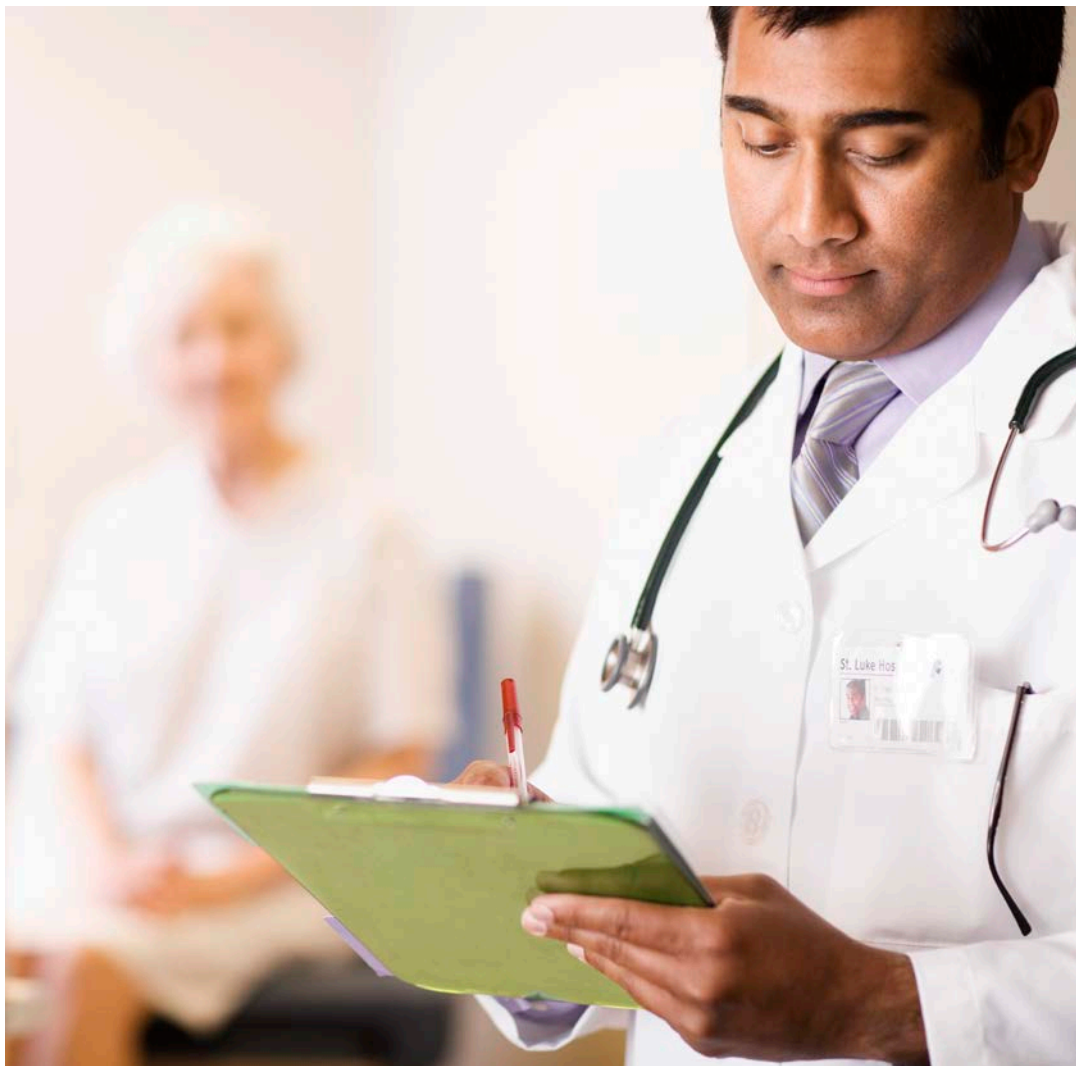




Mercy Care Plan Long Term Care Provider Manual



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Information highlighted in yellow represents a change made since the last edition of the Provider Manual.

CHAPTER 1 – INTRODUCTION TO MERCY CARE

1.0 - Welcome

Welcome to Southwest Catholic Health Network (SCHN), dba Mercy Care Plan (MCP)! MCP's ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Arizonans who need us most.

1.1 - About Mercy Care

Mercy Care, when referring to all lines of business, is a not-for-profit partnership created in 1985 and sponsored by Dignity Health and Carondelet Health Network. Mercy Care 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 Mercy Care.

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

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. MCP 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), providers are required to fully understand and apply AHCCCS requirements when administering covered services.

Please refer to the [AHCCCS](#) website for further information on AHCCCS.

1.3 - MCP Overview and Eligibility

MCP is a managed care organization that provides health care services to people in Arizona's Medicaid program. MCP has held a pre-paid capitated contract with the AHCCCS Administration since 1985. MCP provides services to the Arizona Medicaid populations including:

- **Acute Care:** Members select the managed care plan to administer their benefits. MCP is contracted in Maricopa and Pima Counties to provide covered services to enrolled members.
- **KidsCare:** Healthcare insurance made available by the State of Arizona to offer care at a low cost to Arizona children 18 years old or younger. The KidsCare Office is unable to approve any new applications. Enrollment in the KidsCare Program has been frozen since January 1, 2010 due to lack of funding for the program. Please review the [Kidscare](#) webpage on the AHCCCS website for additional information.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCP is contracted with DDD to provide acute care services.

1.4 - MCP Policies and Procedures

MCP has robust and comprehensive policies and procedures in place throughout its departments that assure all compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates made as needed.

1.5 - Eligibility

AHCCCS determines eligibility for MCPLTC members.

MCPLTC members receive their ID card from MCP.

1.6 – Hospital Presumptive Eligibility

Based on provisions in the Affordable Care Act and effective January 1, 2015, Arizona has developed a Hospital Presumptive Eligibility (HPE) process that allows qualified hospitals to temporarily enroll persons who meet specific federal criteria for full Medicaid benefits in AHCCCS immediately. Hospitals will use special features in Arizona’s electronic application, Health-e-Arizona Plus (HEAplus), to process HPE applications.

Hospitals that choose to participate in HPE must meet performance standards for continued participation. Details about performance standards are included in the [Hospital Presumptive Eligibility Agreement](#).

HPE provides eligible persons with temporary full Medicaid coverage. Persons who are approved for HPE may receive Medicaid services from any registered AHCCCS provider.

For additional detail regarding Hospital Presumptive Eligibility, please review AHCCCS’ [Hospital Presumptive Eligibility](#) web page.

CHAPTER 2 - MERCY CARE PLAN CONTACT INFORMATION

2.0 - Health Plan Contacts Table

<u>Health Plan</u>	<u>Telephone Number</u>	<u>Health Plan Web Address</u>
Mercy Care Plan	602-263-3000 or 800-624-3879 toll-free	www.MercyCarePlan.com

Express Service Codes

Providers may use "Express Service" Monday through Friday from 8:00 a.m. to 5:00 p.m. To reach a specific service department:

1. Dial the appropriate Health Plan telephone number.
2. When you hear the automated attendant, use your telephone keypad to enter the corresponding three digit service code.

Mercy Care is available 24 hours a day, seven days a week to assist providers with prior authorization needs.

<u>Service Area</u>	<u>Express Service Code</u>
Medical Prior Authorization	622
Pharmacy Prior Authorization	625
Claims	626
Member Eligibility and Verification	629
Transportation and Non-Emergency	630
Provider Relations	631

<u>Health Plan</u>	<u>Internal Contact</u>	<u>Telephone Number</u>
Mercy Care	DD Liaison	602-453-6026
	Claim Disputes/Appeals	602-453-6098

Provider Credentialing

Providers wishing to contract with Mercy Care may fax a letter of interest along with a copy of their W-9 to 860-975-3201, Attn: Network Development and Contracting. Contract requests will be reviewed and the requesting provider will be notified of contract status. Please note that providers must be board certified or board eligible. To determine the status of a contract request, please call 602-453-6148.

[2.1 - Health Plan Authorization Services Table](#)

Department

Medical or Family
Planning Prior Authorization

Services

Prior Authorization Department

Medical Fax: 800-217-9345 (Toll Free)

Family Planning Fax: 602-431-7155

You may also call our main number and use the express service code listed above.

Dental

Please contact DentaQuest at 844-234-9831 or
www.dentaquestgov.com.

DES/DDD Prior Authorization:

Health Professionals must also obtain prior authorization from the DES/DDD medical director prior to providing sterilization and pregnancy termination procedures for members enrolled with DES/DDD. Contact Prior Authorization.

Inpatient Hospital and Hospice Services

Fax: 866-300-3926 (Toll Free)

Pharmacy Prior Authorization

Mercy Care Plan – Fax: 800-854-7614 (Toll Free)

Behavioral Health Department

Mercy Care Behavioral Health Coordinator (BHC)
Phone: 800-876-5835
Fax: 800-873-4570

Medical Case Management

Intake Referral – 602-453-8391

[2.2 - Community Resources Contact Information Table](#)

<u>Community Resource</u>	<u>Contact Information</u>
Arizona Early Intervention Program (AzEIP)	Address: 3839 North Third Street, Suite 304 Phoenix, AZ 85012 Phone: 602-532-9960, toll free in AZ 888-439-5609 Fax: 602-200-9820 Email: allazeip2@azdes.gov Website: https://www.azdes.gov/main.aspx?menu=98&id=3026
Arizona's Smokers Helpline (Ashline)	Address: P.O. Box 210482 Tucson, AZ 85721 Phone: 800-556-6222 Fax: 520-318-7222 Website: www.ashline.org
Arizona Women, Infants & Children (WIC)	Address: 150 N. 18 th Avenue, Suite 310 Phoenix, AZ 85007 Phone: 800-252-5942 or 800-2525-WIC To report WIC Fraud & Abuse, call our Fraud Hotline at 866-229-6561 or email http://www.azwic.gov/ Website: http://www.azwic.gov/
Behavioral Health Services	Address: 150 N. 18 th Avenue, #200 Phoenix, AZ 85007 Phone: 602-364-4558 Fax: 602-364-4570 Website: http://www.azdhs.gov/bhs/index.htm
Community Information and Referral	Address: 2200 N. Central Avenue, Suite 601 Phoenix, AZ 85004 Phone: 602-263-8856 800-352-3792 (area codes 520 and 928) Website: http://www.cir.org
Arizona Department of Economic Security – Aging and Adult Service	Phone: 602-542-4446 Website: https://www.azdes.gov

CHAPTER 3 – MERCY CARE PLAN LONG TERM CARE (MCPLTC)

3.0 - Mercy Care Plan Long Term Care (MCPLTC) Overview

The Mercy Care Plan Long Term Care (MCPLTC) program includes additional requirements and benefits compared to the Mercy Care Plan Acute line of business. MCPLTC members are eligible for:

- Home and Community Based Services
- Alternative Living Arrangements
- Residential Skilled Nursing Facilities (SNF) – For additional information please review our [Skilled Nursing Facilities \(SNF\) Guide](#).

Below is a list of services specific to the MCPLTC program:

3.0a – MCPLTC Services Table

<u>Type of Service</u>	<u>Description</u>
Adult Day Health Care	Health care and personal services as part of an adult day center. This may include meals, health checks and therapies.
Attendant Care Services	A trained person from a certified caregiver agency provides services in the member's home such as personal care, housekeeping and meal preparation.
Emergency Alert System	Equipment that provides 24-hour access to emergency help.
Habilitation	This service provides training in independent living skills.
Home Delivered Meals	Healthy meals are prepared and brought to a member's home.
Home Health Service	This service provides nursing, home health aide, and therapy in the member's home.
Homemaker	This service is designed to assist with household jobs like cleaning, shopping or running errands.
Home Modification	This service makes adaptive changes to the home to increase the member's independence.
Hospice Care	Services that help members who need health care and emotional support during the final stages of life.
Personal Care	This service offers help with eating, bathing and dressing.

Private Duty Nursing	Nursing services for members who need more individual and continuous care.
Respite	This service provides personal care to provide a member's family and caregiver support. This service can be provided in the member's home, assisted living facility or skilled nursing home.
Self-Directed Attendant Care	This program is for members who want to be in charge of their attendant caregiver service. Members using this service will hire/fire, train, and be in charge of their own caregivers. Members have more control in this program. They can hire anyone that has the basic skills needed, give work and make schedules within the weekly service hours chosen by MCPLTC case manager.
Spouse Attendant Care	A spouse can become a member's paid attendant caregiver while s/he is living at home. State guidelines must be followed, so please speak to a MCPLTC case manager regarding Spouse Attendant Care.

3.1 - MCPLTC Program Contractor Changes

MCPLTC has a transition coordinator to assist with all program contractor changes. All MCPLTC members have the option of changing program contractors during their annual enrollment choice month. AHCCCS sends a packet of information to each member prior to their annual enrollment choice about how to change program contractors and the dates by which their choice must be communicated to AHCCCS. Members may also change program contractors at other times if the circumstance meets AHCCCS criteria such as:

- moving to another county
- moving to another program contractor to maintain continuity of medical care, or
- residing in a facility that no longer contracts with their current program contractor.

In these situations the member's case manager will put together a packet of information and the transition coordinator will send it to the requested program contractor. If the requested program contractor grants the request, a transition date is determined and AHCCCS is notified and makes the change.

3.2 - Home and Community Based Services (HCBS)

All Home and Community Based providers who provide attendant care, housekeeping, personal care, and respite care are required by AHCCCS to complete a monthly MCPLTC Provider Non-Provision of Services Log for critical services. Your Provider Relations representative is available for initial and ongoing training.

A gap in critical services is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of scheduled type of critical service that are actually delivered to the member.

Critical services received in the member's home are inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. Types of critical services include:

- Attendant care, including spouse attendant care
- Personal Care
- Homemaker
- In-home respite

Please refer to [Chapter 1200, Arizona Long Term Care System Services and Settings for Members Who Are Elderly and/or have Physical Disabilities and/or have Developmental Disabilities](#) in the AHCCCS Medical Policy Manual (AMPM) for additional Home and Community Based Services information.

3.3 - Attendant Care Services - Interruption in Service

There may be times where an interruption in service may occur due to an unplanned hospital admission for the member. While services may have been authorized for attendant care during this time, attendant care agencies should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided.

Example:

Member is authorized to receive 40 hours of attendant care per week over a 5 day period. The member is receiving 8 hours of care a day.

The member is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the member was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the member on the example above, since no services could be performed on January 2, 2010 by the attendant care agency. This is also true for Personal Care, Homemaker, and Respite Services as well.

Each attendant care agency will be responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the attendant care agency will be required to pay back any monies paid by MCPLTC. In accordance with AHCCCS requirements, MCPLTC will be conducting periodic audits to verify this is not occurring.

3.4 - Attendant Care Modifiers

AHCCCS requires the use of specific codes/modifiers for attendant care as follows:

Attendant Care:

Non-Family: S5125-No modifier
Family Non-Resident: S5125-U4
Family Resident: S5125-U5
Spouse: S5125-U3

Agency with Choice

Non-Family: S5125-U7
Family Non-Resident: S5125-U4U7
Family Resident: S5125-U5U7
Spouse: S5125-U3U7

Self-Directed Attendant Care

Non-Family: S5125-U2
Family Non-Resident: S5125-U2U4
Family Resident: S5125-U2U5

Skilled Self-Directed Attendant Care

Non-Family: S5125-U6
Family Non-Resident: S5125-U6U4
Family Resident: S5125-U6U5

Example:

During a six month time frame the member is receiving 20 hours per week of Family Non-Resident attendant care and 10 hours per week of Non-Family attendant care for a total of 30 hours per week.

The attendant care agency needs to pay attention to how many units are allotted for each of these two specific care categories. Billing with incorrect modifiers and units could result in claims being pended and denied for no units available. The attendant care agency must bill in accordance with the authorized services and units.

If there is a change in care during the authorized time period, i.e. the Non Family attendant care worker starts to work more than 10 hours per week (on a consistent basis), the attendant care agency must contact the MCPLTC case manager in order to correct the authorization and adjust the units to reflect the change in care. If this happens for only one occurrence, the agency does not need to contact the case manager, but if a major change is needed to the original

authorization, the attendant care agency would need to work with the MCPLTC case manager to correct the authorization. This will alleviate potential claims from pending or being denied.

3.5 – Non-Provision of Service Log (NPS)

The Non-Provision of Service Log includes information to identify differences between the number of hours the home care worker for critical services were scheduled to provide and the actual number of hours delivered to the member. Providers are required to complete the Non-Provision of Service log each month even if there are no non-provisions of service for the month. The NPS log must be completed by the fifth business day of each month. The provider must complete the notification via the MCPLTC Provider Non-Provision of Service Log (NPS) located on the MCP secure website, MercyOneSource.

Telephone accessibility standards also apply. After-hour phone audits may be conducted by MCP to assure providers have 24-hour coverage available for unforeseen gaps in service. Please note that the AHCCCS standard is to allow HBCS providers 15 minutes to return a call addressing a gap in service. To allow an agency more than 15 minutes to return a phone call when a gap in service is being reported would make it exceptionally difficult for the service to be filled within the two (2) hour requirement.

3.6 - Prior Period of Coverage for Home and Community Based Services (HCBS)

“Prior Period of Coverage” for an HCBS member refers to HCBS in place prior to enrollment with MCPLTC (during the Prior Period of Coverage period). Services were previously provided by another AHCCCS plan.

Prior Period eligibility dates are determined by AHCCCS. The MCPLTC case manager will perform a retrospective assessment to determine the medical necessity of services, along with determination that the services previously delivered were provided by a registered AHCCCS provider in the most cost effective manner.

If the MCPLTC case manager determines that the services are covered, reimbursement will be made to the provider.

3.7 - Case Manager Responsibilities

Each MCPLTC member is assigned to a case manager. The case manager is responsible for working with the member’s PCP to coordinate and authorize the provision of medically necessary services for the member. The case manager is also the member’s advocate and works to facilitate the member’s care.

