrollee disagrees with the determination that the coverage is no longer medically necessary.

Enrollees or their providers can request an expedited or standard pre-service OD decision (e.g. prior authorization). MCA will review and process the request in accordance with the CMS requirements and timeframes. MCA will notify the enrollee of its decision as quickly as the enrollee's health condition requires, but no later than 14 calendar days. MCA must automatically provide an expedited OD if the physician believes a standard review may seriously jeopardize the life, or health of the enrollee, or the enrollee's ability to regain maximum function. An expedited review is completed within 72 hours. If the enrollee requests reimbursement for a service already received, it will be reviewed as a request for a payment OD. If the enrollee's request is denied, the enrollee may exercise his/her appeal rights.

Effective 1/1/2020, CMS requires Organization Determination requests involving Part B drugs to be processed under the following timeframes:

- 72 hours for standard requests
- 24 hours for expedited requests.
- A 14-calendar day extension is not permitted for OD requests involving Part B drugs.

Please ensure you submit OD requests for Part B drugs with supporting clinical documentation.

Medicare Part B Drugs

Medicare Part B drugs are covered under Part B of Original Medicare. Members of our plan can access coverage for these drugs when medically necessary. For additional information please see Chapter 4, Benefits Chart in the MCA Evidence of Coverage. CMS allows Medicare Advantage plans to implement Step Therapy requirements for the Part B drugs. In coordination with CVS Caremark, our Pharmacy Benefits Manager, Mercy Care Advantage has implemented the CVS Caremark® Medical Preferred Part B Step Therapy drug list. You can access the CVS Caremark® Medical Preferred Drug List on the Mercy Care Advantage website.

Providers may submit for Part B drug Prior Authorization or for a Step Therapy Exception for a preferred Part B drug by providing a **supporting statement** reflecting trial and failure of the preferred drug(s), or medical reason why the member cannot take the preferred drug(s), or medical reason why the preferred drug(s) would not be as effective as the non-preferred drug requested for the member.

- Requests for Part B drug Prior Authorization, or a Step Therapy Exception for a can be faxed to the Medical Prior Authorization department at **800-217-9345**. Standard requests for Part B drugs are reviewed within 72-hours.
- For expedited requests for Part B drugs, please call **602-623-3000 or 800-624-3879**. Expedited requests for Part B drugs are reviewed within 24-hours.

Providers may use the MCA Part B Prior Authorization and Step Therapy Exception Request form to make a request. A copy of this form is available under the Provider Forms menu option on the Mercy Care Advantage website.

12.1 - Prior Authorizations (Pre-Service Organization Determinations)

- **Laboratory Services:** Prior authorization is **NOT** required for approved in office lab procedures that are CLIA certified. MCA is contracted with **Sonora Quest** to provide laboratory services. All lab services must be performed by **Sonora Quest** unless approved by MCA under the prior authorization process. If a PHP sends a specimen to a non-contracted laboratory, the PHP shall be solely responsible for reimbursement to the non-contracted laboratory.
- **Prior Authorization:** Prior authorization must be obtained from MCA when referring enrollees outside of the PHP network and/or prior to the enrollee receiving a service that requires PA.
- **Radiology Services:** Prior authorization **IS** required for certain radiology services. The prior authorization summary on the MCA website contains additional information on services that require prior authorization.
- **Infusion or Enteral Therapy Services:** Prior authorization **IS** required for any medically necessary services rendered by an infusion or enteral provider.
- **Durable Medical Equipment (DME);** DME equipment and related services may require prior authorization.

For more detail regarding prior authorization requirements, please consult the MCA **Evidence of Coverage** available on our [Member Materials](#) web page.

12.2 - Referrals for Services

- **Laboratory Services:** PHP's will be held accountable for non-authorized referrals to non-participating labs and the enrollee must be held harmless.
- **Referrals:** Providers must only refer enrollees to MCA participating PHPs. If an MCA enrollee requires services that are not available from a network provider a request for prior authorization must be initiated to refer the member out of network.

- **Radiology Services Referrals:** PHPs must refer enrollees to MCA network radiology providers. Certain radiology services require prior authorization before enrollee is referred.
- **Infusion or Enteral Therapy Referrals:** PHPs must refer enrollees to MCA participating infusion or enteral provider.
- **Durable Medical Equipment (DME) Referrals:** PHPs must refer enrollees to a participating DME provider.

12.3 - Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before MCA, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow MCA's prior authorization rules.

12.4 - Prior Authorization Contacts

Inpatient Hospital and Hospice Services

Fax: 855-773-9287

Medical Prior Authorization

Fax: 800-217-9345

Pharmacy Prior Authorization

Fax: 1-855-230-5544

CHAPTER 13 - ENCOUNTERS, BILLING AND CLAIMS

Encounters

13.0 - Billing Encounters and Claims Overview

The MCA Claims Department is responsible for claims adjudication, resubmissions, claims inquiry/research and provider encounter submissions to CMS.

MCA is required to process claims in accordance with Medicare claim payment rules and regulations.

Physicians and health care professionals must use valid International Classification of Disease, 9th Edition, Clinical Modification (ICD-9 CM) codes and code to the highest level of specificity. Complete and accurate use of CMS' Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and physicians using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-9 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk-Adjustment Processing System.

- The ICD-9 CM codes must be to the highest level of specificity: assign three-digit codes only if there are no four-digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

13.1 - CMS Risk Adjustment Data Validation

Risk Adjustment Data Validation (RADV) is an audit process to ensure the integrity and accuracy of risk-adjusted payment. CMS may require MCA to request medical records to support randomly selected claims to verify the accuracy of diagnosis codes submitted. Medicare Advantage plans like MCA, are annually selected for data validation audits by CMS.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities because MCA may request medical record documentation. Accurate risk-adjusted payment depends on the accurate diagnostic coding derived from the enrollee's medical record.

The Balanced Budget Act of 1997 (BBA) specifically required implementation of a risk-adjustment method no later than January 1, 2000. In 2000-2001, encounter data collection was expanded to include outpatient hospital and physician data. Risk adjustment is used to fairly and accurately adjust payments made to MCA by CMS based on the health status and demographic characteristics of an enrollee. CMS requires MCA to submit diagnosis data regarding physician, inpatient and outpatient hospital encounters on a quarterly basis, at minimum.

CMS uses the Hierarchical Condition Category payment model referred to as CMS-HCC model. This model uses the ICD-9 CM as the official diagnosis code set in determining the risk-adjustment factors for each enrollee. The risk factors based on HCCs are additive and are based on predicted expenditures for each disease category. For risk-adjustment purposes, CMS classifies the ICD-9 CM codes by disease groups known as HCCs.

Physicians and health care professionals are required to submit accurate, complete and truthful risk adjustment data to MCA. Failure to submit complete and accurate risk adjustment data to CMS may affect payments made to MCA and payments made by MCA to the physician or health care professional organizations delegated for claims processing.

Certain combinations of coexisting diagnoses for an enrollee can increase their medical costs. The CMS-HCC model for coexisting conditions that should be coded for hospital and physician services are as follows:

- Code all documented conditions that coexist at time of encounter/visit and that require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Physicians and hospital outpatient departments should not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out” or “working” diagnosis. Rather, physicians and hospital outpatient departments should code the condition(s) to the **highest degree of certainty** for that encounter/visit, such as symptoms, signs, abnormal test results or other reason for the visit.

Annually, CMS conducts a medical record review to validate the accuracy of the risk-adjustment data submitted by MCA. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient and physician diagnoses submitted by the provider to MCA. In addition, Medicare Advantage regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare laws, rules and regulations. CMS may adjust payments to MCA based on the outcome of the medical record review.

For more information related to [Risk Adjustment](#), please click on the link to visit the Centers for Medicare and Medicaid Services website.

Billing and Claims

13.2 - When to Bill an Enrollee

All PHPs must adhere to federal financial protection laws and are prohibited from balance billing any MCA enrollee beyond the enrollee's cost sharing.

An enrollee may be billed **ONLY** when the enrollee knowingly agrees to receive non-covered services under both MCA and MCP.

- Provider **MUST** notify the enrollee in advance that the charges will not be covered under MCA or MCP.
- Provider **MUST** have the enrollee sign a statement (not an Advanced Beneficiary Notice of Non-Coverage (ABN) agreeing to pay for the services and place the document in the enrollee's medical record.
- CMS prohibits providers contracted with Medicare Advantage plans (like Mercy Care Advantage) to require Medicare Advantage members to sign an ABN to hold the member financially liable for non-covered services.

13.3 - When to File a Claim

All claims and encounters must be reported to MCA, including prepaid services.

13.4 - Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to an MCA enrollee must be received in a timely manner. MCA's timely filing limitations are as follows:

- **New Claim Submissions** – Claims must be filed to MCA no later than 12 months, or 1 calendar year, after the date the services were furnished for both participating providers, as well as non-participating providers. For hospital inpatient claims, date of service means the date of discharge of the patient.
- **Claim Resubmission** - Claim resubmissions must be filed within 365 days (1 year) from the date of provision of the covered service or eligibility posting deadline, whichever is later. Please submit any additional documentation that may effectuate a different outcome or decision.

Failure to submit claims and encounter data within the prescribed period may result in payment delay and/or denial.

13.5 - Cost Sharing and Coordination of Benefits

MCA must first identify payers that are primary to Medicare, the amounts payable to those payers, and must then coordinate benefits for its Medicare enrollees with these payers. These payers may include but are not limited to:

- Group health plans that cover working aged individuals and their spouses

- Large group health plans that cover individuals entitled to Medicare based on their employment status
- Group health plans that cover individuals entitled to Medicare based on a diagnosis of end-stage renal disease
- Workers' compensation plans
- Property and casualty insurance plans
- Liability and no-fault insurance plans, including self-insured plans.

If an enrollee receives covered benefits that are covered under another insurance policy or plan, MCA may bill or authorize a provider to bill any of the following:

- The insurance carrier, the employer or any other entity that is liable for payment for the services.
- The Medicare enrollee, to the extent that the carrier has paid him or her, employer or other entity for covered medical expenses.

Medicare Secondary Payer (MSP) rules established under the Medicare Advantage program supersede any state laws, regulations, contract requirements or other standards that would otherwise apply to Medicare Advantage Plans, only to the extent that those state laws are inconsistent with MSP standards.

MCA has the right to authorize providers to collect and retain funds subject to coordinate benefits procedures. For example, if MCA receives a claim for payment of covered services, but it is the responsibility of another insurer, MCA is permitted to return the claim to the provider with instructions to bill the third party.

Coordination of benefits will be handled as follows between:

- **Mercy Care Advantage (Primary) and Mercy Care Plan (Secondary):** For enrollees enrolled in both Mercy Care plans, MCA is primary payer and MCP is secondary.
- **Mercy Care Advantage and Another AHCCCS Plan:** If an MCA enrollee has an AHCCCS plan, the provider is responsible for coordinating benefits and claims submissions.
- **MCA, MCP and Another Health Plan:** If an enrollee has insurance other than MCA and MCP (e.g. group health coverage), the provider is responsible for determining if the other insurance is primary over MCA.

Coordinating MCA Benefits with Mercy Care (except for Mercy Care RBHA)– For MCA members enrolled in both Mercy Care (either Mercy Care Complete Care, Mercy Care Long Term Care and Division of Developmental Disabilities lines of business) and MCA, any cost sharing responsibilities will be coordinated between the two payers. For the most part, providers only need to submit one claim to Mercy Care. Once the claim has been paid by Mercy Care Advantage, the claims payment information will cross over to Mercy Care and benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under the section titled **Instruction for Specific Claim Types**.

Coordinating MCA Benefits with Mercy Care RBHA – For MCA members enrolled in both Mercy Care RBHA and MCA, any cost sharing responsibilities will be coordinated between the two payers. Once the claim has been paid by Mercy Care Advantage, a remit will be sent to the provider. Mercy Care RBHA follows the CMS COBA process. Unfortunately, this may involve delays in getting the claims to cross-over to Mercy Care RBHA to coordinate benefits. To expedite claims payment, we recommend that the provider submit the MCA Explanation of Benefits, along with the claim, to Mercy Care RBHA. This will allow benefits to be coordinated quicker.

As a reminder, Medicaid is the payer of last resort. It’s very important to verify eligibility on all plans the member may be covered under to determine who the claim should be sent to and how the claim should coordinate.

13.6 - Injuries Due to an Accident

Medicare law only permits subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e. auto-liability) is not actually in force, MCA is required to assume responsibility for primary payment.