The MCPLTC case manager authorizes medically necessary services, providing information about room and board or share of cost to providers and members, and assisting members with coordination of appropriate services.

The MCPLTC case manager is the primary point of contact for providers when there are issues or questions about a member. Providers must also contact the MCPLTC case manager whenever there are changes in a member's health status.

3.8 - Service Authorizations

The following table illustrates Acute and HCBS services provided to MCPLTC members that require PCP orders and/or authorization by the program contractor.

NOTE: The MCPLTC case manager only authorizes long term care services, not medical services. Medical service authorization procedures are outlined in [Chapter 16 – Referrals and Authorizations for Medical Services](#).

3.8a – MCPLTC Service Authorization Table

<u>Service</u>	<u>PCP Orders</u>	<u>Program Contractor Authorization</u>
Acute Hospital Admission (Non-Medicare Admission)	X	X
Adult Day Health Services		X
Assisted Living Facility		X
Attendant Care		X
Behavioral Health Services		X
DME/Medical Supplies	X	X
Emergency Alert	X	X
Habilitation		X
Home Delivered Meals		X
Home Health Agency	X	X
Home Modifications	X	X
Homemaker Services		X
Hospice Services (HCBS and Institutional – Non-Medicare)	X	X
ICF/MR	N/A	N/A

Medical Care Acute Services	X	X
Nursing Facility Services	X	X
Personal Care		X
Respite Care (In-Home)		X
Respite Care (Institutional)	X	X
Therapies	X	X
Transportation		X

3.9 - MCPLTC Alternative Living Arrangements

MCPLTC offers different types of medically necessary living arrangements for eligible members. These different types of settings provide supervisory services, personal care or direct care, and are delivered by licensed or certified facilities. Members are required to pay room and board fees in these settings. The MCPLTC case manager will assess the member's need for the appropriate type of setting.

3.9a – MCPLTC Service Types Table

<u>Setting</u>	<u>Description</u>
Adult Foster Care	This setting includes up to 4 residents. The owner of the home must live in the home and provide the care.
Adult Therapeutic Home Care	Provides behavioral health and ancillary services for a Minimum of 1 and a maximum of 3 people.
Child Therapeutic Home Care	Provides services by those licensed with DES as a professional foster care home.
Assisted Living Home	This setting provides care and supervision for up to 10 people.
Assisted Living Center	This setting provides resident rooms or residential units and services to 11 or more residents. Three meals are provided in the main dining hall. Personal care and medication monitoring is provided as needed.

3.10 - Provider Requirements for Assisted Living Facilities

Assisted Living Home and Assisted Living Center Requirements

- The provider at an Assisted Living Facility must collect room and board fees from the member. Room and board is the amount the MCPLTC member pays each month for the cost of food and/or shelter.
- MCPLTC does not pay the member's room and board cost when the member is in an alternative setting. MCPLTC's room and board agreement identifies the level of payment for the setting, placement date, and room and board amount the member must pay and is determined by the MCPLTC case manager at the time of placement.
- The room and board agreement is used for all alternative settings. The amount of room and board will periodically change based on a member's income.
- The Room and Board agreement form is completed at least once a year or more often if there are changes in income.
- Payment issued to the provider is always the contracted amount minus the member's room and board.
- For Adult Foster Care, Foundation for Senior Living is billed for all Adult Foster Care services. For all other alternative living arrangement settings, MCPLTC should be billed directly.
- PHP shall notify MCPLTC in writing immediately if a change in location of the Assisted Living Home or Assisted Living Center is being considered. MCPLTC Case Management will communicate with members and their representatives to determine whether or not a location change is in their best interest.
- PHP will notify MCPLTC in writing immediately if an ownership change is being considered. MCPLTC will decide if a contract with the new owner will be offered. In order to be considered for a contract, a new owner must be licensed by Arizona Department of Health Services (ADHS), have an AHCCCS Provider Identification number and have proof of required liability insurance.

Assisted Living Home Requirements

- PHP must obtain written authorization from the MCPLTC Case Manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services not prior authorized will not be reimbursed.
- PHP shall maintain member case records with information that includes, but is not limited to:
 - Member's name and MCPLTC identification number;
 - Member's relative name(s) address(es) and phone number(s);
 - Emergency contact name and phone number
 - Member's primary care provider address and phone number;

- Member's current medicals and pharmacy phone number; and
- Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to the management and organization of PHP, which include but are not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing and home furnishings and repairs. PHP shall submit copies of policies and procedures to MCPLTC (i) annually, (ii) as developed, and (iii) as the policies and procedures are revised.
- All deposits paid prior to MCPLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is required to refund the member their private pay dollars for this time frame and agrees to accept MCPLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCPLTC. Following MCPLTC enrollment, the MCPLTC contract and the MCPLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCPLTC member are null and void.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCPLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills to members.
- PHP will report to MCPLTC Case Manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.

Assisted Living Center Requirements

- PHP shall ensure that each new PHP staff completes an orientation within ten (10) days from the date of employment which includes, but is not limited to, orientation to the characteristics and needs of Assisted Living Center members; promotion of member dignity, independence, self-determination, privacy, choice and rights; and instruction on the development and implementation of treatment plans.
- PHP shall ensure that each staff member completes a minimum of six (6) hours of ongoing training every twelve (12) months and includes but is not limited to promoting dignity, independence, self-determination, privacy, choice and rights; fire, safety and emergency procedures; and assistance in self-administration of medications.
- PHP must obtain written authorization from the MCPLTC Case Management is the sole authorizing agent for placement and level of care of MCPLTC frail elderly members in an

Assisted Living Center, Behavioral Health Assisted Living or in an Assisted Living Alzheimer's Unit.

- Upon admission, there must be documentation/evidence that the member is free from infectious tuberculosis. Annual testing is to be completed and documented in the member's medical record.
- PHP will report to MCPLTC Case Manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.
- There must always be staff member(s) on duty who speak and read English (fluently), twenty-four (24) hours per day, three hundred sixty five (365) days per year.
- PHP must provide shampoo, hand soap, toilet paper and laundry detergent for each resident.
- One (1) staff member certified in CPR must be on duty at all times.
- All deposits paid prior to MCPLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is required to refund the member their private pay dollars for this time frame and agrees to accept MCPLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCPLTC. Following MCPLTC enrollment, the MCPLTC contract and the MCPLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCPLTC member are null and void.
- PHP shall maintain member case records with information that includes, but is not limited to:
 - Member's name and MCPLTC identification number;
 - Member's relative name(s) address(es) and phone number(s);
 - Emergency contact name and phone number
 - Member's primary care provider address and phone number;
 - Member's current medicals and pharmacy phone number; and
 - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable
- PHP shall maintain policies and procedures required by applicable law which are specific to the management and organization of PHP, which include, but are not limited to admission agreements, personnel policies and staffing ratios, house standards, medication dispensing, and home furnishings and repairs. PHP shall submit copies of its policies and procedures to MCPLTC:
 - Upon request;
 - When new policies and procedures are implemented; and

- When existing policies and procedures are revised by PHP.
- PHP shall maintain policies and procedures specific to a member's personal needs allowance according to applicable law; PHP shall submit such policies to MCPLTC upon request.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCPLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall collect the Room and Board amount determined by the MCPLTC Case Manager from the Member.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCPLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for covered Assisted Living Home Services under their MCPLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCPLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of their contract by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCPLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Three Million Dollars (\$3,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCPLTC.

Additional Requirements for Covered Behavioral Health Assisted Living Center

- PHP must meet minimum staffing ratios of 3.3 hours per patient day (this staffing does not include maintenance, clerical, or administrative staff).
- PHP must meet minimum training hours for new staff six (6) of didactic in-service training in behavioral health topics and ongoing monthly training for all direct care staff.
- PHP shall provide members with recreational and social activities on a daily basis designed to maintain or improve physical and social interaction.
- PHP shall provide service including, but not limited to psychosocial rehabilitation; skills training and development; and assist member on a daily basis to carry out specified goals and objectives as prescribed in the member's treatment plan.
- PHP shall provide a designated unit secured by locked or electronically controlled doors (a wander guard-type system alone does not meet this requirement for locked Behavioral Health Assisted Living Unit)

Additional Requirements for Assisted Living Alzheimer's Units

- PHP shall provide a designated unit secured by locked or electronically controlled doors (a wander guard-type system alone does not meet this requirement).
- PHP shall be staffed with the following ratios: (these staffing ratios exclude facility directors, administrative, clerical and maintenance staff).
 - One (1) staff to ten (10) members from 6:00 am – 2:00 pm
 - One (1) staff to ten (10) members from 2:00 pm – 10:00 pm

- One (1) staff to twenty (20) members from 10:00 pm – 6:00 am

Example: If PHP has thirty-eight (38) members, PHP is required to have three (3) full time staff and then the fourth (4th) staff would be required to work 6 hours and 40 minutes of the 8 hour shift during the hours of 6:00 am to 10:00 pm.

- All staff newly assigned to work on the unit must receive two (2) hours of in-service training prior to actually providing care to members with dementia. Training must include, but is not be limited to:
 - Understanding members with dementia; and
 - How to work with members with dementia.
- All staff on the unit must attend a minimum of one (1) hour every month of in-service education addressing the special needs of members with dementia such as those with Alzheimer’s disease and related disorders, Training must take place and be documented within than every thirty (30) days.
 - Off-site in service education may be included to meet this requirement.
 - Topics for in-service sessions are to include, but are not limited to:
 - Charting and documentation;
 - Understanding persons with dementia;
 - How to work with persons with dementia;
 - Providing services to members based on individual needs;
 - How to maximize independence for persons with dementia;
 - Member rights;
 - Appropriate verbal and non-verbal interaction with members;
 - Pharmacological and physical restraints and their use;
 - Facility protocol to manage/locate members who wander;
 - Activities of daily living as part of the activity program;
 - Fall prevention;
 - Cultural diversity; and
 - Using hospice for members with advanced dementia.
- PHP must have activity staff programming ten (10) hours a week. PHP must offer activities that are appropriate for persons with dementia seven (7) days a week.
- PHP must have buildings and furnishings that are designed for the member’s safety.
- PHP facilities must be designed to maximize comfort for the member’s physical environment, personal, shared surroundings, demonstrate a balance of sensory stimuli that are calming and soothing; and other sensory stimuli that are pleasantly stimulating and engaging.

3.11 - Provider Requirements for Adult Foster Care Home

- For Adult Foster Care, Foundation for Senior Living is billed for all Adult Foster Care services.
- PHP must obtain written authorization from the MCPLTC Case Manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services not prior authorized will not be reimbursed.

- PHP must provide shampoo, hand soap, toilet paper and laundry detergent for each resident.
- All deposits paid prior to MCPLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is required to refund the member their private pay dollars for this time frame and agrees to accept MCPLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCPLTC. Following MCPLTC enrollment, the MCPLTC contract and the MCPLTC Room and Board Placement Agreement should control. All private and previous agreements with an MCPLTC member are null and void.
- PHP shall notify MCPLTC in writing within five (5) business days of PHP changes that include, but are not limited to a change in location, services, licensing, or ownership.
- Referrals for specific covered Adult Foster Care services must be initiated and obtained by the member's primary care provider and/or the MCPLTC Case Manager. Services not authorized by MCPLTC will not be reimbursed.
- PHP shall maintain member case records with information that includes at a minimum the following:
 - Member's name and ALTCS identification number;
 - Member's relative(s) name(s), address(es), and phone number(s);
 - Member's emergency contact(s) name(s), address(es) and phone number(s);
 - Member's primary care provider address and phone number;
 - Member's current medications and pharmacy phone number;
 - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to advanced directives according to applicable law and MCPLTC Policies. PHP must also provide education to PHP staff and subcontractors regarding advance directives.
- PHP shall maintain policies and procedures required by applicable law specific to the management and organization of PHP, which includes, but is not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing; and home furnishings and repairs. PHP must submit copies of policies and procedures to MCPLTC upon request.
- PHP shall not charge Members for any item(s) or service(s) which are covered under this Agreement by AHCCCS or Medicare.
- PHP shall maintain policies and procedures specific to Member's personal needs according to applicable law and submit them to MCPLTC upon request.
- Nursing care services may be provided by PHP if such PHP is a nurse licensed by the State of Arizona to provide covered Adult Foster Care Services according to applicable law. PHP shall keep a record of nursing services rendered and obtain prior authorization according to MCPLTC Policy and Provider Manual.

- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills to members.
- PHP will report to MCPLTC Case Manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCPLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCPLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCPLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCPLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than Five Hundred Thousand Dollars (\$500,000) per occurrence, and an annual aggregate of One Million Dollars (\$1,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCPLTC.

3.12 - Provider Requirements for Skilled Nursing Facilities (SNFs)

Skilled Nursing Facilities (SNFs) provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members. SNFs are responsible for making sure that members residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, members must be seen once every 30 days for the first 90 days, and at least once every 60 days thereafter.
- Members that become eligible while residing in a SNF must be seen within the first 30 days of becoming eligible, and at least once every 60 days thereafter.

Additional nursing facility visits are provided as medically necessary and appropriate.

Providers may also refer to MCP's [Skilled Nursing Facilities \(SNF\) Guide](#) located on our website. The [Skilled Nursing Facilities \(SNF\) Guide](#) includes helpful information regarding the following:

- Billable Days
- Share of Cost
- Patient Trust Accounts
- Behavioral Health Services
- Therapy Authorizations
- Claims
- Claims Payment and Submission

- Discharge from a SNF
- Information and Services offered by MCPLTC for SNF
- Provider Claim Disputes and Member Appeals

Covered services delivered to eligible members in accordance with a PHP’s contract include the following:

- MCPLTC is not responsible to pay for any otherwise covered services rendered to MCPLTC members prior to the date the MCPLTC member becomes enrolled by the State Agency with MCPLTC (except with respect to certain newborns pursuant to the State Agency regulations) or after the MCPLTC member loses eligibility or otherwise is disenrolled from MCPLTC.
- The per diem payment for ALTCS members includes over-the-counter medications. The PHP must use MCPLTC contracted pharmacies and durable medical equipment companies for non-Medicare and MCA enrollees who are on a custodial stay in the facility.
- MCPLTC should be billed for co-payments for MCPLTC members who have Fee for Service Medicare and a Prescription Drug Program or who are on a Medicare Advantage Program, which is not MCA.
- Mercy Care shall reimburse PHP for covered therapy services on a fee for service basis. Mercy Care will update internal payment systems in response to additions, deletions and changes of this nature.

Levels of Care

The appropriate level of care will be determined by the MCPLTC case manager, utilizing the AHCCCS/ALTCS Uniform Assessment Guidelines.

In the event PHP disagrees with the level of care authorized, the PHP may request an administrative review by MCPLTC. In the event PHP disagrees with the decision following the administrative review, PHP may request a second administrative review. The second review request must be made in writing to the MCPLTC Case Management Supervisor within thirty (30) days of the determination of the first administrative review. In the event the original level of care is upheld, the decision is final and not subject to further review by MCPLTC. In the event the original level of care is overturned during the administrative review process, MCPLTC will adjust the level of care in accordance with the date of the PHP’s initial level of care notification.

Levels of care are listed in the table below:

<u>Level of Care</u>	<u>Revenue Codes</u>
Sub-Acute Care Level III	0193
Sub-Acute Care Level IV (Ventilator care)	0194

Custodial Level I	0081
Custodial Level II	0082
Custodial Level III	0083
High Respiratory Services	0071
Bariatric Sub-Acute Level I	0070
Bariatric Sub-Acute Level II	0072
Staff Assisted Dialysis	0079
Hospital Bed Hold	185
Therapeutic Bed Hold	183

- Level of care changes authorized by MCPLTC will be effective on the day of evaluation. Level of care changes may be retroactive to the date of phone or fax notification to the Nursing Facility, but not prior to the date of notification.
- Covered Therapy Services are not included in the MCPLTC member per diem rate, except where specified. PHP shall arrange, or provide covered therapy services, for MCPLTC members residing in its facility. For additional information regarding referrals and authorizations, please refer to [Chapter 16 – Referrals and Authorizations for Medical Services](#) in this provider manual.

Requirements for Specialty Rates

Custodial levels of care are determined according to the AHCCCS Universal Assessment Tool for Acuity Determinations.

These levels are NOT for placements that are Medicare funded by MCA. RUG rates are used for MCA members whose care meets the Medicare criteria for RUG rates.

PHPs providing specialty levels of care must meet the requirements identified below, in accordance with their contract:

Sub-Acute

Level III - Intensive Sub-Acute. This includes any combination of the following:

- complex wound care/decubitus
- total parenteral nutrition or tracheotomy care
- or any therapy up to 3 hours per day (PT/OT/ST)

An RN charge nurse is required to be on the station where Level III members are located 24 hours a day. This level of care is authorized by the MCPLTC Concurrent Review Nurse.

Daily documentation in the medical chart of continued need for sub-acute level of care is required.

PHP must notify MCPLTC staff within 24 hours of when a member no longer requires sub-acute level of care services.

High Respiratory

- All respiratory therapy personnel must be licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCPLTC members in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed Pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director, who will be in charge of all respiratory duties and who will work no less than (40) hours per week.
- Designate one (1) Registered Nurse for each (8) hour shift, who will be in charge of all nursing duties for members requiring respiratory services for that period of time.
- Individuals admitted for respiratory services may be weaning from a ventilator, require multiple respiratory treatments, or have a tracheostomy requiring frequent respiratory therapy monitoring.

Ventilator

- Ensure that all respiratory therapy personnel are licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCPLTC members in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed Pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director, who will be in charge of all respiratory duties and who will work no less than (40) hours per week.
- Designate one (1) Registered Nurse for each (8) hour shift, who will be in charge

of all nursing duties for Members requiring respiratory services for that period of time.