13.7 - How to File a Claim

1) Select the appropriate claim form (refer to table below).

13.7a – Claim Form Types

<u>Service</u>	<u>Claim Form Type</u>
Medical and professional services	CMS 1500 Form
Hospital inpatient, outpatient, skilled nursing and emergency room services	CMS UB-04 Form
General dental services	ADA 2006 Claim Form
Dental services that are considered medical services (oral surgery, anesthesiology)	CMS 1500 Form

Instructions on how to fill out the claim forms can be found in our **Claims Processing Manual** on our [Claims Information](#) web page:

CMS 1500 (02/12) - Form Completion Instructions

CMS UB-04 - Form Completion Instructions

- 2) Complete the claim form.
 - a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.

b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit **original** copies of claims electronically or through the mail (do **NOT** fax or hand-deliver). To include supporting documentation, such as enrollees' medical records, clearly label and send to the Claims Department at the correct address.

a) Electronic Clearing House

Providers who are contracted with MCA can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.

- The EDI vendors that MCA uses are as follows:
 - Change Healthcare
 - SPSI
 - SSI
- Contact your software vendor directly for further questions about your electronic billing.

Contact your Network Management Specialist/Consultant for more information about electronic billing. Additional information can be attained by accessing the Mercy Care Advantage Provider Notification titled **Electronic Tools** available on our [Notices](#) web page.

All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and MCA policies and procedures.

b) Through the Mail

13.7b - Claim Submission Addresses

Medical Claims*	Mercy Care Advantage Claims Department P.O. Box 982975 El Paso, TX 79998-2975	Through Electronic Clearinghouse
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Dental	Mercy Care Advantage Dental Claims Department P. O. Box 61235 Phoenix, AZ 85082-1235	Through Electronic Clearinghouse
Refunds**	Mercy Care Attention: Finance Department P.O. Box 90640 Phoenix, AZ 85066	Not Applicable

*See individual sections for further information: **13.14 - Claim Resubmission** and **13.15 - Claim Disputes**.

**Refunds must include supporting documentation as follows:

- The overpayment claim number(s); and or
- The remittance advice specific to the overpayment.

[13.8 - Correct Coding Initiative](#)

MCA follows the same standards as **Medicare’s Correct Coding Initiative (CCI)** policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service. Please click on the link for additional information.

MCA utilizes ClaimCheck as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror MCA’s comprehensive code auditing solution through ClaimCheck. It enables MCA to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through MCA’s website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Further detail on how to use Clear Claim Connection can be accessed in MCA's secure web portal under the document titled [Mercy Care Provider Web Portal Instructions](#) under Provider Documents. You must have a Web Portal log in to access.

13.9 - Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

13.10 - Incorrect Coding

Examples of **incorrect coding** include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service to use an additional code when one higher level, more comprehensive code is appropriate.
-

13.11 - Modifiers

Appropriate modifiers must be billed to reflect services provided and for claims to pay appropriately. MCA can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. MCA follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one line, reporting one unit with a 50 modifier.

Modifier 57 – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. MCP follows CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners indicate:

“Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.”

Please refer to your Current Procedural Terminology (CPT) manual for further detail on all modifier usage.

13.12 - Checking Status of Claims

Providers may check the status of a claim by accessing MCA’s secure website or by calling the Claims Inquiry department.

Online Status through MCP’s Website

MCA encourages providers to take advantage of using online status, as it is quick, convenient, can be used off-hours, and used to determine status for multiple claims. To register, go to [Mercy Care Web Portal](#) and Log In or contact your Network Management Specialist/Consultant to establish a Login. More information is available in this Provider Manual under section **4.41 – Mercy Care Web Portal**. Mercy Care Web Portal is available 24 hours a day/7 days a week to providers. Using Mercy Care Web Portal will make better use of your time and allow us to focus on more complex claim questions for both you and other providers calling in.

Calling the Claims Inquiry Claims Research Department

Claim status calls are limited to 3 member status requests during our peak business hours (between 10:00 a.m. to 3:00 p.m.). Unlimited status requests will be answered during non-peak hours.

The Claims Inquiry Claims Research (CICR) Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a claim.
- Correct errors in claims processing:

- Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
- Excludes rebilling a claim (the entire claim must be resubmitted with corrections, see section **13.14 - Claim Resubmission**).

Please be prepared to give the service representative the following information:

- Provider name and AHCCCS or NPI number with applicable suffix if appropriate.
- Enrollee name and AHCCCS enrollee identification number.
- Date of service.
- Claim number from the remittance advice on which you have received payment or denial of the claim.

13.13 - Payment of Claims

MCA processes claims and notifies the provider of outcome using a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MCA encourages providers to take advantage of receiving Electronic Remittance Advices (ERA), as you will receive much sooner than receiving through the mail, enabling you to post payments sooner. Please contact your Network Management Specialist/Consultant for further information on how to receive ERA. The **Mercy Care Electronic Remit Request Form** is also available under MCA's [Provider Forms](#) web page.

Remittance Advice samples are also available. [Links to those remits](#) are available under the section **13.26 - Provider Remittance Advice** in this Provider Manual.

Through **Electronic Funds Transfer (EFT)**, providers can direct funds to a designated bank account. MCA encourages you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. You may enroll in EFT by submitting a **Mercy Care Plan EFT Enrollment Form** found on the MCA [Provider Forms](#) web page.

Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT implementation. Your Network Management Specialist/Consultant will assist you with this.

Additional information can be attained by accessing MCA's [Provider Forms](#) web page and review the document titled **Electronic Tools**.

13.14 - Claim Resubmission

Providers have twelve (12) months from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the Resubmission Form located on MCA's website.
- An updated copy of the claim. All lines **must** be rebilled. 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.
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address as indicated in **13.7b - Claim Address Table**.

Resubmissions can be submitted electronically, however, we are unable to accept electronic attachments at this time.

When submitting paper resubmissions, failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

13.15 - Claim Disputes

Conditions for payment are outlined in PHP's contractual agreement and fee schedule with MCA. Claim payments are adjudicated in accordance with the provider agreement. CMS prohibits Medicare Advantage plans from applying the mandated Medicare enrollee appeal process to participating providers. PHPs are encouraged to contact the Claims Department with questions on how their claim paid. MCA will work with the provider to resolve the issue if an error is discovered. In some situations, MCA may require the provider to resubmit the claim for reprocessing. Please note that MCA contracted providers do not have appeal rights and cannot balance bill the enrollee.