- Provide care for members who are on a ventilator
- Provide care for members on BiPap with a back-up breath rate
- Maintain respiratory therapy notes of member's condition, including daily documentation of heart rate, breath sounds and any medical condition, during and after respiratory procedures, including response to treatment and how many hours of ventilator usage each day.
- Notify the MCPLTC case manager or Concurrent Review Nurse within 24 hours of the initiation of ventilator/BiPap treatment and/or ventilator weaning.
- Provide the services of a licensed pulmonologist who will:
 - Conduct a physical examination and complete medical history as it pertains to ventilator services on each newly admitted MCPLTC ventilator dependent member within seven (7) days of admittance, when ordered by the MCPLTC PCP.
 - Perform routine on-site visits which include evaluation for potential weaning and appropriate diagnosis and treatment on each MCPLTC ventilator dependent member when ordered by the MCPLTC PCP.
 - Re-evaluate, at least annually, each MCPLTC ventilator dependent member to review continued prospects of weaning the member from dependency on the ventilator. .
 - Visit and evaluate MCPLTC ventilator dependent members at least every thirty (30) days.
 - Ensure that appropriate discharge orders accompany member when leaving the ventilator unit including a discharge summary from the ventilator unit which includes input from the nursing facility pulmonologist and a plan for any on-going treatments, including respiratory treatments.
 - Provide education and training for ventilator dependent members and their families when appropriate to increase member's functioning and self-sufficiency.
 - Evaluate member's ability to provide self-care and/or family's ability to care for the member.
 - Provide on-going nursing and therapy consultation and training to promote the development of the member's ability to provide self-care and the family's ability to care for the member.
 - Provide training on maintenance of equipment and nursing care to members who are discharging home.
 - Maintain adequate documentation that reflects the member's/family's ability to provide care.

- Coordinate with MCPLTC case manager or Concurrent Review Nurse regarding DME, supplies, home nursing and other follow-up care that may be needed for members who are discharging to the community.

Staff Assisted Dialysis

- In order to qualify for staff assisted dialysis level of care, members must be unable to attend outpatient dialysis due to their medical condition.
- PHP must provide medical documentation to the MCPLTC Case Manager substantiating need for staff assisted dialysis in lieu of outpatient dialysis prior to admission to the facility at the staff assisted dialysis level of care.
- Perform dialysis treatment as ordered by a nephrologist.
- Evaluate and monitor the member's condition on an on-going basis.
- Inform the member's PCP and nephrologist of relevant diagnostic study results within 72 hours of receipt of results; and report adverse results within 24 hours of receipt of results.
- Administer medications and perform other treatments/diagnostic studies as ordered by the nephrologist.
- Provide all services, supplies, items and equipment and ESRD related laboratory tests covered under the composite/service rates necessary to perform dialysis treatments.
- Approval of requests to provide staff assisted dialysis services beyond the initially authorized time frame is dependent on PHP's submission of medical documentation supporting member's need for ongoing staff assisted dialysis.

Wandering Dementia Program

- Provide a safe and secure nursing home environment for MCPLTC members who have been assessed by the MCPLTC Case Manager as needing this environment due to exhibition of problematic wandering to a degree that endangers the member and other nursing home residents and who cannot be safely managed in a traditional nursing home unit.
- Provide secure living area indoors and outdoors by means of locks (a wander guard type system alone will not meet this requirement) and/or electronically controlled access. Secured areas will be large enough to permit members space to walk, while remaining in sight of the nursing station. Mirrors or video monitors may be used to assist visual supervision of members.
- Provide dining area on the secured unit or nearby with staffing to supervise members going to and returning from meals. If possible, the dining area will be separate from that of the other units in the facility. If not possible, meals for the unit will be scheduled at different times than those of the other units.
- Maintain a 3.0 NHPPD (Nursing Hours per Patient Day) minimum staffing level on the unit.
- All staff newly assigned to work on the unit will receive two (2) hours of in-service training prior to working with the dementia members. The subjects will include

understanding members with dementia and how to provide care to members with dementia.

- All staff on the unit will attend a minimum of one (1) hour every month of in-service education addressing the special needs of dementia members such as those with Alzheimer's disease and related disorders and how to provide care for them.
- The unit will have an activity program which offers activities that are appropriate for persons with dementia, including at least one planned activity per day in the Wandering Unit.
- Develop a facility protocol to manage wandering members which includes:
 - Identify potential wanderers to all staff to enable recognition of members who may be found off the wandering unit.
 - Compile a file of member photographs that can be used to identify members to police in the event a resident elopes from the facility.
 - Develop an intercom code or other procedure to alert all staff when a member is temporarily off of the wandering unit.
 - Assign responsibility to each employee for an area of the facility to search in the event of an alert for a wandering member.
 - In the event of complete but unsuccessful search for a wandering member, notify police, and case manager within no later than 30 minutes from the time the Member was identified as missing from the unit.

Bariatric

Bariatric services are reserved for individuals that have a very poor prognosis for weight loss. These members will typically exhibit a body mass index (BMI) that is severe enough to make care difficult due to the individual's inability to change position, ambulate, or transfer without hands on assistance from three or more nursing home staff. Additional care requirements specifically related to the member's morbid obesity must be evident in the facility documentation, prior to approval of a bariatric level of care.

- The facility will be required to provide medical documentation supporting the need for a bariatric level of care to the MCPLTC Care case manager prior to admission and prior to continued authorization.
- Documentation of care planning and ongoing efforts to effect member weight loss must be provided to the MCPLTC case manager prior to continued authorization for this level of care.
- PHP shall provide the following:
 - Additional nutritional counseling to assist member with appropriate caloric needs.
 - Physical, occupational or restorative therapies tailored to the member.
 - Demonstrate an ongoing multidisciplinary approach to weight loss.

- Provide all services, medications, supplies and bariatric equipment necessary including a bariatric bed to maintain the member at the bariatric level of care (excludes customized DME).

Hospital Bed Hold

Bed holds require authorization by MCPLTC staff. PHP must notify the MCPLTC case manager within 24 hour of hospital admission if there is a request for a hospital bed hold. There are a maximum of twelve (12) days that may be authorized per member, per contract year (October 1- September 30).

Therapeutic Bed Hold

Bed holds require authorization by MCPLTC staff. There are a maximum of nine (9) days that may be authorized per member, per contract year (October 1- September 30).

Respite

Respite placement in a nursing facility is authorized by MCPLTC staff according to AHCCCS requirements. The purpose is to provide an interval of rest and/or relief to a family member or other unpaid person caring for the member, and to improve the emotional and mental well-being of the member. There is a maximum of 25 respite days per contract year (October 1-September 30) provided member has not used respite in any other setting during the contract year.

Additional Requirements for All Behavioral Health Specialty Rates

Provider shall provide all of the following Behavioral Health Services:

- Psychiatric nursing care services
- Rehabilitative services
- Restorative services
- Overall management and evaluation of a member's care plan
- Observation and assessment of a member's changing condition
- Attendants for off-site appointments
- One-on-one services for short durations

Mercy Care Behavioral Health Case Manager and the Behavioral Health Program Team, which shall include the member, the member's authorized representative, the Clinical Program Director, Unit Coordinator, and other nursing home clinical staff involved in the member's clinical care will reassess all members placed on the Behavioral Health High Acuity Unit monthly and report to MCPLTC all changes to the member's needs, ensuring that placement on the unit remains appropriate.

PHP shall provide a minimum of forty (40) hours of on-the-job training for new staff in the Behavioral Health High Acuity Unit covering the services provided on the unit. In addition to didactic in-service requirements during which the new staff observe and participate, but are not left alone or responsible for direct member care.

PHP shall provide a secure outdoor area separate from any outdoor area utilized by other facility residents. The outdoor area for the covered behavioral health program services must be available to members twenty-four (24) hours per day, must have *secured* gates and have a fence no less than six (6) feet high, and be designed in such a manner as to ensure the staff's ability to directly observe and supervise members at all times.

PHP shall comply with MCPLTC documentation requirements that include but are not limited to:

- The development of a behavioral treatment plan for each member;
- Charting of all behavior related to the behavioral treatment plan; and
- Maintain a system to track the increase and decrease of targeted behaviors.

PHP shall provide the foregoing documentation upon request from MCPLTC.

Behavioral Health High Acuity

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health High Acuity, as follows:

- 7.66 nursing hours per patient day (NHPPD), including 1.66 NHPPD of Registered Nursing (RN) or Licensed Practical Nursing (LPN), and 6.00 NHPPD of Certified Nursing Assistants (CAN). These hours are to be dedicated exclusively to residents of the Behavioral Health High Acuity Unit.
- Assuming a full census, the Behavioral Health High Acuity Unit shall be staffed with two licensed nurses throughout the day and evening shifts (6:00 a.m. to 10:30 p.m.) for a total of sixteen (16) hours, and one (1) licensed nurse on the night shift (10:00 p.m. to 6:30 a.m.).
- For all persons (including MCPLTC members and non-members) the Behavioral Health High Acuity Unit shall be staffed with the ratio of CNAs to residents as follows:

Day Shift:	1 CNA to 2 residents
PM Shift:	1 CNA to 2 residents
Night Shift	1 CNA to 4 residents

Behavioral Health Standard Rate

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Standard Rate as follows:

- PHP shall maintain the following staffing ratio:
 - 5.45 Nursing Hours Per Patient Day (NHPPD), including 0.40 NHPPD Registered Nurse (RN) Program Coordinator
 - 1.20 NHPPD Licensed Practical Nurse (LPN)
 - 0.25 NHPPD Activity Program Staff

- 3.60 NHPPD paraprofessional therapeutic assistants

These hours are to be dedicated exclusively to the members in the Behavior Unit and shall be maintained at the same rate for all members including those who are not on MCPLTC.

Behavioral Health Step-Down

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Step-Down Rate as follows:

- PHP shall maintain 3.00 Nursing Hours per Patient Day (NHPPD) minimum staffing, including 1.0 NHPPD Licensed Nurses, and 2.0 NHPPD Certified Nursing Assistants. These hours shall be dedicated exclusively to the Step-Down Unit. This staffing shall be maintained at the same rate for non-MCPLTC residents who are placed on the Step-Down Unit.
- A Unit Coordinator must work exclusively on the Step-Down Unit seven (7) days per week, eight (8) hours per day. The Licensed Nurse Unit Coordinator's hours must not be counted in the 3.0 NHPPD.

Behavioral Health Troublesome

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Troublesome Rate as follows:

- Ensure that all new staff will receive a minimum of six (6) hours of didactic in-service training prior to working on the unit. Training shall include, but not be limited to the following:
 - Charting and documentation
 - Appropriate verbal and non-verbal interaction with Members
 - Psychotropic medication management
 - Behavior Management
 - Activities of daily living as part of the specialized activity programming
- Provide on-site in-service with topics including but not limited to:
 - Charting and documentation
 - Civil commitment procedures
 - Appropriate verbal and non-verbal interaction with members
 - Medication management
 - Behavior management
 - Activities of daily living as part of the specialized activity programming

CHAPTER 4 - PROVIDER RELATIONS

4.0 - Provider Relations Overview

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

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

A Provider Relations representative is assigned to each provider's office. You may reach your representative directly by calling 602-263-3000 or 800-624-3879, Express Service Code 631. A listing of Provider Relations Assignments can be found on the Provider website under [Find Your Provider Representative](#).

Contact Provider Relations 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 Secure Portal Login ID
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice

CHAPTER 5 – MEDICAL PROVIDER RESPONSIBILITIES

General Provider Responsibilities

5.0 - Provider Responsibilities Overview

These responsibilities are 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. MCP 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 Member Care

5.1 - AHCCCS Registration

Each provider must first be registered with AHCCCS and obtain an AHCCCS provider ID number. An active Medicare number must also be attained if providing service for MCA.

5.2 - Appointment Availability Standards

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

5.2 – Appointment Availability Standards Table

<u>Provider Type</u>	<u>Routine Services</u>	<u>Urgent Care</u>	<u>Emergent Care</u>	<u>High Risk</u>	<u>Wait Time in Office Standard</u>
PCP	Within 21 hours	Within 2 days	Within 24 hours		Less than 45 minutes
Specialty Referrals	Within 45 days	Within 3 days of request	Within 24 hours		Less than 45 minutes
Dental Care	Within 45 days	Within 3 days of request	Within 24 hours		Less than 45 minutes

Maternity	First Trimester - within 14 days of request	Second Trimester - within 7 days of request	Third Trimester - within 3 days of request	Within 3 days of identification of high risk status	Less than 45 minutes
Behavioral Health	Within 30 days		Within 24 hours		Less than 45 minutes
Non Urgent/ Non Emergent Transportation					Less than one hour before or after appointment

5.3 - 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 MCP:

- 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., members 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.

5.4 Covering Physicians

Provider Relations must be notified if a covering provider is not contracted or affiliated with MCP. This notification must occur in advance of providing coverage and MCP must provide authorization. Reimbursement to covering physicians is based on the Mercy Care Fee Schedule. **The covering physician must bill under their own Tax Identification Number.** Failure to notify MCP of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

5.5 Locum Tenens

AHCCCS requires credentialing of individual providers or those through an organization such as a Federally Qualified Health Center (FQHC) who is contracted with a health plan. This includes the credentialing of Locum Tenens.

Locum Tenens will be provisionally credentialed in order to expedite the credentialing process.

5.6 - Verifying Member Eligibility

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

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

Website*: www.MercyCarePlan.com. Link available on homepage or you can login to the secure website portal. *You must have a confidential password to access. To register, either contact your Provider Relations representative or fill out the [MercyOneSource Provider Web Portal Registration Form](#) available by clicking the link or in the forms section of our website. More information is available in this Provider Manual under section [5.39 – MercyOneSource](#).

MediFax: MediFax is an electronic product available through AHCCCS that stores key member information. Use to verify MCP member eligibility for pharmacy, dental, transportation and specialty care.

AHCCCS Interactive Voice Response (IVR): To use, dial 602-417-7200. For providers outside of Maricopa County only please dial 800-331-5090.

MCP Telephone Verification: Use as a last resort. Call Member Services to verify eligibility at 602-263-3000 and use Express Service Code 629. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as member identification number, date of birth and address, before any eligibility information can be released. When calling MCP, use the prompt for the providers.

Monthly Roster: Monthly rosters are found on the secure website portal. Contact your Provider Relations representative for more information. Note that rosters are only updated once a month. More information is available in this Provider Manual under section [5.39 - MercyOneSource](#) regarding provider rosters.

5.7 - Preventive or Routine Services

Providers are responsible for providing appropriate preventive care for eligible members. Preventive health guidelines are located on the MCP website in the [Member Handbook](#). These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations
- EPSDT

5.8 – Well-Woman Preventative Care Services Provider Requirements

Provider requirements for well-woman preventative care services are included below.

COVERED SERVICES INCLUDED AS PART OF A WELL-WOMAN PREVENTATIVE CARE VISIT

An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventative care visit is inclusive of a minimum of the following:

- A physical exam (well exam) that assesses overall health.
- Clinical breast exam.
- Pelvic exam (as necessary, according to current recommendations and best standards of practice).
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. Refer to 310-H, *Health Risk Assessment and Screening Tests* for further information pertaining to health risk assessments and associated screening tests.

NOTE: Genetic screening and testing is not covered, except as described in Chapter 300, *Medical Policy for Covered Services*.

- Screening and counseling is included as part of the well-woman preventative care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
 - Proper nutrition
 - Physical activity
 - Elevated BMI indicative of obesity
 - Tobacco/substance use, abuse, and/or dependency
 - Depression screening
 - Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
 - Sexually transmitted infections
 - Human Immunodeficiency Virus (HIV)
 - Family planning counseling

- Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
 - Reproductive history and sexual practices
 - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
 - Physical activity or exercise
 - Oral health care
 - Chronic disease management
 - Emotional wellness
 - Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
 - Recommended intervals between pregnancies
 - NOTE: Preconception counseling does not include genetic testing.
- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

WELL-WOMAN PREVENTATIVE CARE SERVICE STANDARDS

Immunizations – Mercy Care will cover the Human Papilloma Virus (HPV) vaccine for female members 11 to 26 years of age. For adult immunizations, this information is covered in the AHCCCS Policy 310-M, *Immunizations*. Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the [CDC website](#) where this information is included). Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age, and must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIS) registry.

Screenings – Information regarding screening tests is contained in the AHCCCS Policy 310-H, *Health Risk Assessment and Screening Tests*. Please feel free to review for further details pertaining to specific screening and limitations related to health risk assessments and associated screening tests for those members over 21 years of age. You may also refer to AHCCCS Policy 430, *EPSDT Services* for further details related to covered services for members less than 21 years of age.

5.9 - Educating Members on their own Health Care

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

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;

- any information the member needs in order to decide among all relevant treatment options;
- the risks, benefits, and consequences of treatment or non-treatment; and,
- The member'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.

5.10 - Urgent Care Services

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

MCP 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.

MCP educates its members regarding the appropriate use of Urgent Care Services. Urgent Care Services are to be used when a member 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

5.11 - Emergency Services

Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department.

MCP educates its members 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

5.12 - Primary Care Providers (PCPs)

The primary role and responsibilities of primary care providers participating in MCP include, but are not be limited to:

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

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the member. These services will include, at a minimum, the treatment of routine illness, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible members under age 21, adult health screening services and medically necessary treatments for conditions identified in an EPSDT or adult health screening.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to MCP members 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 members to providers or hospitals within the MCP network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with MCP's Prior Authorization Department in regard to prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
- Coordinating the medical care of the MCP members 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 member's health care needs.

5.13 - 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 members upon receipt of a written referral form from the member's primary care provider or

from another MCP participating specialist. Specialists are required to coordinate with the primary care provider when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member 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 member, other specialists or other providers.

5.14 - Second Opinions

A member may request a second opinion from a provider within the contracted network. The provider should make a recommendation and refer the member to another provider.

5.15 - Provider Assistance Program for Non-Compliant Members

The provider is responsible for providing appropriate services so that members understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. If you need assistance helping non-compliant members, MCP's Provider Assistance Program is available to you. The purpose of the program is to help coordinate and/or manage the medical care for members at risk. You may complete the [Provider Assistance Program Form](#) located on MCP's website and submit it to Member Services for possible intervention.