13.16 - Non-Contracted Provider Reconsiderations

A provider that does not have a contractual arrangement with MCA, on his or her own behalf, is permitted to file a standard appeal (reconsideration) for a denied claim payment only if a waiver of liability form is completed and submitted with the appeal. The waiver of liability form is a binding agreement which the provider has agreed to hold the enrollee financially harmless, regardless of the outcome of the appeal. This form can be found on the MCA website at www.MercyCareAZ.org. The provider must submit the appeal with the required documentation and be received by MCA within 60 calendar days of the Remittance Advice for the claim denial.

If MCA receives the appeal without the completed waiver of liability form, the request will be held for up to 60 days after the request is received. If MCA does not receive the form by the conclusion of the appeal time frame, MCA will forward the case to the independent review entity with a request for dismissal.

MCA will notify the provider of a decision in writing not later than 60 days after receipt of the appeal and waiver of liability form.

To appeal a claim denial, write a letter and mark the top of the request “appeal” and include the following:

- Statement indicating basis for appeal
- A signed Waiver of Liability
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information, clinical records or documentation

Send information to:

**Mercy Care Advantage
Attention: Appeals Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040
Fax: 602-351-2300**

13.17 - Provider Payment Dispute Resolution Process for Non-Contracted Providers

Providers that do not have a contractual relationship with MCA have access to a Medicare Advantage Payment Dispute Process. If the non-contracted provider believes that the payment amount received for a service provided to an MCA plan enrollee is less than the amount they would be entitled to receive under Original Medicare, or provider disagrees with a decision made by MCA to pay for a different service than the service for which was billed, the provider has the right to dispute the payment amount.

To file a payment dispute, please send your written dispute to:

**Mercy Care Advantage
Appeals Department
Attention: Provider Payment Dispute Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040
Fax: 602-351-2300**

Please provide MCA with all appropriate documentation to support your payment dispute (e.g., remittance advice and letter addressing your concerns). You must submit your payment dispute to MCA no later than 60 days from the date you initially received the disputed payment from MCA.

MCA will review your payment dispute and respond to you within 30 days from the time the provider payment dispute is first received by MCA. If we determine that you are owed additional payment amounts after reviewing your payment dispute, we will pay you this additional amount, including any interest owed under federal law, if applicable. We will inform you in writing if the payment dispute is not decided in your favor.

If a non-contracted provider has difficulty accessing the plan's dispute resolution process, s/he may file a complaint with 1-800-MEDICARE indicating that the plan's internal dispute process has failed to resolve the issue.

[Instruction for Specific Claims Types](#)

[13.18 - MCA General Claims Payment Information](#)

MCA claims are always paid in accordance with the terms outlined in the PHP's contract. Prior authorized services from Non-Participating Health Providers will be paid in accordance with Original Medicare claim processing rules.

[13.19 - Skilled Nursing Facilities \(SNF\)](#)

Providers submitting claims for SNFs should use the **CMS UB-04 Form**.

Refer to our **Claims Processing Manual, Chapter 6 – Skilled Nursing Facilities** on our [Claims Information](#) web page for additional information.

Providers must bill in accordance with standard Medicare RUGS billing requirement rules for MCA, following consolidated billing. For additional information regarding [CMS Consolidated Billing](#), please click on the link.

The coordinating claim on the Medicaid side will require separate billing in accordance with the provider contract. This is one of the few situations where billing requirements differ on the MCA side versus the MCP side.

[13.20 - Home Health Claims](#)

Providers submitting claims for Home Health should use **CMS 1500 (02/12) Form**.

Providers must bill in accordance with their contract terms. Non-Participating Health Providers must bill according to CMS HHPPS requirement rules for MCA. For additional information regarding [CMS Home Health Prospective Payment System \(HHPPS\)](#), please click on the link.

[13.21 – Oral Surgery Claims](#)

Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on **CMS 1500 (02/12) Form**.

[13.22 - Durable Medical Equipment \(DME\) Rental Claims](#)

Providers submitting claims for DME Rental should use **CMS 1500 (02/12) Form**.

DME rental claims are only paid up to the purchase price of the durable medical equipment.

There is a billing discrepancy rule difference between Days versus Units for DME rentals between MCA and MCP. Units billed for MCA equal 1 per month. Units billed for MCP equal the amount of days billed. Since appropriate billing for CMS is 1 Unit per month, to determine the amount of days needed to determine appropriate benefits payable under MCP, the claim

requires the date span (from and to date) of the rental. MCP will calculate the amount of days needed for the claim based on the date span.

13.23 - Same Day Readmission

Providers submitting claims for inpatient facilities should use **CMS UB-04 Form**.

There may be occasions where an enrollee may be discharged from an inpatient facility and then readmitted later that same day. MCA defines same day readmission as a readmission with 24 hours.

***Example:** Discharge Date: 10/2/10 at 11:00 a.m.
Readmission Date: 10/3/10 at 9:00 a.m.*

Since the readmission was within 24 hours, this would be considered a same day readmission per above definition.

13.24 - Hospice Claims

An MCA member who elects hospice care, but chooses not to disenroll from MCA, is entitled to continue to receive through the plan any Medicare Advantage benefits other than those that are the responsibility of the hospice. Under such circumstances, MCA is paid a reduced capitation rate by CMS for the member and MCA is responsible for continued coverage of all supplemental benefits offered. CMS pays:

- the hospice program for hospice care furnished to the enrollee, and
- MCA, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment

Claims related to supplemental benefits provided need to be submitted to MCA. All other claims need to be resubmitted to Original Medicare for processing, regardless of whether they are related to hospice services or not.

During a hospice election, hospice related medication costs are included in the Part A benefit paid to the hospice agency under capitation. CMS has specifically called out (4) categories of medications that are always Part A covered drugs and biologicals (Pain, Laxatives, Anti-anxiety, and Anti-nausea) that are included under the Medicare Part A per-diem payments of the Medicare hospice program and are excluded from coverage under Medicare Part D benefit. **Hospice agencies should not submit Part D claims for drugs and biologicals that fall within the (4) categories of medications identified by CMS.** When drugs and biologicals are incorrectly billed under a members Part D benefit, CMS expects MCA to conduct appropriate reconciliation and payment recoupment.

13.25 - HCPCS Codes

There may be differences in what codes can be billed for Medicare versus Medicaid. MCA follows Medicare billing requirement rules, which could result in separate billing for claims

under MCP. While most claims can be processed under both MCA and MCP, there may be instances where separate billing may be required.

13.26 – COVID-19 Compliance Guidelines

MCA follows all COVID-19 compliance guidance issued by CMS and AHCCCS. Please access our [News and Events](#) page for further detail regarding COVID-19 compliance guidelines.

Remittance Advice

13.27 - Provider Remittance Advice

MCA generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call your Network Management Specialist/Consultant if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to MCP for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to MCP due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to MCP after this payment cycle. This will result in a negative Amount Paid.

- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Enrollee/Patient Name
 - ID
 - Birth Date
 - Account Number,
 - Authorization ID, if Obtained
 - Provider Name,
 - Claim Status,
 - Claim Number
 - Refund Amount, if Applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

The following Remittance Advice samples are available under the [Provider Forms](#) section on MCA's website:

- **Mercy Care Advantage Remit Format for Check**
- **Mercy Care Advantage Remit Format for EFT**

More information is available in this Provider Manual under section **4.7 – Mercy Care Provider Portal** regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also can receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact your Network Management Specialist/Consultant to assist you with this process.

CHAPTER 14 – MCA ENROLLEE GRIEVANCES AND APPEALS

14.0 - Grievances

Grievances are defined as any enrollee complaint or dispute, other than one involving an adverse organization determination, expressing dissatisfaction with the way MCA or a delegated entity provides health care services, regardless of whether any remedial action can be taken. Enrollees or their representative may make the complaint or dispute, either orally or in writing, to MCA, a provider, or a facility. An expedited grievance may also include a complaint that MCA refused to expedite an OD or reconsideration or invoked an extension to an OD or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet the accepted standards for delivery of health care.

Examples of grievance issues include, but are not limited to quality of care provided, accessibility, availability or quality of services, interpersonal relationships, cultural barriers or insensitivity or failure to respect an enrollee's rights.

14.1 - Filing and Resolving Grievances

MCA will review and attempt to resolve any enrollee grievance under the Medicare grievance process. Enrollees are encouraged to submit their grievance verbally or in writing. Enrollees should first contact MCA Member Services for assistance, but if they have already called and were not satisfied, they can submit their grievance in writing to:

**Mercy Care Advantage
Grievance and Appeals Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Fax: 602-351-2313**

Enrollees should submit a grievance no later than 60 calendar days after the event or incident that precipitates the grievance. Grievances received beyond 60 calendar days may be dismissed if good cause cannot be established. MCA will investigate the complaint and respond to the grievance in accordance with CMS requirements. MCA will notify the enrollee of its decision as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date MCA receives the grievance.

14.2 - Quality Improvement Organization - Quality of Care Grievances

An enrollee may file a grievance regarding concerns of the quality of care received with MCA, or with the CMS newly restructured Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs). In Arizona, the BFCC-QIO is Livanta, which is located at:

9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Phone: (877) 588-1123
TTY: 1-855-887-6668
Fax: Appeals – (855) 694-2929
All other reviews – (844) 420-6672

14.3 - Enrollee Initiated Appeals (Reconsiderations)

MCA enrollees have the right to appeal an adverse organization determination by MCA if they disagree with the decision to deny a requested benefit or service, or one that involves a denied claim or reimbursement request. Reconsiderations must be submitted in writing within 60 calendar days of the date of the denial notice sent to the enrollee. MCA may extend this timeframe if the enrollee provides evidence of “good cause”.

14.4 - Filing an Appeal on Behalf of an Enrollee

Regardless of whether the enrollee files a standard appeal, or asks for an expedited review, the enrollee can solicit the help of a friend, lawyer, advocate, relative, physician, or someone else. The enrollee can appoint a trusted individual to represent them as an appointed representative. The appeal must include the enrollee’s **Appointment of Representative (AOR)** form, or legal representative documents, available on our [Provider Forms](#) web page. Enrollees are encouraged to contact the Medicare Rights Center toll free at 1-888-HMO-9050 for assistance in filing an appeal.

14.5 - How to Appoint a Representative

The enrollee may appoint an individual to act as his/her representative to file an appeal by completing the following steps:

- Complete the 07/05 edition of the CMS **Appointment of Representative (AOR)** 1696 form.
- Provide the enrollee’s name, Medicare number and the CMS -1696 form that appoints an individual as the enrollee’s representative (**Note:** an enrollee may appoint a physician, relative, friend, attorney or advocate).
- The enrollee must sign and date the form.
- The appointed representative must also sign and date this form.
- The appointed representative must include this signed form with the appeal.
- A contracting physician may serve as an enrollee’s representative upon appointment.

A non-contracted health care provider that has furnished a service to an enrollee may file a standard appeal of a denied claim if he/she completes the **Medicare Waiver of Liability** form available on our [Provider Forms](#) web page that attests the provider will not hold the enrollee financially liable regardless of the outcome of the appeal.

14.6 - Standard Appeal Resolution

- MCA’s Appeals team will review its initial decision. A medical director, who was not involved in the original determination, will review the reconsideration based on known evidence of Medicare coverage and medical necessity.

- MCA will issue a decision as expeditiously as the enrollee’s health requires, but no later than 30 days from receipt of the request.
- The timeframe may be extended by up to 14 days if the enrollee requests the extension or if MCA needs additional information and the extension may benefit the enrollee. MCA will decide as expeditiously as the enrollee’s health requires, but no later than the end of any extension period.
- If MCA decides in the enrollee’s favor, MCA will provide or authorize the requested service as expeditiously as the enrollee’s health requires, but no later than 30 days from the date the request was received.
- When MCA upholds its original decision to deny, MCA will automatically forward the case file to the CMS contracted Independent Review Entity (IRE), MAXIMUS Federal Services. The IRE will review the case to determine if MCA made the decision based on Medicare regulations and guidelines. MAXIMUS Federal Services will notify the enrollee or representative of the final decision.
- If the enrollee disagrees with the IRE decision, and the amount in dispute reaches a certain threshold, an appeal may be submitted to an Administrative Law Judge.
- Effective 1/1/2020, CMS requires Appeal requests involving Part B drugs to be processed under the following timeframes:
 - 7 calendar days for standard requests
 - A 14-calendar day extension is not permitted for Appeal requests involving Part B drugs.
 - Please ensure you submit Appeals requests for Part B drugs with supporting clinical documentation.