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

Documenting Member Care

5.16 - Member'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 member's medical record. The member'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 member, including confidential information must be made available electronically to MCP, AHCCCS or any government agency upon request. Medical records necessary for the payment of claims must be made available to MCP 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 MCP or any government entity upon request. MCP may request medical records for the purpose of transitioning a member to a new health plan or provider. The medical record will be made available free of charge to MCP for these purposes.

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

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. The following requirements are taken directly from the AHCCCS Medical Policy Manual 940.1:

- Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)
- Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members 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 members if available)
- Dental history if available, and current dental needs and/or services
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years)
- Documentation, initialed by the member'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 a member's health status changes or new medications are prescribed
 - Behavioral health history
 - Documentation as to whether or not an adult member 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 member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- b) **Medical Record Maintenance** – The provider must maintain member information and records for the longer of six (6) years after the last date provider services were provided to Member, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the member medical record shall survive the termination of a Provider's contract with MCP, 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 a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or MCP that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, MCP will require and assist the PCP with the coordination of the referral and transfer of care through the behavioral health case management team at MCP. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

5.17 - Advance Directives

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

- Providing written information to adult members 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 member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member 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.

5.18 - Medical Record Audits

MCP will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when MCP 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 to AHCCCS for quality review upon request. MCP shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.

5.19 - Documenting Member Appointments

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

5.20 - Missed or Cancelled Appointments

Providers must:

- Document and follow-up on missed or canceled appointments.
- Notify Member Services by completing a [Provider Assistance Program](#) form located on MCP's website for a member who continually misses appointments.

MCP encourages providers to use a recall system. MCP reserves the right to request documentation supporting follow up with members related to missed appointments. Providers may also notify MCP Quality Management of missed appointments utilizing the [Missed Appointment Log](#) for the QM staff to follow-up with members.

5.21 - Documenting Referrals

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

5.22 - Respecting Member Rights

MCP is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers and members each year. Member rights are incorporated herein and may be reviewed in the [Member Handbook](#) located in the MCP website.

5.23 - 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 Participating Health Providers (PHP) are required to adhere to HIPAA regulations. For more information about these standards, please visit the [Health Information Privacy](#) website. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

5.24 - 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. (Resource: [National Standard for Culturally and Linguistically Appropriate Services in Health Care – Final Report](#))

Mercy Care Plan (MCP) 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 Plan'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 Plan’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.

- Encourage patients to use tools that would help them obtain information to manage their health care. Ask Me 3 is one of these tools. Ask Me 3 is a patient education program designed to improve communication between patients and health care providers, encourage patients to become active members of their health care team, and promote improved health outcomes. The program encourages patients to ask their health care providers three questions:
 - What is my main problem?
 - What do I need to do?
 - Why is it important for me to do this?

For additional information regarding Ask Me 3, their website is referenced below under the Provider References Section.

- Use Language Services for Mercy Care Plan members. Providers must deliver information in a manner that is understood by the member. MCP complies with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. MCP strongly recommends the use of professional interpreters, rather than family or friends.
 - The TTY line is available for members who are hearing impaired.
 - Voiance is the service provider contracted with Mercy Care Plan. 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 Voiance directly at either of the following phone numbers:
 - Clinical Services (CL): 1-877-756-4839, pin 1028;
 - or Non-Clinical Services (NC): 1-877-756-4839, pin 1030

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

In order 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. Encourage members to use Ask Me 3.
6. 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 Mercy Care’s website. 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>
- <http://www.npsf.org/?page=askme3>
- www.healthliteracy.com
- www.healthliteracymissouri.org
- <http://nccc.georgetown.edu/information/providers.html>
- <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.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx>
- <http://www.healthypeople.gov/2020/leading-health-indicators/Leading-Health-Indicators-Development-and-Framework>

5.25 - 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.

5.26 - Primary Care Provider (PCP) Assignments

MCP automatically assigns members to a provider upon enrollment. Members have the right to change their provider at any time. Member eligibility changes frequently, as a result, providers must verify eligibility prior to delivering services.

5.27 - Plan Changes

MCP members generally are not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe. Plan change requests may be granted based on continuity of medical care. Often, these requests involve continuity of prenatal care. The plan change determination will be made by the MCP medical director or designee based on information provided by the PCP.

Provider Guidelines and Plan Details

5.28 - Cost Sharing and Coordination of Benefits

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance such as Medicare, a Medicare HMO or a commercial carrier, MCP will coordinate payment of benefits in accordance with the terms of the PHPs contract and federal and state requirements. AHCCCS registered providers must coordinate benefits for all MCP members in accordance with the terms of their contract and AHCCCS guidelines.

Mercy Care Plan is the payor of last resort, unless specifically prohibited by State or Federal law. This means that Mercy Care Plan shall not be used as a source of payment for covered services only after all other sources of payment have been exhausted. Mercy Care will take reasonable measures to identify potentially legally liable third party sources and reports these to AHCCCS.

Mercy Care coordinates benefits in accordance with AHCCCS regulations so that costs for services that would otherwise be payable by Mercy are cost avoided or recovered from a liable third party. The two methods used for coordination of benefits are cost avoidance and post-payment recovery.

Cost Avoidance

Mercy Care will take reasonable measures to determine all legally liable parties - any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. Mercy Care will cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. For purposes of cost avoidance, establishing liability takes place when Mercy Care receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established,

Mercy Care will adjudicate the claim for payment. Mercy Care will then utilize post-payment recovery which is described in further detail below if it turns out a legally liable party is responsible for the payment of covered services.

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, Mercy Care is responsible for making these payments.

Claims for an inpatient stay for labor, delivery and postpartum care, including professional fees when there is no global OB package, will be cost avoided by Mercy Care.

Mercy care shall not deny a claim for timely filing if the untimely claim submission results from a provider's efforts to determine the extent of liability.

Post Payment Recoveries

Post-payment recovery is necessary in cases where Mercy Care has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, Mercy Care will adjudicate the claim and then utilize post-payment recovery processes which include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payor Sources, and Other Third Party Liability Recoveries.

Pay and Chase: Mercy Care will pay the full amount of the claim due per the contracted rate with the provider and then seek reimbursement from any third party if the claim is for the following reasons:

- Prenatal care for pregnant women, including services which are part of a global OB Package;
- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program;
- Services covered by third party liability that are derived from an absent parent who's obligation to pay support is being enforced by the Division of Child Support Enforcement; or
- Services for which Mercy Care fails to establish the existence of a liable third party at the time the claim is filed.

Retroactive Recoveries Involving Commercial Insurance Payor Sources: For a period of two years from the date of service, Mercy Care will engage in retroactive third party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, Mercy Care will seek recovery from the commercial insurance. **Mercy Care will not recoup related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way.**

Mercy Care has two years from the date of service to recover payments for a particular claim, or to identify claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when Mercy Care has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment. After two years from the date of service, AHCCCS will direct recovery efforts for any claims not identified by Mercy Care.

The overall timeframe for submission of claims for recovery is limited to three years from the date of service.

Other Third Party Liability Recoveries: Mercy Care will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining through the use of trauma code edits, utilizing codes provided by AHCCCS. Mercy Care shall not pursue recovery in the following circumstances, unless the case has been referred to Mercy Care by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tort feasons
- Restitution Recoveries
- Worker's Compensation Cases

Mercy Care works directly with AHCCCS in regard to Other Third Party Liability Recoveries.

5.29 - Clinical Guidelines

To help provide MCP 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.

MCP has adopted the evidence based guidelines published by the [National Guideline Clearinghouse](#).

5.30 - Office Administration Changes and Training Requirements

Providers are responsible to notify MCP'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 Provider Services representative to schedule any needed staff training.

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

- Medical records standards
- Fraud and abuse 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.

5.31 - Consent Forms

The following consent forms are available on the AHCCCS website:

- Certificate of Medical Necessity for Pregnancy Termination (AHCCCS Medical Policy Manual Exhibit 410-1) -
- Consent for Sterilization (AHCCCS Medical Policy Manual Exhibit 420-1)
- Hysterectomy Consent Form (AHCCCS Medical Policy Manual Exhibit 820-1)
- Consent for the release of confidential medical records (substance abuse treatment/HIV/AIDS).

5.32 - Contract Additions or Terminations

In order to meet contractual obligations and state and federal regulations, providers **must** report any terminations or additions to their contract at least 90 days prior to the change. Providers are required to continue providing services to members throughout the termination period.

5.33 - Continuity of Care

Providers terminating their contracts without cause are required to continue to treat MCPLTC 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.

The Bureau of Health Systems Development has recently posted a new interactive website to help people easily locate a clinic that provides free or low cost primary, mental and dental health services to people without health insurance. These Sliding Fee Schedule clinics determine, based on gross family income, the portion of billed charges that the uninsured client will be responsible for. Sliding Fee Schedules are based on current Federal Poverty Guidelines.

The [Interactive SFS Clinics](#) map will help you find a clinic in your community, simply by moving the cursor over your neighborhood, or by typing in your zip code or city.

The site also includes a downloadable complete listing of primary care or behavioral health SFS providers.

You can also download a [Mobile App](#) to find federally-funded health centers on the go.

You may also contact MCP’s Case Management Department for assistance.

5.34 - Contract Changes or Updates

Providers **must** report any changes to demographic information to MCP at least 90 days prior to the change in order to be in compliance with contractual obligations and state and federal regulations. Providers are required to continue providing services to members throughout the termination period. For information on where to send change information, refer to the below table.

5.33a – Provider Record Updates Table

<u>Type of Change</u>	<u>Notification Requirements</u>	<u>Send To</u>	<u>Time to Process</u>
Individual or group Name	Must mail updated W-9 and letter describing change and effective date.	Provider Relations	90 days
Tax ID number	Must mail updated W-9 and Letter describing change and effective date.	Provider Relations	90 days
Address	Must fax to 860-975-3201 or mail.	Provider Relations	90 days
Staffing changes	Must fax 860-975-3201 or Mail letter describing change And effective date.	Provider Relations	90 days
Adding new office locations	Must fax 860-975-3201 or mail letter describing change and effective date.	Provider Relations	90 days
Adding new Physicians to current	Must fax 860-975-3201 or mail letter describing change	Provider Relations	90 days

and effective date.

5.35 - 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 MCP members until they are credentialed. For providers who work in Pima and Maricopa Counties, Mercy Care Plan requires either an active Board Certification or substantial evidence of experience, training, and competency in the field in which you will practice.

5.36 - 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.

5.37 - Marketing

Providers may not market Mercy Care's name, logo, or likeness without prior approval. If a provider advertisement refers to Mercy Care's name, logo, or likeness, the advertising must be prior approved by AHCCCS.

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

As a prerequisite to contracting with an organizational provider, Mercy Care must ensure that the organizational provider has established policies and procedures that meet AHCCCS 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 and unexpected death to Mercy Care.

5.39 - MercyOneSource

MCP provides a web-based platform enabling health plans to communicate healthcare information directly with providers. Users can perform transactions, download information, and work interactively with member healthcare information. The following information can be attained from the MercyOneSource platform:

- **Member Eligibility Search** – Verify current eligibility on one or more members. Please note that eligibility may also be verified through the AHCCCS website.
- **Panel Roster** – View the list of members currently assigned to the provider as the primary care provider (PCP).
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.

- **Claims Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
- **Remittance Advice Search** – Search for provider claim payment information by member name, member ID, provider name, provider ID, date of service, or date range or specific claim number. Only remits associated with the user’s account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed.
- **Submit Authorizations** – Submit an authorization request for a member.
- **HEDIS** – Check the status of the member’s compliance with any of the HEDIS measures. “Yes” means the member has measures that they are not compliant with; “No” means that member has met the requirements.

Important provider documents are also available for your use once you sign into Mercy OneSource, including:

- MercyOneSource Provider Web Portal Instructions
- MercyOneSource Add User Process
- MercyOneSource Provider Web Portal Registration Form
- Current and Historical Mercy Care Fee Schedules
- Web Portal Instructions for CareWebQI (Submitting an Authorization)
- Pro-Report Log On

For registration information regarding MercyOneSource, please access the [MercyOneSource Registration Form](#) available on the website under the Forms section. Once you have your log in you may access [MercyOneSource](#) by clicking on the link.

CHAPTER 6 - COVERED AND NON COVERED MEDICAL SERVICES

6.0 - Coverage Criteria

With the exception of emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified providers. Benefit limits apply.

Each line of business has specific covered and non-covered services. Participating providers are required to administer covered and non-covered services to members in accordance with the terms of their contract and member's benefit package.

6.1 - Covered Services

For a combined listing of covered services for MCP, please refer to Mercy Care's [Member Handbook](#) under "Services that are Covered", available on Mercy Care's website.

Providers may arrange medically necessary non-emergent transportation for MCPLTC members by calling Member Services at 602-263-3000 or 800-624-3879, Express Service Code 630.

6.2 - Non Covered Services

- Services from a provider who is NOT contracted with MCP (unless prior approved by MCP)
- Cosmetic services or items
- Personal care items such as combs, razors, soap etc.
- Any service that needs prior authorization that was not prior authorized
- Services or items given free of charge, or for which charges are not usually made
- Services of special duty nurses, unless medically necessary and prior authorized
- Physical therapy that is not medically necessary
- Routine circumcisions
- Services that are determined to be experimental by the health plan medical director
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother
- Health services if you are in prison or in a facility for the treatment of tuberculosis
- Experimental organ transplants, unless approved by AHCCCS
- Sex change operations
- Reversal of voluntary sterilization
- Medications and supplies without a prescription
- Treatment to straighten teeth, unless medically necessary and approved by MCP
- Prescriptions not on MCP's list of covered medications, unless approved by MCP
- Diapers solely for personal hygiene
- Physical exams for the purpose of qualifying for employment or sports activities

Other Services that are Not Covered for Adults (age 21 and over):

- Hearing aids, including bone-anchored hearing aids.

- Cochlear implants;
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs;
- Percussive vests;
- Services performed by a podiatrist (except for QMB members);
- Routine eye examinations for prescriptive lenses or glasses;
- Routine dental services and emergency dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members);
- Outpatient speech and occupational therapy (except for Medicare QMB members).

CHAPTER 7 - EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

7.0 - EPSDT Program Overview

The Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21 as described in 42 USC 1396d (a) and (r). The EPSDT program is governed by federal and state regulations and community standards of practice. All PCPs who provide services to members under age 21 are required to provide comprehensive health care, screening and preventive services, including, but not limited to:

- Primary prevention
- Early intervention
- Diagnosis
- All services required to treat or improve a defect, problem or condition identified in an EPSDT screening.

Please refer to the MCP website for **Claims Coding for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Well-Child Visits** under Provider Notifications for specific claim codes.

7.1 - Requirements for EPSDT Providers

PCPs are required to comply with regulatory requirements and MCP preventative requirements which include:

- Documenting immunizations within 30 days of immunization into Arizona State Immunization Information System (ASIS) and enroll every year in the Vaccine for Children Program.
- Providing all screening services according to the AHCCCS Periodicity Schedule and community standards of practice. The **Periodicity Schedule** can be viewed by accessing the AHCCCS' website.
- Ensuring all infants receive both the first and second newborn screening tests. Specimens for the second test may be drawn at the PCP's office and mailed directly to the Arizona State Laboratory, or the member may be referred to MCP's contracted laboratory for the draw.
- Using current AHCCCS standardized EPSDT tracking forms to document services provided and compliance with AHCCCS standards. The **EPSDT Tracking Forms** are available on Mercy Care's website under Forms. They are also available on the AHCCCS website.
- Sending copies of EPSDT tracking forms to MCP on a monthly basis. Please send forms by mail to: 4350 E. Cotton Center Blvd., Bldg. D, Phoenix, AZ 85040 - Attn: Quality Management or fax the forms to 602-431-7157.
- Using all clinical encounters to assess the need for EPSDT screening and/or services.

- Documenting in the medical record the member's decision not to participate in the EPSDT program, if appropriate.
- Making referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Scheduling the next appointment at the time of the current office visit for children 24 months of age and younger.
- Reporting all EPSDT encounters on required claim forms, using the Preventive Medicine Codes.
- Referring MCP members (Acute and DD) to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.
- Referring members to WIC, AzEIP and Head Start as appropriate.
- Initiating and coordinating referrals to behavioral health providers as necessary.

An EPSDT screening includes the following basic elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments).
- Developmental screening (using an AHCCCS approved developmental screening tool) for members age 9, 18 and 24 months.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests appropriate to age and risk for the following: blood lead, tuberculosis skin testing, anemia testing and sickle cell trait.
- Health education and counseling about child development, healthy lifestyles and accident and disease prevention.
- Appropriate dental screening and referral.
- Fluoride varnish application every six months (by providers who have completed training) for members' age 6-24 months with at least one tooth eruption.
- Appropriate vision and hearing/speech testing.
- Obesity screening using the BMI percentile for children.
- Anticipatory guidance.

7.2 - Health Education

The PCP is responsible for ensuring that health counseling and education are provided at each EPSDT visit. Anticipatory guidance should be provided so that parents or guardians know what to expect in terms of the child's development. In addition, information should be provided regarding accident and disease prevention, and the benefits of a healthy lifestyle.