14.7 - Expedited Reconsideration Resolution

- Enrollees have the right to request an expedited decision affecting medical treatment if the enrollee or their physician believes that applying the standard decision timeframe could seriously jeopardize the enrollee’s life, health or ability to regain maximum function. To request an expedited review, the enrollee, the enrollee’s appointed or legal representative, or physician may submit a written reconsideration request to MCA.
- If the enrollee has submitted a standard appeal, their physician may change the appeal to an expedited review by calling the MCA Appeals unit.
- If MCA decides, based on medical criteria, that the situation is time-sensitive, or if any physician requests an expedited review, MCA will issue a decision as expeditiously as the Enrollee’s health requires, but no later 72 hours after receiving the request.
 - This timeframe may be extended up to 14 days if the enrollee requests the extension or if the plan needs additional information and the extension benefits the enrollee. MCA will decide as expeditiously as the enrollee’s health requires, but no later than the end of the 14-day extension period.
- If the request does not meet the definition of time sensitive, it will be handled within the standard review process. The enrollee will be informed in writing that the request for expedited review has been denied and that the standard timeframe will be applied.

If the enrollee disagrees with MCA's decision to deny the request for the expedited timeframe, the enrollee may file an expedited grievance with MCA.

Appeal requests involving Part B drugs to be processed under the following timeframes:

- 72 hours for expedited requests.
- A 14-calendar day extension is not permitted for Appeal requests involving Part B drugs.
- Please ensure you submit Appeals requests for Part B drugs with supporting clinical documentation.

14.8 - Submitting an Appeal

Submit an appeal to:

**Mercy Care Advantage
Grievance and Appeals Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Fax: 602-351-2300**

CHAPTER 15 - MCA ENROLLEE COVERAGE DETERMINATIONS, EXCEPTIONS, APPEALS AND GRIEVANCES FOR PRESCRIPTION DRUGS

15.0 - Medicare Prescription Drug Coverage Determinations

MCA provides Medicare Part D prescription drug coverage to MCA enrollees. CVS Caremark is the Pharmacy Benefit Manager (PBM) that Mercy Care Advantage has contracted to administer the MCA Medicare prescription drug benefit. MCA enrollees will have access to CVS Caremark participating pharmacies. Medicare Part D Coverage Determinations are processed by the Mercy Care Advantage Pharmacy Department.

While typically prescribing providers submit requests for a coverage determination, enrollees have the right to request a coverage determination concerning a prescription drug they believe they are entitled to receive under their plan, including:

- Basic prescription drug coverage.
- The amount, if any, that the enrollee is required to pay for a drug.

An MCA enrollee, their authorized representative and/or their prescribing provider may submit requests to MCA to make a coverage determination for a formulary exception. MCA has provided a form on the MCA's Member and Provider website titled **MCA Pharmacy Coverage Determination Form** available on our [Provider Forms](#) web page. If an enrollee or their authorized representative submits an exception request, the MCA Pharmacy Department will reach out to the prescribing provider to obtain their supporting statement. This information must be received before the request can be reviewed.

The MCA Pharmacy Department will process coverage determinations under the standard timeframe of 72 hours, unless the prescriber has indicated that the enrollee would be harmed if the standard timeframe is applied. In these cases, the MCA Pharmacy Department will process the review under the expedited timeframe of 24 hours, or as fast as the enrollee's health condition requires. If the MCA Pharmacy Department fails to process the request within the required timeframe, CMS requires the request to be submitted to the Independent Review Entity, MAXIMUS Federal Services. Should this occur, MCA will notify both the enrollee and the prescribing provider that MAXIMUS will conduct the review.

MCA provides the **MCA Pharmacy Coverage Determination Form** for your convenience under the Forms section of the MCA website.

Providers may initiate a request by calling MCA Member Services at 602-586-1730 or 1-877-436-5288 and selecting option 2 to follow the prompts to reach the MCA Pharmacy Department.

**Faxed requests:
Mercy Care Advantage
Part D Coverage Determination
Pharmacy Department
1-855-230-5544**

A coverage determination is any decision made by MCA regarding a request for Part D drug benefit or payment. There are two (2) types of coverage determinations:

- **Formulary UM Requirements** – A request for approval for a formulary UM requirement such as prior authorization, step therapy and quantity limitations.
- **Formulary Exceptions** - Request for Part D prescription drug not listed on the formulary or a request for an exception to the formulary UM requirements.

15.1 - Formulary Exceptions

As a Medicare Part D Prescription Drug Plan, MCA must approve a formulary exception to the MCA Formulary if it is determined the requested drug treatment is medically necessary. The MCA Pharmacy Department is responsible to review and process Medicare Part D Coverage Determinations and Exception requests initiated by MCA enrollees, their authorized representative and/or their prescribing provider. Mercy Care Pharmacy Department is required to follow specific review guidelines to determine if a request meets CMS-defined criteria for formulary exception.

Based on the information given by prescribing provider, the MCA Pharmacy Department must review for evidence of medical necessity, which is required to support an approval. The prescriber should provide any medical records that support their position. If MCA Pharmacy Department is unable to determine medical necessity, they will deny the request.

The prescribing physician must provide a written supporting statement that the requested prescription drug is medically 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;
- The number of doses available under a dose restriction 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 enrollee;
- 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 enrollee; or would likely cause harm.

Medical documentation to support the prescriber's request is recommended. If the MCA Pharmacy Department does not receive the prescriber's supporting statement, they will base their review on the information available and the request may be denied.

Once the physician's supporting statement is received and the MCA Pharmacy Department has made a coverage determination for a formulary exception, they will notify the enrollee or the enrollee's appointed representative and the prescribing physician involved as expeditiously as the enrollee's health condition requires, but no later than 72 hours for standard requests, and no later than 24 hours for expedited requests.

For a complete description of MCA's coverage determination and exceptions process, and how to contact MCA if you are assisting an enrollee with this process, please refer to the **Grievances, Determinations & Appeals** section available under [Mercy Care Advantage/Members](#) section of the MCA website.