Screenings

7.3 - Periodic Screenings

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of the child's development. The **AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1)** can be viewed on the AHCCCS website. This schedule follows the Center for Disease Control (CDC)

recommendation. Children may receive additional inter-periodic screening at the discretion of the provider. MCP does not limit the number of well-child visits that members under age 21 receive. Claims should be billed with the following CPT/ICD-9-CM Diagnosis (prior to 10/1/15) or ICD-10-CM Diagnosis (effective 10/1/15 and after) Codes based on age appropriateness:

Codes to Identify Well-Child Visits – Ages 0 – 15 Months

CPT

99381, 99382, 99391, 99392, 99461

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

After 10/1/15

Z00.121, Z00.129, Z00.110, Z00.111, Z02.89, Z00.8, Z00.70, Z00.71

Codes to Identify Well-Child Visits – Ages 3 – 6 Years

CPT

99382, 99383, 99392, 99393

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

After 10/1/15

Z00.21, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

Codes to Identify Well-Care Visits – Adolescents

CPT

99383-99385, 99393-99395

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

After 10/1/15

Z00.21, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

Well Child Visits for sports and other activities should be based on the most recent EPSDT Well Child Visit, as the annual Well Child Visits are comprehensive and should include all of the services required for sports or other activities. AHCCCS does not cover sports or other physicals solely for that purpose. If it can be combined with a regularly scheduled EPSDT visit, it is covered, though no additional payment would be allowable for completing the school or other organization paperwork that would allow the child to participate in the activity.

7.4 - Nutritional Assessment & Nutritional Therapy

MCP covers nutritional therapy for EPSDT members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake. The following requirements apply:

- Must be assessed at each visit.
- Members in need of nutritional therapy should be identified and referred to MCP.
- Nutritional therapy requires prior authorization and approval by the MCP Medical Director.
- Once prior authorization has been attained, a fully completed [Commercial Oral Nutritional Supplements \(EPSDT Members\)](#) form should be filled out and sent directly to the Durable Medical Equipment provider for handling.

7.5 – Developmental Screening Tools

As of 8/1/14, the following developmental screening tools are available for members at their 9, 18 and 24 month EPSDT visit:

- [Ages and Stages Questionnaires™ Third Edition \(ASQ\)](#) is a tool which is used to identify developmental delays in the first 5 years of a child's life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference.
- [Ages and Stages Questionnaires®: Social-Emotional \(ASQ: SE\)](#) is a tool which is used to identify developmental delays for social-emotional screening.
- The [Modified Checklist for Autism in Toddlers \(M-CHAT\)](#) may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated.
- [The Parents' Evaluation of Developmental Status \(PEDS\)](#) may be used for developmental screening of EPSDT-aged members.

Providers may bill for this service as long as the following criteria is met:

- The member's EPSDT visit is at either 9, 18, or 24 months;
- Prior to providing the service, the provider is required to complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to CAQH.
- The code is appropriately billed (96110-EP). Copies of the completed tools must be retained in the medical record and submitted to the health plan with the completed EPSDT Tracking Form.

7.6 – PCP Application of Fluoride Varnish

Effective 4/1/2014, a change was made to the [AHCCCS Medical Policy Manual \(AMPM\) under Policy 431 - EPSDT Oral Health Care](#). The change advises that the physician, physician's assistant or nurse practitioner must perform an oral health screening as part of the EPSDT physical examination. Please refer to this document if you have further questions about this change.

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least 6 months of age, with at least 1 tooth eruption. Additional applications occurring every 6 months during an EPSDT visit, up until the recipient's 2nd birthday, will also be reimbursed.

PCPs and attending physicians must refer EPSDT recipients to a dentist for appropriate services based on the needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 431-1). Evidence of the referral must be documented on the EPSDT Tracking Form and in the recipient's medical record. Recipients must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT recipients for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to physician referrals, EPSDT recipients are allowed self-referral to an AHCCCS registered dentist.

AHCCCS recommended training for fluoride varnish application is located at the [Smiles for Life](#) website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should fax a copy of their certificate to Mercy Care's Provider Relations Department at 860-975-3201. This certificate will be used in the credentialing process to verify completion of training necessary for reimbursement.

An oral health screening must be part of an EPSDT screening conducted by a PCP. However, it does not substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

7.7 - Pediatric Immunizations/Vaccines for Children Program

EPSDT covers all child and adolescent immunizations. Immunizations must be provided according to the [Advisory Committee on Immunization Practices \(ACIP\)](#) guidelines and be up-to-date. Providers are required to coordinate with the Arizona Department of Health Services' (ADHS) Vaccine for Children Program (VFC) to obtain vaccines for MCP members who are 18 years of age and under.

Additional information can be attained by calling [Vaccine for Children](#) at 602-364-3642 or by accessing their website.

Arizona law requires the reporting of all immunizations administered to children under 19 years old. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database, the Arizona State Immunization Information System (ASIIS) that can be accessed online to obtain complete, accurate records.

Please note that on October 1, 2012 a policy change with the VFC program went into effect. With this update, federal vaccines can no longer be used to immunize privately insured children. Although a newborn may be eligible for Medicaid, hospitals cannot make an absolute determination that a newborn is not also eligible for private insurance at the time that this immunization would be administered. Because of this, the hospitals face the potential of administering VFC vaccines to newborns against the federal requirements. Since many hospitals have dis-enrolled from the VFC program due to this new policy, newborns who are delivered at the facilities may not receive the birth dose of the Hepatitis B vaccine.

Mercy Care Plan requests that all primary care providers and pediatricians caring for newborns review each member's immunization records fully upon the initial visit, and subsequent follow-up visits, regardless of where the child was delivered. It is our intention to ensure that the newborns receive all required vaccines, and that those who have not received the birth dose of the Hepatitis B vaccine in the hospital be "caught up" by their primary care provider.

7.8 - Body Mass Index (BMI)

Providers should calculate each child's BMI starting at age three until the member is 21 years old. Body mass index is used to assess underweight, overweight, and those at risk for overweight. BMI for children is gender and age specific. PCPs are required to calculate the child's BMI and percentile. Additional information is available at the CDC website regarding [Body Mass Index \(BMI\)](#).

The following established percentile cutoff points are used to identify underweight and overweight in children:

7.8a – Body Mass Index (BMI) Table

Underweight	-	BMI for age <5 th percentile
At risk of Overweight	-	BMI for age 85 th percentile to <95 th percentile
Overweight	-	BMI for age > 95 th percentile

7.9 - Blood Lead Screening

All children are considered at risk of, and must be screened for lead poisoning.

- Children at 12 months of age and at 24 months of age must receive a blood lead test.

- Children between 36 months and 72 months of age must receive a blood lead test if they have not been previously screened.

A verbal risk assessment must be completed at each EPSDT visit for children six months through 72 months to determine risk category and the need for any follow up services.

Providers must report blood lead levels equal to or greater than 10 micrograms of lead per deciliter of whole blood to the ADHS.

7.10 - Eye Examinations and Prescriptive Lenses

EPSDT includes eye exams and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams and refer members to the contracted vision provider for further assessment.

7.11 - Hearing/Speech Screening

Hearing evaluation consists of appropriate hearing screens given according to the EPSDT schedule. Evaluation consists of history, risk factors, parental questions and impedance testing.

- Pure-tone testing should be performed when medically necessary.
- Speech screening shall be performed to assess the language development of the member at each EPSDT visit.

7.12 - Behavioral Health Screening

Screenings for mental health and substance abuse problems are to be conducted at each EPSDT visit. Treatment services are a covered benefit for members under age 21. The PCP is expected to:

- Initiate and coordinate necessary referrals for behavioral health services.
- Monitor whether a member has received services.
- Keep any information received from a behavioral health provider regarding the member in the member's medical record.
- Initial and date copies of referrals or information sent to a behavioral health provider before placing in the member's medical record.
- If the member has not yet been seen by the PCP, this information may be kept in an appropriately labeled file in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as one is established.

7.13 - Dental Screening and Referrals

Oral health screenings are to be conducted at every EPSDT visit. The PCP must screen children less than three years of age at each visit to identify those who require a dental referral for evaluation and treatment.

In addition to the screening, members three years of age and older must be referred to a dentist at least annually. American Association of Pediatric dentistry recommends that the

dental visits begin by age one but the referral isn't mandatory until age 3. Documented dental findings and treatment must be included in the member's medical record in the PCP's office. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

- Urgent - (Within 24 hours) Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer
- Early - (Within three weeks) Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas
- Routine - (Next regular checkup) none of the above problems identified.

The member's parent or guardian may also self-refer and schedule dental appointments for the member with any MCP contracted general dentist. They may go directly to the dentist without seeing the PCP first and no authorization is required.

7.14 - Tuberculin Skin Testing

Tuberculin skin testing should be performed as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

- Confined or suspected of TB;
- In jail during the last five years;
- Living in a household with an HIV-infected person or the child is infected with HIV; and
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

State Programs

7.15 - Arizona Early Intervention Program (AzEIP)

AzEIP is an early intervention program that offers a statewide system of support and services for children birth through three years of age and their families who have disabilities or developmental delays. This program was jointly developed and implemented by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services, such as physical therapy, occupational therapy, speech/language therapy and care coordination under Sec. 1905 [42 U.S.C 1396d].. Concerns about a child's development may be initially identified by the child's Primary Care Provider or by AzEIP.

MCP coordinates with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner to promote optimum child health and development. For additional information, please contact the MCP AzEIP Coordinator.

Please refer to Mercy Care Plan/Provider Tools/Provider Notifications, Arizona Early Prevention Program on MCP's website for additional information regarding referrals and locations.

7.16 - Children's Rehabilitative Services (CRS)

Effective October 1, 2013 AHCCCS enrolled children with CRS-qualifying conditions under the Acute line of business were transitioned to United Health Care Community Plan for not only CRS related conditions but for all medical care.

7.17 - AHCCCS Office of Special Programs

Children who have been diagnosed with the following genetic metabolic conditions and who need medical foods may receive services directly through the AHCCCS Office of Special Programs. AHCCCS covers medical foods, within the limitations specified in the AHCCCS Medical Policy Manual (AMPM), Chapter 320-H, Medical Foods, for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- 3 Methylcrotonyl CoA Carboxylase Deficiency
- Isovaleric Acidemia
- Methylmalonic Acidemia
- Propionic Acidemia
- Arginosuccinic Acidemia
- Tyrosinemia Type I
- HMG CoA Lyase Deficiency
- Cobalamin A, B, C Deficiencies

Metabolic Disorder Medical Foods – Coverage Entity:

- Members receiving EPSDT services that have been diagnosed with a metabolic disorder included in the AMPM, Chapter 320-H, Medical Foods, are eligible for services through CRS.
- Members receiving EPSDT services must receive metabolic formula through CRS.
- Members receiving EPSDT services who require modified low protein foods receive them through AHCCCS Administration.
- AHCCCS Administration is responsible for providing both necessary metabolic formula and modified low protein foods for members 21 years of age and older who have been diagnosed with one of the inherited metabolic disorders included in the AMPM, Chapter 320-H, Medical Foods section.
- MCP is responsible for initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist, lab tests and other services related to the provision of medical foods for enrolled members diagnosed with a metabolic disorder included in the AMPM, Chapter 320–H, Medical Foods section.

Further information can be obtained by contacting the Office of Special Programs at 602-417-4053 or by referring to the AHCCCS Medical Policy Manual and referring to [Chapter 320-H, Medical Foods](#).

CHAPTER 8 - BEHAVIORAL HEALTH

8.0 - Behavioral Health Overview

Comprehensive mental health and substance abuse (behavioral health) services are available to MCPLTC members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and case manager. MCPLTC members may also self-refer for a behavioral health evaluation. The level and type of behavioral health services will be provided based upon a member's strengths and needs and will respect a member's culture. Behavioral health services include:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health case management services
- Behavioral health nursing services
- Emergency behavioral healthcare
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level I residential treatment centers and sub-Acute facilities)
- Lab and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised, therapeutic and medical day programs)
- Psychological rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Home Care Training to Home Care Client

8.1 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MCPLTC members. These may include, but are not limited to, the following licensed agencies or individuals:

- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Licensed substance abuse counselors
- Residential treatment facilities

- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse programs

8.2 - Alternative Living Arrangements

MCPLTC also includes the following alternative living arrangements:

- **Behavioral Health Level II and III** – these settings provide behavioral health treatment with 24-hour supervision. Services may include on site medical services and intensive behavioral health treatment programs.
- **Traumatic Brain Injury Treatment Facility** – this setting provides treatment and services for people with traumatic brain injuries.
- **DDD Group Homes** – these settings provide behavioral health treatment with 24-hour supervision.

8.3 - Emergency Services

MCP covers behavioral health emergency services for MCPLTC members. If a member is experiencing a behavioral health crisis, please contact the **MCP Behavioral Health Hotline at 800-876-5835**.

During a member's behavioral health emergency, the MCP Behavioral Health Hotline clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by MCPLTC.

8.4 - Behavioral Health Consults

Behavioral Health consults are required by AHCCCS on all MCPLTC members who receive behavioral health services. Behavioral Health Consults are done between an MCP case manager and a behavioral health case manager reviewing the behavioral health provider's progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultations Process:

- Consults must take place quarterly for long term care members that are receiving behavioral health services and 30 days after a referral for behavioral health services is made.
- Behavioral health consultations must be reviewed face-to-face with, and the outcome signed by, a Masters Level Behavioral Health Clinician.

MCP behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime.

8.5 - Behavioral Health Screening

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each EPSDT visit for members under age 21

8.6 - Behavioral Health Appointment Standards

MCP routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- Emergency - Within 24 hours of referral.
- Routine - within 30 days of referral.

8.7 - Behavioral Health Provider Coordination of Care Responsibilities

It is critical that a strong communication link be maintained with behavioral health providers including:

- PCPs and other interested parties such as CPS (if the guardian and MCP has the paper work)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian)
- Veterans Office (when guardian)
- Children's schools (participation in the ISP with parental or guardian consent)
- The court system (when completing paper work for all court ordered treatments or evaluations)
- Other providers not described above

Information can be shared with the other party that is necessary for the member's treatment. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

8.8 - PCP Coordination of Care

The PCP will be informed of the member'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, diagnosis and treatment within 10 business days of receiving the request from the behavioral health provider.

Where there has been a change in a member'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 member. All efforts to coordinate on care on behalf of the member should be documented in the member's medical record.

8.9 - Prior Authorization Requirements and Process

MCP requires prior authorization for outpatient behavioral health services and hospital admissions to assure medical necessity. A request for authorization will be decided within 14 days of receipt for a standard request. An expedited request for authorization will be responded to within three business days of receipt of the request. Unauthorized services will not be reimbursed. Authorization is not a guarantee of payment.

To request an authorization:

- Contact the member's Case Manager for prior authorization prior to delivery of services.
- Explain to the Case Manager the type of services to be delivered, frequency of services to be delivered, and duration of services provided.

8.10 - Family Involvement

Family involvement in a member's treatment is an important aspect in recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, have less dependence on outside agencies, and tend to rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (step-parent, guardian, and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, providing transportation or social support to the member. Information can be shared with other parties with written permission from the member or the member's guardian.

8.11 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MCP's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MCP behavioral health coordinator will work with AzSH to ensure the member has sufficient testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MCP behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.

- For re-authorization for continued behavioral health services, contact the member's case manager and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

8.12 - Court Ordered Treatment and Petition Process

At times an MCP member may need to be petitioned through the Mental Health Court.

Maricopa County

Emergent Petition

For an Emergent Petition, which is defined as: "Only persons who, as a direct result of a mental disorder, display behaviors that are a Danger to Self or Danger to Others, and the person is likely, without IMMEDIATE hospitalization, to suffer serious physical harm or illness, or likely to inflict serious physical harm upon another person." The provider will need to file the petition in person at one of the following facilities:

Urgent Psychiatric Care Center/ConnectionsAZ

602-416-7600
903 N. 2nd Street
Phoenix, AZ 85004

Psychiatric Recovery Center West/Recovery Innovations

602-416-7600
11361 N. 99th Avenue, Suite 402
Peoria, AZ 85345

Non-Emergent Petition

Non-Emergent Petitions are known as a Gravely Disabled or Persistently and Acutely Disabled (PAD) and are defined: "As a result of a mental disorder is likely to cause serious physical harm or illness because he/she is unable to provide for their basic needs, or if not treated has probability of causing the person to suffer severe mental, emotional, or physical harm, or impairs the person's capacity to extent they are incapable of understanding and expressing the consequence of accepting treatment." The Non-Emergent Petitions are filed by calling the EMPACT-SPC PAD line at (480) 784-1514, extension 1158 ("Non-Emergent Petition Team).

For members who are already under Court Ordered Treatment through the Mental Health Court, MCP is responsible for tracking the status of the member's treatment and reports to the Mental Health Court as necessary. As such, treating providers must notify MCP of any treatments.

Pima County

Emergent Petition

Only persons who, as a direct result of a mental disorder, display behaviors that are DTS or DTO, and the person is likely, without immediate hospitalization, to suffer serious physical harm or serious illness, or is likely to inflict serious physical harm upon another person, is appropriate for an emergency petition that precludes the use of the pre-petition non-emergent screening process.

The Emergent Petition can be initiated by police, crisis teams, family members, or anyone who has directly witnessed the alleged behavior(s). In addition, there must be two witnesses available to verify the member's behavior once it goes to court.

To initiate the Emergent petition the petitioner would call Tucson Police Department (TPD) if it warrants a 911 call or call Southern Arizona Mental Health Corporation (SAMHC) to dispense the Mobil Acute Services (MAC team). TPD calls the Crisis Response Network (CRN) to triage to find out which evaluating hospital has an opening. The MAC team would coordinate with TPD and CRN.

Southern Arizona Mental Health Corporation (SAMHC)

520-617-0043

The evaluating hospitals are:

Sonora Behavioral Health

6050 N. Corona Rd. Bldg. 3

Tucson, AZ 85704

520-469-8700

Pale Verde Hospital
2695 N. Craycroft Rd.
Tucson, AZ 85712
520-324-3522

University of Arizona Medical Center-South Campus
Abrams Annex
2800 E. Ajo Way
Tucson, AZ 85713
520-626-5582

Non-Emergent (PAD/GD) Petition

Non-Emergent Petitions are facilitated by the SAMHC pre-petition evaluation team. Any party may initiate a request for a Non-Emergent Petition by calling SAMHC at 520-617-0043 or 520-618-8694. Two witnesses must be available to verify the individual's behavior if there is a hearing scheduled. A person may only be petitioned if he/she is a resident of Pima County and/or if the behavior in question occurred in Pima County. A person must also be suffering from a mental disorder and meet the legal definition of DTS, DTO, GD, or PAD.

For members who are already under Court Ordered Treatment through the Mental Health Court, MCP is responsible for tracking the status of the member's treatment and reports to the Mental Health Court as necessary. As such, treating providers must notify MCP of any treatments.

Court Order Definitions

A **Mental Disorder** is deemed by ARS Title 36 as follows: A substantial disorder of the person's emotional processes, thought, cognition or memory. **Exclusions:** the person is primarily disabled due to drug abuse, alcoholism, or mental retardation; declining mental abilities that accompany impending death; or character and personality disorders characterized by life-long and deeply ingrained anti-social behaviors that can be reasonably expected, on the basis of competent medical opinion, to result in serious physical harm.

Danger to Others (DTO) [ARS § 36-501-4]: Judgment of a person having a mental disorder is so impaired that he/she is unable to understand his need for treatment and as a result of his/her mental disorder, his/her continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.

Danger to Self (DTS) [ARS § 36-501-5]: Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious treat thereof, or if the threat is expected that it will be carried out in light of context and previous acts AND which as a result of a mental disorder will, without hospitalization, result in serious physical harm or serious illness to the person EXCEPT that behavior which establishes only the condition of Gravely Disabled.

Gravely Disabled (GD) [ARS § 36-501-15]: Condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he/she is unable to provide for his/her basic physical needs.

Persistently or Acutely Disabled (PAD) [ARS § 36-501-29]: Severe mental disorder which, (1) if not treated has a substantial probability of causing the person to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality; (2) substantially impairs the person's capacity to the extent they are incapable of understanding and expressing an understanding of the consequences of accepting treatment as well as the alternatives to the particular treatment after the advantages, disadvantages, and alternatives are explained; AND, (3) has a reasonable prospect of being treatable by outpatient, inpatient, or combined treatment.

8.13 - Behavioral Health Treatment Plans and Daily Documentation

Behavioral Health Treatment Plan

A Behavioral Health Treatment Plan must be developed and reviewed/updated annually on each MCPLTC member, and as needed should a change in the member's condition require a modification to the treatment plan. The treatment plan should include strengths, measurable goals and presenting behavioral issues. For the behavioral issues, list recommended behavioral interventions to be utilized. Amended/renewed plans should indicate goals achieved or barriers interfering with success and recommendations to address this.

Daily Documentation

Daily documentation is required to reflect MCPLTC member's behaviors and issues that occur. This should include frequency of behaviors, frequency and type of staff interventions required throughout the day, and the member's level of responsiveness to interventions/redirections.

CHAPTER 9 - FAMILY PLANNING

9.0 - Family Planning Overview

Family planning services are provided through Aetna Medicaid Administrators, LLC. Family planning services are those services provided by health professionals to eligible persons who voluntarily choose to delay or prevent pregnancy. In order to allow members to make informed decisions, counseling should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted diseases.

9.1 - Provider Responsibilities for Family Planning Services

All providers are responsible for:

- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services.
- Providing medically necessary management of members with family planning complications.
- Notifying members of available contraceptive services and making these services available to all members of reproductive age using the following guidelines:
 - Information for members who are 17 years of age and younger must be given the information through the member's parent or guardian.
 - Information for members between 18 and 55 years of age must be provided directly to the member or legal guardian.
 - Whenever possible, contraceptive services should be offered in a broad-spectrum counseling context, which includes discussion of mental health and sexually transmitted diseases, including AIDS.
 - Members of any age whose sexual behavior exposes them to possible conception or STDs should have access to the most effective methods of contraception.
 - Every effort should be made to include male or female partners in such services.
- Providing counseling and education to members of both genders that is age appropriate and includes information on:
 - Prevention of unplanned pregnancies.
 - Counseling for unwanted pregnancies. Counseling should include the member's short and long - term goals.
 - Spacing of births to promote better outcomes for future pregnancies.
 - Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
 - Sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

- Contraceptives should be recommended and prescribed for sexually active members. PHPs are required to discuss the availability of family planning services annually. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Such discussions must be documented in the member's medical record.

9.2 - Covered and Non Covered Services

Full health care coverage and voluntary family planning services are covered.

The following services are not covered for the purposes of family planning:

- Treatment of infertility;
- Pregnancy termination counseling;
- Pregnancy terminations;
- Hysterectomies;
- Hysteroscopic tubal sterilization;
- Services to reduce voluntary, surgically induced fertilized embryos.

9.3 - Prior Authorization Requirements

Prior authorization is required for Family Planning Services, Sterilization or Pregnancy Termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement.

To obtain authorization for family planning services, please complete the Aetna Medicaid Administrators LLC [Prior Authorization: Aetna Family Planning Service Request Form](#), available on MCP's website. Requests should be faxed to:

Aetna Medicaid Administrators, LLC - 800-573-4165

To obtain authorization for Sterilization or Pregnancy Termination:

- Complete applicable form(s):
 - For sterilization: Aetna Medicaid Administrators LLC's [Prior Authorization: Aetna Family Planning Service Request Form](#) listed above and the [Consent for Sterilization Form](#). Permanent sterilization is only covered for MCP members 21 years of age or older.
 - For pregnancy termination: Aetna Medicaid Administrators LLC's [Prior Authorization: Aetna Family Planning Service Request Form](#), listed above.
- Fax completed prior authorization form and signed consent form prior to the procedure to:

Aetna Medicaid Administrators, LLC
800-573-4165

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD), Health Professionals must obtain prior authorization from the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD in addition to Aetna Medicaid Administrators, LLC. Notification of approved requests will be faxed or mailed to the provider.

CHAPTER 10 - MATERNITY

10.0 - Maternity Overview

MCP assigns newly identified pregnant members to a PCP to manage their routine non-OB care. The OB provider manages the pregnancy care for the member and is reimbursed in accordance with their contract.

If a member chooses to have an OB as their PCP during their pregnancy, MCP will assign the member to an OB PCP. If an OB provider has been assigned for OB services for a pregnant member, the member will remain with their OB PCP until after their postpartum visit when they will return to their previously assigned PCP.

10.1 - High Risk Maternity Care

In partnership with OB providers, MCP case managers identify pregnant women who are "at risk" for adverse pregnancy outcomes. MCP offers a multi-disciplinary program to assist providers in managing the care of pregnant members who are at risk because of medical conditions, social circumstances or non-compliant behaviors. MCP also considers factors such as noncompliance with prenatal care appointments and medical treatment plans in determining risk status. Members identified as "at risk" are reviewed and evaluated for ongoing follow up during their pregnancy by an obstetrical case manager.

10.2 - OB Case Management

MCP's perinatal case management provides comprehensive care management services to high risk pregnant members, for the purpose of improving maternal and fetal birth outcomes. The perinatal case management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high risk pregnant women. Perinatal case managers take a collaborative approach to engage high risk pregnant members telephonically throughout their pregnancy and post-partum period.

Members who present with high risk perinatal conditions should be referred to perinatal case management. These conditions include:

- a history of preterm labor before 37 weeks of gestation;
- bleeding and blood clotting disorders;
- chronic medical conditions;
- polyhydramnios or oligohydramnios;
- placenta previa, abruption or accreta;
- cervical changes;
- multiple gestation;
- teenage mothers;
- hyperemesis;
- poor weight gain;
- advanced maternal age;

- substance abuse;
- mental illness;
- domestic violence;
- non-compliance with OB appointments.

Referrals can be made by faxing the member information on the OB Referral Form electronically to OBfaxes@aetna.com or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.

10.3 - OB Incentive Program

MCP’s perinatal case management offers an OB incentive program for providers. The OB incentive program rewards providers with \$25.00 for each member ACOG submitted within the first trimester. Identification of high risk conditions within the first trimester promotes early intervention of care coordination services and serves to improve birth outcomes.

10.4 - Obstetrical Care Appointment Standards

MCP has specific standards for the timing of initial and return prenatal appointments. These standards are as follows:

Initial Visit

All OB providers must make it possible for members to obtain initial prenatal care appointments within the time frames identified:

Table 10.4 – Pre-Natal Care Appointment Availability

<u>Category</u>	<u>Appointment Availability</u>
First Trimester	Within 14 days of the request for an appointment
Second Trimester	Within seven days of the request for an appointment
Third Trimester	Within three days of the request for an appointment
Return Visits	Return visits should be scheduled routinely after the initial visit. Members must be able to obtain return prenatal visits: First 28 weeks - every four weeks From 28 to 36 weeks - every two to three weeks From 37 weeks until delivery – weekly
High Risk Pregnancy Care	Within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

Return visits scheduled as appropriate to their individual needs; however, no less frequently than listed above.

Postpartum Visits

Postpartum visits should be scheduled routinely after delivery. Routine postpartum visits should be scheduled within 21 and 60 days after delivery.

10.5 - General Obstetrical Care Requirements

All providers must adhere to the standards of care established by the American College of Obstetrics and Gynecology (ACOG), which include, but are not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG Form, documenting all aspects of maternity care.
- Completion of history including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, family and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam (including determination and documentation of pelvic adequacy).
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional, medical and educational factors.
- Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan.

10.6 - Additional Obstetrical Physician and Practitioner Requirements

- Educate members on healthy behaviors during pregnancy, including proper nutrition, effects of alcohol and drugs, the physiology of pregnancy, the process of labor and delivery, breast feeding and other infant care information.
- Offer HIV/AIDS testing and confidential post testing counseling to all members.
- Ensure delivery of newborn meets MCP criteria.
- Remind delivery hospital of requirement to notify MCP on the date of delivery.
- Refer member to MCP case management, and other known support services and community resources, as needed.
- Encourage members to participate in childbirth classes at no cost to them. The member may call the facility where she will deliver and register for childbirth classes.

Providers may also consult with an MCP medical director for members with other conditions that are deemed appropriate for perinatology referral. Please call 602-263-3000 or 800-624-3879 with requests for assignment to a perinatologist.

In non-emergent situations, all obstetrical care physicians and practitioners must refer members to MCP providers. Referrals outside the contracted network must be prior authorized. Failure to obtain prior authorization for non-emergent OB or newborn services out of the network will result in claim denials. Members may not be billed for covered services if the provider neglects to obtain the appropriate approvals.

10.7 - Provider Requirements for Medically Necessary Termination of Pregnancy

Medically necessary pregnancy termination services are provided through Aetna Medicaid Administrators, LLC. An Aetna Medicaid Administrators, LLC Medical Director will review all requests for medically necessary pregnancy terminations. Documentation must include:

- A copy of the member's medical record;
- A completed and signed copy of the [Exhibit 410-4 -Certificate of Necessity for Pregnancy Termination](#).
- Written explanation of the reason that the procedure is medically necessary. For example, it is:
 - Creating a serious physical or mental health problem for the pregnant member.
 - Seriously impairing a bodily function of the pregnant member.
 - Causing dysfunction of a bodily organ or part of the pregnant member.
 - Exacerbating a health problem of the pregnant member.
 - Preventing the pregnant member from obtaining treatment for a health problem.

If the pregnancy termination is requested as a result of incest or rape, the following information must be included:

- Identification of the proper authority to which the incident was reported, including the name of the agency.
- The report number.
- The date that the report was filed.

When termination of pregnancy is considered due to rape or incest, or because the health of the mother is in jeopardy secondary to medical complications, please contact SA at 602-798-2745 or 888-836-8147. All terminations requested for minors must include a signature of a parent or legal guardian or a certified copy of a court order.

For members enrolled in the DES/DDD, health professionals must obtain prior authorization from the DES/DDD medical director prior to providing termination procedures in addition to Aetna Medicaid Administrators, LLC.

10.8 - Reporting High Risk and Non-Compliant Behaviors

Obstetrical physicians and practitioners must refer all "at risk" members to MCP's Case Management department by calling 602-263-3000 or 800-624-3879 and selecting the option for maternity care. Providers may also fax their information to 602-351-2313. The following types of situations must be reported to MCP for members that:

- Are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Fail to follow prescribed bed rest.
- Fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Admit to or demonstrate continued alcohol and/or other substance abuse.
- Show a lack of resources that could influence well-being (e.g. food, shelter and clothing).
- Frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood altering drugs.
- Fail to appear for two or more prenatal visits without rescheduling and fail to keep rescheduled appointment. Providers are expected to make two attempts to bring the member in for care prior to contacting the MCP Case Management department.

10.9 - Outreach, Education and Community Resources

MCP is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant women and to enter them into prenatal care as soon as possible. PCPs are expected to ask about pregnancy status when members call for appointments, report positive pregnancy tests to MCP and to provide general education and information about prenatal care, when appropriate, during member office visits. Pregnant members will continue to receive primary care services from their assigned PCP during their pregnancy.

MCP is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including:

- **WIC Nutritional Program** - Please encourage members to enroll in this program.

Various other services are available in the community to help pregnant women and their families. Please call MCP's Case Management department for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the ADHS Hot Line at 800-833-4642.

10.10 - Providing EPSDT Services to Pregnant Members under Age 21

Federal and state mandates govern the provision of EPSDT services for members under the age of 21 years. The provider is responsible for providing these services to pregnant members under the age of 21, unless the member has selected an OB provider to serve as both the OB and PCP. In that instance, the OB provider must provide EPSDT services to the pregnant member.

Additional Claims Information

While these services are already performed in the initial prenatal visit, additional information is necessary for claims submission. The provider (PCP or OB) providing EPSDT services for

members 12-20 years of age, must submit the medical claims for these members. When submitting claims, please include one of the following codes that reflect the appropriate EPSDT visit:

Ages 12 through 17 years

- New Patient - 99384
- Established Patient - 99394

Ages 18 through 20 years

- New Patient - 99385
- Established Patient - 99395

10.11 - Loss of AHCCCS Coverage during Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although members are responsible for maintaining their own eligibility, providers are encouraged to notify MCP if they are aware that a pregnant member is about to lose or has lost eligibility. MCP can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at 602-263-3000 or 800-624-3879 to report eligibility changes for pregnant members.

10.12 - Pre-Selection of Newborn's PCP

Prior to the birth of the baby, the mother selects a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

CHAPTER 11 - DENTAL AND VISION SERVICES

Dental Services

11.0 – DentaQuest

Effective January 1, 2015, DentaQuest will administer dental benefits for MCP. DentaQuest has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MCP will administer the following for our members:

- Grievances
- Customer Service Calls from Members

All claims with a date of service prior to January 1, 2015 will be processed by MCP. Please submit those claims to:

By Mail

Mercy Care Plan
Dental Claims Department
P.O. Box 61235
Phoenix, AZ 85082-1235

Electronic Submissions

Through Electronic
Clearinghouse

Claims with dates of service on or after January 1, 2015 need to be sent to DentaQuest at the following claims address:

DentaQuest of Arizona, LLC – Attention: Claims
12121 N Corp Parkway
Mequon, WI 53092

For electronic claims submissions, DentaQuest works directly with the following Clearinghouses:

Emdeon (888-255-7293)
Tesla (800-724-7420)
EDI Health Group (800- 576-6412)
Secure EDI (877-466-9656)

Mercury Data Exchange (866-633-1090)

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

If you have additional questions regarding your claims for DentaQuest, you may contact them directly at 844-234-9831. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding DentaQuest can be found in their Office Reference Manual on-line at www.dentaquestgov.com.

For additional information regarding our transition to DentaQuest, please refer to our Provider Notification, [DentaQuest Partnership with Mercy Care Plan Effective January 1, 2015](#).

[Vision Services](#)

[11.1 - Vision Overview](#)

MCP covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.
- For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.
- Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT, KidsCare program and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, please review the AHCCCS Medical Policy Manual, Chapter 300.

[11.2 - Coverage for Children \(Under Age 21\)](#)

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program.
- Members under age 21 with vision screening of 20/60 or greater should be referred to the Nationwide for further examination and possible provision of glasses.
- Replacement of lost or broken glasses is a covered benefit.
- Contact lenses are not a covered benefit.

11.3 - Nationwide Referral Instructions

Nationwide is MCP's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by their PCP's office to a Nationwide provider listed on MCP's website. The member may call Nationwide directly to schedule an appointment.

11.4 - Coverage for Adults (21 years and older)

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should only be referred to a contracted ophthalmologist for the diagnosis and treatment of eye disease.

11.5 - Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MCP's Member Services department at 602-263-3000 or 800-624-3879 (toll-free), Express Service Code 629.

CHAPTER 12 - CASE MANAGEMENT AND DISEASE MANAGEMENT

12.0 - Case Management and Disease Management Overview

Once an individual becomes an MCPLTC member, they are assigned a case manager. The case manager is responsible for working with the member's PCP to coordinate and authorize the provision of necessary services for that member. The case manager is also the member's advocate and works to facilitate the member's care. Part of that responsibility involves developing the authorizations necessary for MCPLTC services, providing information about room and board or share of cost to providers and members, and assisting members with coordination of appropriate services. The case manager is the primary point of contact for providers when there are issues or questions about a member. In addition, the case manager must be contacted whenever there is a change in a member's health status.

MCPLTC has a comprehensive case management program. The case management team considers the medical, social and cultural needs of members by targeting, assessing, monitoring and implementing services for members identified as "at risk."

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

- Considers the medical, social and cultural needs of members in targeting, assessing, monitoring and implementing services for members.
- Provides assistance to members and families in navigating through the complex medical and behavioral health systems.

Please refer to the [Clinical Guidelines](#) available on MCP's website for 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)

12.1 - Behavioral Health

The Case Management department is available to assist and help members who are experiencing problems related to behavioral health services. Please refer to [Chapter 7 - Behavioral Health](#) for additional information.

12.2 - Disease Management

The disease management team administers disease management programs intended to enhance the health outcomes of members. Disease management targets members who have illnesses that have been slow to respond to coordinated management strategies in the areas of diabetes, respiratory (COPD, asthma), and cardiac (CHF). The primary goal of disease management is to positively affect the outcome of care for these members through education and support and to prevent exacerbation of the disease, which may lead to unnecessary hospitalization.