15.2 - How to File a Part D Prescription Drug Redetermination (Appeal)

- An enrollee or enrollee's representative or prescribing physician or other prescriber may request a redetermination (appeal) if a request for a Part D prescription drug coverage determination is denied.
- A standard redetermination request must be filed orally or in writing to the MCA Appeals Department within 60 calendar days from the date of the notice of the coverage determination. If the representative is appointed, the request must include the enrollee's written **Appointment of Representative** form available on our [Provider Forms](#) web page to file an appeal on his/her behalf.
- Submit an appeal to:
 - Faxed requests:** 1-855-230-5544
Attention: Mercy Care Advantage Coverage Determinations and Redeterminations Department
 - Mailed Requests:**
Mercy Care Advantage
Part D Coverage Determination and Redeterminations Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
- MCA will issue a decision within 7 calendar days for a standard redetermination. If waiting for the standard timeframe would seriously affect the enrollee's health, MCA will complete an expedited redetermination within 72 hours. The redetermination time frame is calculated from the date and time the redetermination request is received by MCA, and if a request involves a formulary exception that was denied for lack of a prescriber's supporting statement, the timeframe begins when the statement is received. Medical documentation to support to the request is typically required.

- If MCA upholds their original decision to deny, the enrollee or their appointed or legal representative may submit an appeal in writing to MAXIMUS Federal Services, the CMS contracted independent review entity (IRE). Prescribers must be appointed by the enrollee to submit an appeal to the IRE. If the representative is appointed, the appeal must include the **Appointment of Representative** form available on our [Provider Forms](#) web page. Legal representative documentation is required for legal representatives to file on the enrollee's behalf. The written appeal must be sent to the IRE within 60 calendar days after the date of the appeal denial notice from MCA.

- IRE reconsideration requests can be mailed or faxed to:
 - Part D Prescription Drug Benefit Appeals**
 - C2C Innovative Solutions, Inc.**
 - Part D Drug Reconsiderations**
 - P.O. Box 44166**
 - Jacksonville, FL 32231-4166**
 - Phone: (904) 394-4700**
 - Standard Appeals Fax: - (904) 539-4097**
 - Expedited Appeals Fax: (904) 539-4093**

CHAPTER 16 – FRAUD, WASTE AND ABUSE

16.0 - Fraud, Waste and Abuse Overview

MCA supports efforts to detect, prevent and report fraud, waste and abuse within the Medicare system. These efforts are consistent with our mission to provide care to the poor and those with special needs while exercising sound fiscal responsibility. Management of limited resources is a key part of this responsibility.

Fraudulent activity hurts everyone. We hope you will join us in our efforts to ensure that tax dollars spent for health care are spent responsibly and used to provide necessary care for as many enrollees as possible.

CMS requires that Medicare Advantage have a compliance plan that guards against potential fraud, waste and abuse under 42 C.F.R. §422.503 (b)(4)(vi) and 42 C.F.R §423.504(b)(4)(vi).

CMS combats fraud by:

- Close coordination with contractors, provider and law enforcement agencies.
- Developing Medicare Program compliance requirements that protect stakeholders.
- Early detection through medical review and data analysis.
- Effective education of physicians, providers, suppliers and beneficiaries.

A provider's best practice for preventing Fraud, Waste and Abuse is to:

- Develop a compliance program.
- Monitor claims for accuracy - ensure coding reflects services provided.
- Monitor medical records – ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communication with colleagues and staff enrollees.
- Ask about potential compliance issues in exit interviews.
- Act if you identify a problem.
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

16.1 - Fraud, Waste and Abuse Defined

Fraud: An intentional act of deception, misrepresentation, or concealment to gain something of value.

Waste: Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

Examples of Fraud, Waste and Abuse include:

- Charging in excess for services or supplies.
- Providing medically unnecessary services.
- Billing for items or services that should not be paid for by Medicare.
- Billing for services that were never rendered.
- Billing for services at a higher rate than is justified.
- Misrepresenting services resulting in unnecessary cost to the Medicare program, improper payments to providers, or overpayments.
- Physical or sexual abuse of enrollees.

Fraud, Waste and Abuse can incur risk to providers:

- Participating in illegal remuneration schemes, such as selling prescriptions.
- Switching a patient prescription based on illegal inducements rather than based on clinical needs.
- Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Theft of a prescriber’s Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing log-in information.
- Falsifying information to justify coverage.
- Failing to provide medically necessary services.
- Offering beneficiaries a cash payment as an inducement to enroll in Part D.
- Selecting or denying beneficiaries based on their illness profile or other discriminating factors.
- Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.
- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services – for example, by not referring a patient to an appropriate provider.
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the patient failed to keep. Another example is a “gang visit” in which a physician visits a nursing home billing for 20 nursing home visits without furnishing any specific service to individual patients.
- Double billing such as billing both Medicare and the beneficiary, or billing Medicare and another insurer.
- Misrepresenting the date services were rendered or the identity of the individual who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

Fraud, Waste and Abuse can incur risk to individuals as well:

- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the patient’s medical history.

- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addiction.

In addition, enrollee fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition to illegally receive the drug benefit.
- Attempting to use the enrollee identity card to obtain prescriptions when the enrollee is no longer covered under the drug benefit.
- Looping (i.e., arranging for a continuation of services under another beneficiaries ID).
- Forging and altering prescriptions.
- Doctor shopping is when a beneficiary consults several doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market

16.2 - CMS Requirements

Federal law requires MCA to have a Compliance Plan. MCA must:

- Create a Compliance Plan that incorporates measures to detect, prevent, and correct fraud, waste, and abuse.
- Create a Compliance Plan that must consist of training, education, and effective lines of communication.
- Apply such training, education and communication requirements to all entities which provide benefits or services under MCA.
- Produce proof from related entities to show compliance with these requirements.

Anyone can report a compliance concern to the MCA Compliance Officer as follows:

E-mail: [MercyCareAdvantageMedicare Compliance@Aetna.com](mailto:MercyCareAdvantageMedicareCompliance@Aetna.com)

16.3 - Seven Key Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. **Written Standards of Conduct:** Development and distribution of written Standards of Conduct and Policies and Procedures that promote MCA's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. **Designation of a Compliance Officer:** Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. **Effective Compliance Training:** Development and implementation of regular, effective education, and training.
4. **Internal Monitoring and Auditing:** Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. **Disciplinary Mechanisms:** Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in CMS programs.