The objectives of disease management programs are to:

- Identify members who would benefit from the specific disease management program
- Educate members on their disease, symptoms and effective tools for self-management
- Monitor members 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 member and the provider;
- Monitor effectiveness of interventions.

The following conditions are specifically included in MCP's Disease Management programs and have associated [Clinical Guidelines](#) that are reviewed annually.

12.3 - Asthma

The Asthma Disease Management program offers coordination of care for identified members with primary care providers, specialists, community agencies, the members' caregivers and/or family. Member education and intervention is targeted to empower and enable compliance with the physician's treatment plan.

Providers play an important role in helping members manage this chronic disease 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 members and their families better understand the disease and its prevention/treatment

12.4 - Chronic Obstructive Pulmonary Disease (COPD)

The COPD Disease Management program is designed to decrease the morbidity and mortality of members with COPD. The goal of the program is to collaborate with providers to improve the

quality of care provided to members with COPD, decrease complication rates and utilization costs, and improve the members' health. The objectives of the COPD Disease Management Program are to:

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

12.5 - Congestive Heart Failure (CHF)

The CHF Disease Management program is designed to develop a partnership between MCP, the PCP and the member to improve self-management of the disease. The program involves identification of members with CHF and subsequent targeted education and interventions. The CHF Disease Management program educates members with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

12.6 - Diabetes

The Diabetes Disease Management program is designed to develop a partnership between MCP, the PCP and the member to improve self-management of the disease. The program involves identification of members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing member compliance with diabetes care and self-management regimens. Providers play an important role in helping members manage this chronic condition. MCP 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 MCP's Diabetes Management Clinical 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.

12.7 - Active Health

MCP 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, members will be receiving letters concerning their "Care Considerations" as well.

Active Health will expand MCP's opportunities to identify members 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 member 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 an MCP member, 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 member 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. MCP'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 member 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 member is on any type of drug to lower cholesterol.

CHAPTER 13 - CONCURRENT REVIEW

13.0 - Concurrent Review Overview

MCP 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 MCP of all member 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 MCP 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 MCP 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 members. MCP medical directors may make rounds on site as necessary. MCP concurrent review staff will notify the facility case management department and business office at the end of the member's hospitalization stay, by fax, of the days approved and at what level of care.

13.1 – 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.

Additionally when MCP is the primary payer through the Medicare Plan or ALTCS, MCP uses:

- CASII (Child and Adolescent Intensity Instrument);
- LOCUS (Level of Care Utilization System) for members 18 and older;
- ASAM Criteria (American Society of Addiction Medicine Criteria), used for substance use disorder treatment; and
- AHCCCS guidelines for residential treatment centers for all ALTCS members.

13.2 - 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 member and for involving the member and family in implementing the plan.

The MCP 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 members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted MCP providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers). The CRN is key in assisting with discharge planning and may authorize services required for a safe discharge such as pharmacy, home health and DME. MCP 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 MCP of all members.
- Informing hospital staff and attending physician of covered benefits as indicated.

13.3 - Physician Medical Review

MCP 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 MCP 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. MCP 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 MCP 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 MCP claim dispute process.

CHAPTER 14 - PHARMACY MANAGEMENT

14.0 - Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized provider, such as a PCP, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The [Preferred Drug List](#) (PDL), also referred to as a Formulary, identifies the medications, selected by the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of MCP's members in a cost effective manner.

14.1 - Updating the Preferred Drug Lists (PDLs)

MCP PDLs are developed, monitored and updated by the Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee continuously reviews the PDLs and medications are added or removed based on objective, clinical and scientific data. 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 PDLs. Market share shifts, price increases, generic availability and varied dosage regimens may affect the actual cost of therapy.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the PDL, other medications may be deleted.
- Participating physicians may request additions or deletions for consideration by the P&T Committee. Requests should include:
 - Basic product information, indications for use, its therapeutic advantage over medications currently on the PDL.
 - Which drug(s), if any, the recommended medication would replace in the current PDL.
 - Any published supporting literature from peer reviewed medical journals.

MCP may invite the requesting physician to the P&T Committee to support the addition to the PDL and answer related questions, however, MCP does not permit pharmaceutical representatives to participate or attend P&T Committee meetings. All PDL requested additions should be sent to:

Aetna Medicaid Administrators, LLC
Corporate Director of Pharmacy
4645 E. Cotton Center Blvd.
Building 1, Suite 200
Phoenix, AZ 85040

14.2 - Notification of PDL Updates

MCP will not remove a medication from the PDL without first notifying providers and affected members. MCP will provide at least 60 days' notice of such changes. MCP is not required to send a hard copy of the PDL each time it is updated, unless requested. A memo may be used to notify providers of updates and changes and may refer providers to view the updated PDL on the MCP website. MCP may also notify providers of changes to the PDL via direct letter or the MCP website. MCP will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

14.3 - Prior Authorization Required

Prior authorization is required:

- If the drug is not included on the PDL.
- If the prescription requires compounding.
- For injectable medications dispensed by a pharmacy, with the exception of heparin and insulin. Note: If the member has a primary insurance that reimburses for injectable medications, MCP will only coordinate benefits as the secondary payer if the MCP pharmacy prior authorization process was followed.
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call 602-263-3000 or 800-624-3879 to initiate prior authorization for the requested specialty medication.
- For medication quantities which exceed recommended doses.
- For specialty drugs which require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications that may require additional documentation, e.g. Peg-Intron.

Allow up to 14 calendar days for the prior authorization review process.

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs. Please see section [**14.11 - Request for Non-PDL Drugs**](#) for additional information.

14.4 - Over the Counter (OTC) Medications

A limited number of OTC medications are covered for MCP members. OTC medications require a written prescription from the physician that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any MCP contracted pharmacy. OTCs are limited to the package size closest to a 30-day supply. Some medications may require step therapy. Please refer to the [**Provider Drug List**](#) for more information.

14.5 - Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with A-rated products is mandatory unless

the brand has been specifically authorized or as otherwise noted. Medications on the PDL noted with an asterisk (*) will be filled with the brand name only, even when a generic form is available. In all other cases, brand names are listed for reference only.

14.6 - Diabetic Supplies

Diabetic supplies are limited to a one-month supply (to the nearest package size) with a prescription.

14.7 - Injectable Drugs

The following types of injectable drugs are covered when dispensed by a licensed pharmacist or administered by a participating provider in an outpatient setting:

- Immunizations
- Chemotherapy for the treatment of cancer
- Medication to support chemotherapy for the treatment of cancer
- Glucagon emergency kit
- Insulin; Insulin syringes
- Immunosuppressant drugs for the post-operative management of covered transplant services
- Rhogam
- Rabies vaccine

14.8 - Exclusions

The following items, by way of example, are not reimbursable by MCP:

- Anorexiant
- DESI drugs (those considered less than effective by the FDA)
- Non-FDA approved agents
- Rogaine
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes
- Non-indicated uses of FDA approved medications without prior approval by MCP
- Lifestyle medications (such as medications for erectile dysfunction)
- Medications used for fertility

14.9 - Family Planning Medications and Supplies

Aetna Medicaid Administrators, LLC administers the family planning benefit for MCP that includes:

- Over-the-counter items related to family planning (condoms, foams, suppositories, etc.) are covered and do not require prior authorization. However, the member must present a written prescription, to the pharmacy including the quantity to be dispensed. A supply for up to 30-days is covered.
- Injectable medications, administered in the provider's office, such as Depo-Provera will be reimbursed at the MCP Fee Schedule, unless otherwise stated in the Provider's contract.

- Oral contraceptives are covered for MCP members, through Aetna Medicaid Administrators, LLC.

14.10 - Behavioral Health Treatment of ADHD, Anxiety, Depression and Post-Partum Depression

Please refer to [Chapter 8 - Behavioral Health](#) in this Provider Manual for additional information. PCPs must use the [AHCCCS Clinical Guidelines](#) for the treatment and prescribing of medications for ADHD, Anxiety and Depression.

PCPs may prescribe behavioral health medications to treat selected behavioral health disorders. These include ADD/ADHD, mild depression or anxiety disorder. Behavioral health must be:

- Included on the MCP PDL.
- Limited to a 30-day supply.
- Prescribed in generic forms and will be substituted with generic as they become available unless otherwise designated.

14.11 - Request for Non-PDL Drugs

A physician requesting a change to Mercy Care Plan's Preferred Drug List (PDL) should include the following information in the request:

- Basic product information
- Indications for use
- Therapeutic advantage
- Which drug(s) it would replace in the current PDL
- Any supporting literature from medical journals

The requesting physician may be invited to attend the Pharmacy and Therapeutics Committee meeting to support the PDL addition request and answer questions.

Requests should be sent to:

Aetna Medicaid Administrators, LLC
Corporate Pharmacy Director
4645 E. Cotton Center Blvd.
Building 1, Suite 200
Phoenix, AZ 85040

CHAPTER 15 - QUALITY MANAGEMENT

15.0 - Quality Management Overview

MCP works in partnership with providers to continuously improve the care given to MCP members. The MCP 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 members.
- The Prevention and Wellness unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters. Findings are reported to AHCCCS and to providers about their performance on specific quality indicators.
- The Credentialing unit is responsible for provider credentialing/recredentialing activities.
- The Special Needs unit is responsible for coordination and liaison with the programs for Children's Rehabilitation Services (CRS) clinics located in four regions of the state. In addition, the unit works to coordinate Acute care health services for MCP and DD members.

15.1 - Quality Management Department Responsibilities

The QM department is responsible for development of policies related to quality management in relation to Clinical Guidelines. Whenever possible, MCP adopts Clinical Guidelines from national organizations known for their expertise in the area of concern. [Clinical Guidelines](#) are available at the MCP website. Providers may also request copies from the QM department or their Provider Relations representative.

15.2 - Quality Management Plan

A quality management plan is developed each year to guide the efforts of the MCP Quality Management (QM) department in accomplishing its goals for the upcoming year. The QM department works closely with the chief medical officer (CMO) and the MCP medical directors on all QM responsibilities. For more information about MCP Quality Management program, or to obtain a written summary of the program, please contact your Provider Relations representative or call the QM department at 602-263-3000 or 800-624-3879.

15.3 - Quality of Care, Peer Review and Fair Hearing Process

The QM department reviews potential quality of care (QOC) issues referred by internal and external sources. Applicable medical records are requested from providers as needed for review. The QOC, peer review and fair hearing processes are all confidential. Each QOC issue is assigned a severity level based on potential adverse effect(s) for the member. In addition, cases are trended and reported to the QM/UM Committee. QOC Severity Levels:

- Level 0 - No quality of care or utilization issue exists and no action is needed.
- Level 1 - Potential for significant adverse effect(s) on the member was not found, no harm or negative outcome occurred, and the risk of further problems is low.

- Level 2 - Potential for significant adverse effect(s) was evident. Because of the care received or services provided, or because of the omission of care or services, the member required a change in the plan of care or suffered a complication, which caused no major life impact.
- Level 3 - Medical management resulted in significant adverse effect(s). Because of the care received or services provided, or omission of care or services, the member suffered a major complication or poor outcome.

15.4 - Escalation Process

All potential QOC issues involving health professionals are forwarded to the CMO or one of the MCP medical directors for review. After review, it may be determined that a case should be referred to a specialist for further review. The case is sent to the medical care ombudsman. The program is sent for review by a provider in the same specialty as the subject provider.

If indicated by the evaluation conducted by the MCP medical director or specialist review, the QOC case is forwarded to the Executive Session of the QM/Utilization Review (UM) Committee for peer review discussion, final determination and recommendation for action. Health professionals have the right to appeal adverse actions such as termination from MCP.

To exercise this option, the appeal process for a fair hearing must be followed. A copy of the peer review/fair hearing policy is available to all providers upon request.

15.5 - Ambulatory Medical Record Review

The purpose of the review is to verify that medical records of contracted family practice, internal medicine, and general practice, obstetric and pediatric physicians comply with established AHCCCS, NCQA, and MCP medical record keeping standards. Reviews are completed every three years. In addition, OB/GYN specialists must comply with ACOG standards. Records are reviewed for completeness of documentation, coordination of care and evidence of appropriate health maintenance screenings. QM nurses review the medical records at the physician's office. The steps for conducting a medical records review include:

- Approximately two weeks before a review is scheduled, the office is contacted by telephone to arrange a mutually convenient time for the review.
- A letter or fax is sent further stating when the QM staff will arrive, and which member records should be pulled and ready for review.
- The number of nurses assigned is based on the number of records to be reviewed. The review team will need a private area where they can work.
- A report will be created following the visit. The report will identify trends that were noted, as well as any significant areas that need follow up.
- The report will be sent to the physician's office after the review is completed.
- Physicians with a low score may be asked to provide a quality improvement plan detailing methods to improve future service delivery and documentation. Follow-up medical record reviews will be conducted as needed.

15.6 - Quality Management Studies

MCP uses a variety of information sources to conduct quality management studies, including member medical records, claims, prior authorization logs, statistical reports and utilization review reports. As part of the quality improvement process, MCP asks its provider network to assist in the collection of medical record information or other information as needed for special studies or reviews. The QM department is managing the following annual clinical studies.

- Reducing hospital readmissions
- Increasing utilization of E-Prescribing

15.7 - Data Collection and Reporting

The QM department collects data and analyzes MCP performance for the following indicators:

- Well-child visits in the first 15 months of life
- Well-child visits for members age 3-6
- EPSDT participation rates
- Childhood immunization (for members 24 months old)
- Adolescent immunization
- Annual dental visits for members age 1-20
- Preventive Dental Care
- Dental Sealant Application
- Children's access to primary care providers
- Adolescent well-care visits
- Cervical cancer screening
- Adult access to preventive/ambulatory health services
- Mammograms
- Diabetes management
- Appropriate Asthma medication
- Chlamydia screening
- Prenatal care
- Postpartum services
- Hospital Readmissions
- PCP follow-up after discharge
- ED Utilization
- Inpatient Utilization
- Diabetes, COPD and CHF Admissions
- Flu Shots

Clinical indicators are reviewed regularly to monitor progress. Findings and results of studies and surveys are shared with health professionals via newsletters.

15.8 - Reports

The QM department has developed reports for health professionals on the following topics:

- **Well woman:** A quarterly report of members who are in need of a mammogram, cervical cancer screening or chlamydia screening.

- **Diabetes:** A quarterly report of members diagnosed with diabetes and diabetes-related services rendered during the past 12 months.
- **Immunizations:** A monthly report listing members due for one or more immunizations.
- **Well Child:** A monthly report listing members due for a Well Child visit.
- **HEDIS Star:** A quarterly report listing MCA members in need of one or more of the following services:
 - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
 - Breast Cancer Screening
 - Controlling High Blood Pressure
 - Comprehensive Diabetes Care
 - Colorectal Cancer Screening
 - Osteoporosis Management in Women Who Had a Fracture

15.9 - Credentialing/Re-Credentialing

The Credentialing Committee (comprised of both network peer physicians and MCP medical directors) reviews all credentialing information and forwards their recommendations to the CMO who presents the information to the Quality Management Oversight Committee and the MCP Board of Director's for a final decision. Providers have the following rights:

- To review their application and information obtained from outside sources, (e.g. state licensing agencies and malpractice carriers) with the exception of references, recommendations or other peer-review protected information.
- To correct erroneous information submitted by another source. MCP will notify credentialing applicants if information obtained from other sources (e.g. licensure boards, National Practitioner Data Bank, etc.) varies substantially from that provided by the applicant.

15.10 - Streamlining Process

MCP is dedicated to improving and streamlining credentialing processes and timelines for those providers credentialed and re-credentialed directly through MCP. In addition, contractual relationships have been developed to delegate credentialing and re-credentialing activities to approved, qualified outside entities throughout the state. This practice has been put into place to decrease the time spent completing multiple credentialing applications for providers belonging to one of these entities, and to ensure a complete and comprehensive network for MCP members.

Providers' credentialed/re-credentialed through a delegated entity must still be approved through the MCP Board of Directors prior to providing health care services to members. Providers are re-credentialed every three years and must complete the required reappointment application. Updates of malpractice coverage, state licenses and Drug Enforcement Agency (DEA) certificates, if applicable, are also required. The MCP Special Needs Unit (SNU) coordinates care and services with the carve-out programs for MCP members enrolled in one or more of the following programs:

- AZ Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS)

- ADHS Division of Children’s Rehabilitation Services (CRS) and
- AZ Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

MCP performs the following activities:

- Assists in resolving coordination of benefit issues.
- Monitors timeliness of services delivered by MCP providers.
- Provides information or clarification to parents/guardians and providers.
- Ensures services are provided by the appropriate resource – either MCP or the carve out program.
- Serve as the MCP liaison for the state agencies listed above, and their contractors for CRS, behavioral health and DD services.

15.11 - CRS Eligible Members

MCP coordinates benefits between network providers and the CRS clinics or private insurance carriers; assisting the parents/guardians of members with the CRS enrollment process; follow up to ensure members receive necessary services and consulting with MCP departments about services that should be covered by CRS and those that are MCP’s responsibility.

15.12 - Behavioral Health

For members with a developmental disability, activities include coordination of benefits with DES/DDD and private insurance carriers; consultation with other MCP departments to ensure that they receive medically necessary services; monitoring the timeliness of service delivery; providing information to members and their parents/guardians and providers and coordinating with DES/DDD support managers regarding long term care and other services that members are also entitled to receive.

CHAPTER 16 - REFERRALS AND AUTHORIZATIONS FOR MEDICAL SERVICES

16.0 - Referral Overview

It may be necessary for a MCP member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services providers only need to complete a Referral Form and refer the member to the appropriate MCP PHP. MCP's website includes a provider search function for your convenience. More information is available in this Provider Manual under section [5.39 - MercyOneSource](#) concerning prior authorization.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain medical specialists for specific services such as an OB/GYN.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan (covered benefit).
- The member must be enrolled in MCP on the date of service (s) and eligible to receive the service.