6. Effective Lines of Communication: Between the compliance officer and the organization's employees, managers, and directors and enrollees of the compliance committee, as well as related entities.
 - i. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
 - ii. Related entities must report compliance concerns and suspected or actual misconduct involving MCA.
7. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

16.4 - Relevant Laws that Apply to Fraud, Waste and Abuse

There are several relevant laws that apply to Fraud, Waste and Abuse:

The False Claims Act (FCA)

The False Claims Act (FCA) was enacted in 1863 to fight procurement fraud in the Civil War. The FCA has historically prohibited knowingly presenting or causing to be present to the federal government a false or fraudulent claim for payment or approval.

The FCA was recently amended through the American Recovery and Reinvestment Act of 2009 (ARRA) to expand the scope of liability and give the government enhanced investigative powers. FCA liability now extends to subcontractors working on government funded projects as well as those who submit claims for reimbursement to government agents and state agencies. This may indicate FCA liability for claims submitted to MCA.

Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Beneficiary Inducement Statute

The Beneficiary Inducement Statute prohibits certain inducements to Medicare beneficiaries, i.e., waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

Self-Referral Prohibition Statute (Stark Law)

Prohibits physicians from referring Medicare patients to an entity with which the physician or physician's immediate family enrollee has a financial relationship – unless an exception applies.

Red Flag Rule (Identity Theft Protection)

Requires “creditors” to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

Health Insurance Portability and Accountability Act (HIPAA)

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identifier numbers (NPIs)

OIG and GSA Exclusion Program

Prohibits identified entities and or individuals excluded by the OIG or GSA from conducting business or receiving payment from any Federal health care program.

16.5 - Administrative Sanctions

Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare provider number application.
- Suspension of provider payments.
- Addition to the OIG List of Excluded Individuals/Entities (LEIE).
- License suspension or revocation.

16.6 - Civil Monetary Penalties (CMPs), Litigation and Settlements

The Social Security Act authorizes the imposition of CMPs when Medicare determines that an individual or entity has violated Medicare rules and regulations. Typically, penalties involve assessments of significant damages such as CMPs up to \$25,000 for each Medicare Advantage enrollee adversely affected.

The United States Attorney's Office may file a civil suit or decide that the interest of the Medicare Program is best served by settling a case out of court. The civil suit or settlement may include a Corporate Integrity Agreement (CIA, which requires the individual or entity to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and be subject to period audits by the federal government.

16.7 - Potential Civil and Criminal Penalties

The Federal government has administrative remedies available in cases that have resulted in False Claims Act (FCA) violations. The False Claims Act, 31 U.S.C. §§ 3729, provides that anyone who violates the law is liable for a civil monetary penalty in addition to three times the damages. After June 20, 2020, False Claims Act penalties, for conduct after November 2, 2015,

will be from \$11,665 to \$23,331 per violation. For the party that had responsibility for the false claim, the government may seek to exclude it from future participation in Federal health care programs or impose integrity obligations against it.

16.8 - Remediation

Remediation may include any or all the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
 - Automatic disbarment
 - Prison time

16.9 - Exclusion Lists

The Office of Inspector General (OIG) has the authority to exclude individuals and entities from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal healthcare programs for any items or services they furnish, order, or prescribe. This includes those that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). OIG maintains a list of all currently excluded individuals and entities called the [List of Excluded Individuals/Entities](#) (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). To avoid CMP liability, health care entities should routinely check the list to ensure that new hires and current employees are not on it.

Mercy Care has processes implemented to comply with the routine verification requirements and will deny MCA claims billed by an excluded provider.

16.10 - CMS Medicare Parts C and D Preclusion List

CMS has implemented a new Preclusion List that contains providers (individuals or entities) who fall within any of the following categories:

- (1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- (2) Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

For providers to receive payment for health care items, services or Part D drugs furnished to beneficiaries enrolled in a Medicare Advantage plan, the provider must not be included on the CMS Preclusion List. Updates to the Preclusion List will be made approximately every 30 days.

Medicare Advantage Plans must download the Preclusion List each month and verify the list against claims systems and their contracted provider network to determine if any providers are identified. Medicare Advantage Plans must prevent claims payment and remove contracted providers included on the CMS Preclusion List from their network.

Mercy Care has implemented processes to comply with this new CMS requirement. For more information about this new CMS requirement, please visit the CMS website at:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html>

16.11 - Compliance Program and Anti-Fraud Initiatives

Beginning January 1, 2019, CMS no longer requires health care providers participating in Medicare Advantage Plans to complete CMS-issued general compliance and fraud, waste and abuse training. Under contract with Mercy Care, providers are required to maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud waste and abuse ("FWA"). The compliance program shall include dissemination to employees and Downstream Entities of written policies and/or standards of conduct articulating the commitment to compliance with applicable law, initially within ninety (90) days of hire/contracting, and at least annually thereafter. The compliance program must include methods of communication regarding the obligation to report potential non-compliance or FWA issues (internally and to payers, as applicable), and a no-tolerance policy for retaliation or retribution for good faith reporting, and reporting mechanisms to employees and Downstream Entities. Training and education for employees and Downstream Entities must be provided to ensure they are familiar with the compliance program and FWA requirements. The compliance program must establish and maintain a process to oversee and ensure that employees and Downstream Entities perform applicable services in accordance with applicable law and require implementation of disciplinary actions and corrective actions up to terminations where needed to ensure such compliance. Providers need to ensure that any Downstream Entities maintain an effective compliance program.

16.12 - Reporting Potential Fraud, Waste and Abuse

Aetna Special Investigations Unit (SIU):

By Phone: 1-800-338-6361

By Fax: 1-860-975-9719

By E-Mail: aetnasiu@aetna.com

These mechanisms are continuously monitored by Aetna SIU personnel. We encourage everyone to report identified suspected fraud, waste or abuse affecting Mercy Care Advantage. Mercy Care coordinates with the Aetna Special Investigation Unit to investigate potential FWA identified under the Mercy Care Advantage Medicare contract. These SIU Investigators will conduct appropriate outreach to contracted providers to obtain medical records information required to support their investigation efforts. Contracted providers need to comply with these types of requests as outlined in the Mercy Care provider contract requirements.

Providers may also make a report to the Office of Inspector General HHS Tips Hotline: 800-447-8477