If MCP's network does not have a PHP to perform the requested services, members may be referred to out of network providers if:

- The services required are not available within the MCP network.
- MCP prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MCP's policies. Both referring and receiving providers must comply with MCP policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider.

Referrals are a means of communication between two providers servicing the same member. Although MCP encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to MCP as long as the communication between providers is documented and maintained in the members' medical records.

16.1 - Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MCP.
- Obtain prior authorization for services that require prior authorization or are performed by a non-participating health provider.
- Complete a Referral Form and mail or fax the referral to the receiving provider.

16.2 - Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization and that the provider has received a completed MCP referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with MCP's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with MCP on the date of service, MCP will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the Prior Authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

16.3 - Period of Referral

Unless otherwise stated in a PHP's contract or MCP documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, as long as the member is enrolled and eligible with MCP on the date of service.

16.4 - Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MCP member may self-refer to any MCP contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a MCP contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MCP referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:

- Through twenty-eight weeks of gestation – every four weeks
- Between twenty-nine and thirty six weeks gestation every two weeks
- After the thirty sixth week – once a week
- Schedule first-time appointments within the required time frames
- Members in first trimester – within seven calendar days
- Members in third trimester – within three calendar days
- High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

16.5 - Ancillary Referrals

All practitioners and providers must use and/or refer to MCP contracted Ancillary providers.

16.6 - Member Self-Referrals

MCP members are allowed to self-refer to participating providers for the following covered services:

- Family Planning Services
- OB Services
- GYN Services
- Dental Services for Members Under Age 21
- Vision services for Members Under Age 21

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described above.

16.7 - Prior Authorization of Medical Services

MCP requires prior authorization for select acute outpatient services and planned hospital admissions. Prior authorization is not required for the following:

- Emergency services
- **Prior to 10/1/14** - Observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, to evaluate the medical condition and/or treatment of a recipient. Extensions to the 24-hour limit must be prior authorized. **After 10/1/14 prior authorization is no longer required for observation, due to the change in pricing at APR-DRG.**
- Both participating and non-participating facility services for the following obstetrical services:
 - OB Observation
 - Vaginal Delivery if stay is no longer than 48 hours
 - Cesarean delivery if the stay is no longer than 96 hours

Prior authorization guidelines are reviewed and updated regularly. To request an authorization, to find out what requires authorization, or check on the status of an authorization, please visit MercyOneSource. More information is available in this Provider Manual under section [5.39 -](#)

[MercyOneSource](#) concerning authorizations. You may also call our Prior Authorization department at 602-263-3000 or 800-624-3879 (toll-free) and dial Express Service Code 622.

16.8 - Types of Requests

- **Urgent Request:** Request is appropriate for a non-life threatening condition, which if not treated promptly, will result in a worsened or more complicated patient condition. An urgent request will be responded to within 3 working days upon receipt. MCP may change an urgent request to a routine request if the urgent request does not meet criteria for urgent status. The member and provider will be notified if the status changes and be provided with the new timeframes to process the request.
- **Routine Request:** Request will be responded to within a maximum of fourteen (14) calendar days upon receipt of request.

16.9 - Medical Prior Authorizations

Medical Prior Authorization team is responsible for processing prior authorization request for nonemergency, elective procedures and services.

16.10 – Complex Radiology Service Authorizations

Effective November 1, 2014, MedSolutions administers prior authorization services for complex radiology services for MCP. Services requiring authorization but performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Prior authorization is required for the following complex radiology services:

- CT/CTA
- MRI/MRA
- PET

Services performed in conjunction with an inpatient stay, observation, or emergency room visit are not subject to authorization requirements.

In order to request an authorization from MedSolutions, please submit your request online, by phone or by fax to:

- Log onto the [MedSolutions Online Web Portal](#).
- Call MedSolutions at 888-693-3211.
- Fax a [MedSolutions Request Form](#) (available online at the MedSolutions Online Web Portal) to 888-693-3210.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call MedSolutions' toll-free number for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

MedSolutions recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. MedSolutions will communicate authorization decisions by fax to both the ordering physicians and requested facilities. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what is authorized, the rendering facility must contact MedSolutions for review and authorization prior to claim submission.

16.11 - Pharmacy Prior Authorization

The Pharmacy Prior Authorization team is responsible for processing prior authorization requests for the following:

- Medications not included in the MCP Preferred Drug List (PDL), also referred to as a formulary.
- Medications that require prior authorization.
- Step therapy medications.
- Medications with quantity limits.

A team of registered pharmacists and certified pharmacy technicians authorize based on a set of pre-established clinical guidelines. Refer to [Chapter 14 – Pharmacy Management](#) in this Provider Manual for additional information.

16.12 - Dental Prior Authorizations

The Dental Prior Authorization team is responsible for receiving, reviewing, documenting and issuing dental authorization for covered services. Refer to [Chapter 11 – Dental and Vision Services](#) for additional information.

16.13 - Extensions and Denials

If MCP requires additional clinical documentation to make a decision on the prior authorization request, MCP will extend the turnaround time for an additional fourteen (14) calendar days. MCP will notify the provider and member of this extension and detail the request for additional documentation. If the requested supporting documentation is not received within the requested timeframe, MCP may deny the request for prior authorization on the date that the timeframe expires.

16.14 - Prior Authorization and Referrals for Services

- **Laboratory Services and Referrals:** Prior authorization is **NOT** required for approved in office lab procedures that are on Mercy Care's in office lab codes list. MCP is contracted with Sonora Quest to provide laboratory services. For a listing of Mercy Care's in office lab codes list, please reference our provider notification titled **Laboratory Services Network and In Office Lab Codes** located on MCP's website.

- **Radiology Services Referrals:** Prior authorization **IS** required before referring members for certain radiology services. To request an authorization, find out what requires authorization or check on the status of an authorization, please visit MercyOneSource. If a PHP sends a specimen to a non-contracted laboratory, the PHP shall be solely responsible for reimbursement to the non-contracted laboratory.
- **Infusion or Enteral Therapy Referrals:** Prior authorization is **NOT** required to refer members to a contracted infusion or enteral provider. However, any medically necessary services rendered by an infusion, enteral provider or through a home health agency must be prior authorized. All infusion medications must be processed through the MCP PBM (Pharmacy Benefit Manager) pharmacy benefit. Referrals may be processed through the PBM. All enteral needs are processed through the nutritional therapy contracted provider for MCP and comply with medical necessity criteria.
- **Durable Medical Equipment (DME) Referrals:** Prior authorization is **NOT** required to refer members to a contracted DME provider. However, certain services may require prior authorization, as indicated in the provider's contract.
- **DES/DDD Prior Authorization:** Prior authorization **IS** required. Providers must also obtain prior authorization from the DES/DDD medical director prior to provide sterilization and pregnancy termination procedures for members enrolled with DES/DDD.

16.15 - Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before MCP, 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 MCP's prior authorization rules.

16.16 - Prior Authorization Contacts

Inpatient Hospital and Hospice Services

Fax: 866-300-3926 (Toll Free)

Pharmacy Prior Authorization

Fax: 800-854-7614 (Toll Free)

Behavioral Health Department

(For Acute and DD members)

Mercy Care Behavioral Health Coordinator (BHC)

Fax: 602-414.7669

CHAPTER 17 - BILLING, ENCOUNTERS AND CLAIMS

17.0 - Billing Encounters and Claims Overview

The MCP Claims department is responsible for claims adjudication, resubmissions, claims inquiry/research and provider encounter submissions to AHCCCS.

All providers who participate with MCP must first register with AHCCCS to obtain an AHCCCS Provider Identification Number. Please contact AHCCCS directly for this number. Once you have obtained your 6 digit AHCCCS provider ID, notify Provider Relations.

Billing

17.1 - When to Bill a Member

A member may be billed when the member knowingly receives non-covered services.

- Provider **MUST** notify the member in advance of the charges.
- Provider should have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

MCP members may **NOT** be billed for covered services or for services not reimbursed due to the failure of the provider to comply with MCP's prior authorization or billing requirements. Please refer to *Arizona Revised Statute A.R.S. §36-2903.01 (L) and Administrative Codes R9-22-702, R9-27-702, R9-28-702, R9-30-702 I and R9-31-702* for additional information. In particular, Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"

MCP members should not be billed, or reported to a collection agency for any covered services your office provides.

Provider may **NOT** collect copayments, coinsurance or deductibles from members with other insurance, whether it is Medicare, a Medicare HMO or a commercial carrier. Providers must bill MCP for these amounts and MCP will coordinate benefits. Unless otherwise stated in contract, MCP adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

17.2 - Prior Period Coverage

On occasion, AHCCCS eligible members are enrolled retrospectively into MCP. The retrospective enrollment is referred to a Prior Period of Coverage (PPC). Members may have received services during PPC and MCP is responsible for payment of covered services that were received.

For services rendered to the member during PPC, the provider must submit PPC claims to MCP for payment of covered benefits. The provider must promptly refund, in full, any payments made by the member for covered services during the PPC period.

While prior authorization is not required for PPC services, MCP may, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, MCP reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

Encounters

17.3 - Encounter Overview

An encounter is a record of an episode of care indicating medically necessary services provided to an enrolled member. To comply with federal reporting requirements, AHCCCS requires the submission of claims and encounters for all services provided to enrolled members. Fines and penalties are levied against MCP for failure to correctly report encounters in a timely manner. MCP may pass along these financial sanctions to a provider that fails to comply with encounter submissions.

17.4 - When to File an Encounter

Encounters should be filed for **all** services provided, even those that are capitated. MCP uses the encounter information to determine if care requirements have been met and establish rate adjustments.

17.5 - How to File an Encounter

In order to comply with federal reporting requirements, the AHCCCS Administration conducts data validation studies on a random sample of members' medical records to compare recorded utilization information with submitted encounter data. The study evaluates the correctness or omission of encounter data. ***It is imperative that claims and encounters are submitted with correct procedure and diagnosis coding, and that the codes entered on the claim correspond to the actual services provided as evidenced in the member's medical record.***

Services rendered must also coincide with the category of service listed on the provider record with AHCCCS. If services do not coincide, claims will be reversed and monies recouped. If providers do not properly report all encounters, MCP may be assessed monetary penalties for noncompliance with encounter submission standards. We may then pass these financial

sanctions on to providers, or terminate contracts with providers who are not complying with these standards.

Claims

17.6 - When to File a Claim

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

17.7 - Timely Filing of Claim Submissions

Unless a contract specifies otherwise, Mercy Care ensures that for each form type (Dental/Professional/Institutional) 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

Mercy Care shall not pay:

- Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
- Claims that are submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later (A.R.S. §36-2904.G).

Regardless of any subcontract with Mercy Care Plan, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor); the provider may file a claim for payment with the responsible Contractor. The provider must submit a clean claim to the responsible Contractor no later than:

- 60 days from the date of the recoupment,
- 12 months from the date of service, or
- 12 months from date that eligibility is posted, whichever date is later.

The responsible Contractor shall not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

17.8 - MCP as Secondary Insurer

MCP is the payer of last resort. It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary. For example, if Medicare is primary and MCP is secondary.

- File an initial claim with MCP if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely in order to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to MCP, showing the other insurer payment amount or denial reason, if

applicable, and enclosing a complete legible copy of the remittance advice or Explanation Of Benefits (EOB) from the other insurer.

- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, MCP will coordinate payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997, MCP will pay co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lower of either MCP's fee schedule or the Medicare/other insurance allowed amount.

Claims should be submitted within 180 days from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not.

Claims should be submitted within one year from the last date of service or six months from the date of the other insurance explanation of benefits, whichever is later, once the other insurance explanation of benefits is received.

17.9 - Dual Eligibility Mercy Care Advantage (MCA) Cost Sharing and Coordination of Benefits

For MCA members enrolled in both MCP 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 MCP and MCA 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](#).

When adjudicating Medicare Part A SNF claims, the Medicare Part A payment methodology for SNF stays was determined to not be comparable to the sub-acute payment methodology used for Medicaid. Based on this, AHCCCS has determined that payment of Medicare SNF daily deductible for days 21-100 is required. MCP will coordinate benefits with Original Medicare or MCA by paying for coinsurance and copays for Part A and Part B services provided in a SNF.

17.10 - Injuries due to an Accident

In the event the member is being treated for injuries suffered in an accident, the date of the accident should be included on the claim in order for MCP to investigate the possibility of recovery from any third-party liability source. This is particularly important in cases involving work-related injuries or injuries sustained as the result of a motor vehicle accident.

17.11 - How to File a Claim

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

Table 17.11a – Claim Form Type

Service

Medical and Professional Services
Family Planning Services – Medical

Claim Form

Form 1500 (02-12)
Form 1500 (02-12)

Obstetrical Care
Hospital Inpatient, Outpatient, Skilled Nursing Facility and
Emergency Room Services
General Dental Services
Dental Services that are Considered Medical Services
(Oral Surgery, Anesthesia)

[Form 1500 \(02-12\)](#)
[CMS UB-04 Form](#)

[ADA 2012 Claim Form](#)
[Form 1500 \(02-12\)](#)

Instructions on how to fill out each claim form type can be found on Mercy Care's website by clicking on the below link:

[Form 1500 \(02-12\) Completion Instructions](#)
[UB-04 \(CMS 1450\) Completion Instructions](#)
[ADA Dental Claim 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 members' medical records, clearly label and send to the Claims department at the correct address.
 - a) **Electronic Clearing House**
Providers who are contracted with MCP 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 MCP uses are as follows:
 - Emdeon
 - SPSI
 - SSI
 - Contact your software vendor directly for further questions about your electronic billing.
 - Contact your Provider Relations representative for more information about electronic billing.

Additional information can be attained by reviewing Mercy Care's Provider Notification titled [Electronic Tools](#).

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

b) Through the Mail

Table 17.11b Claim Address

<u>Claims</u>	<u>Mail To</u>	<u>Electronic Submission*</u>
Medical	Mercy Care Plan Claims Department P.O. Box 52089 Phoenix, AZ 85072-2089	Through Electronic Clearinghouse
Dental	DentaQuest of Arizona, LLC Attention: Claims 12121 N Corp Parkway Mequon, WI 53092	Through DentaQuest Electronic Clearinghouse
Refunds	Mercy Care Plan Attention: Finance Department P.O. Box 52089 Phoenix, AZ 85072-2089	N/A

*See individual sections for further information: [17.19 - Claim Resubmission or Reconsideration](#) and [18.1 - Provider Claim Disputes](#).

17.12 - Correct Coding Initiative

MCP and AHCCCS follow the same standards as Medicare’s Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please review the [AHCCCS Medical Policy Manual \(Chapter 800\)](#).

MCP 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 both AHCCCS and CMS, in addition to pertinent coding information received from other medical organizations or societies.

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

Providers will have access to Clear Claim Connection through MCP’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 found on the application itself by using the help link. Clear Claims Connection can be found after logging in to [MercyOneSource](#).

17.13 - 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.

17.14 - 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 in order to use an additional code when one higher level, more comprehensive code is appropriate.

17.15 - Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. MCP 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 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. MCP 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/Nonphysician 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.”

EP Modifier – Service provided as part of a Medicaid early periodic screening diagnosis and treatment [EPSDT] program – must be appended to CPT code 96110 to receive additional developmental screening tool payment. For additional information please refer to our provider notification, [Early Periodic Screening, Diagnostic and Treatment \(EPSDT\) Updates](#), which is available on our website.

SL Modifier – State Supplied Vaccine – If a vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code. For additional information please refer to our provider notification, [Vaccine for Children \(VFC\) - Requirements for Submission of Claims for Vaccine Administration](#), which is available on our website.

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

17.16 - Medical Claims Review

To ensure medical appropriateness and billing accuracy, any inpatient and outpatient outlier claims are sent for Medical Claims Review.

Prior to 10/1/14

An outlier is identified on the claim with a condition code of 61 and is used to identify claims with extraordinary cost per day. For inpatient outlier claims, this includes those that are greater than \$60,000 billed if covered costs per day exceed the statewide average cost threshold.

After 10/1/14

Effective 10/1/14, claims will be paid at APR-DRG. Please refer to section [16.21 – Inpatient Claims](#) for further detail.

17.17 - Checking Status of Claims

Providers may check the status of a claim by accessing MCP's secure website or by calling the Claims Inquiry Claims Research (CICR) department.

Online Status through MCP's Secure Website

MCP encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims. To register, go to <http://www.MercyCarePlan.com> and select "Login" at the top of the page or contact your Provider Relations representative to establish a Login. More information is available in this Provider Manual under section [5.39 - MercyOneSource](#).

Calling the Claims Inquiry Claims Research Department

The Claims Inquiry 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 particular 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 [17.19 - Claim Resubmission or Reconsideration](#)).

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

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

17.18 - Payment of Claims

MCP processes and records the payment of claims through a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MCP 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 Provider Relations representative for further information on how to receive ERA. Remittance Advice samples are available under the [Forms](#) section of the Mercy Care website. Links to those remits are available under the section [17.265 - Provider Remittance Advice](#) in this Provider Manual.

Through **Electronic Funds Transfer (EFT)**, providers have the ability to direct funds to a designated bank account. MCP 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 an [Electronic Funds Transfer \(EFT\) Form](#). Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT implementation. Your Provider Relations representative will assist you with this.

Additional information can be attained by accessing the [Electronic Tools](#) Provider Notification on Mercy Care's website.

17.19 - Claim Resubmission or Reconsideration

Providers have 12 months from the date of service to request a resubmission or reconsideration of a claim. A request for review or reconsideration of a claim does not constitute a 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.

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

- Use the [Resubmission Form](#) located under the Forms section of Mercy Care's website.
- An updated copy of the claim. All lines **must** be rebilled or a copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" or "Reconsideration" at the top of the claim in black ink and mail to appropriate claims address as indicated in [17.11b - Claim Address Table](#).

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

If billing a resubmission electronically, you must submit with:

- **Professional Claims** - A status indicator of 7 in the submission form location and the Original Claim ID field need to be filled out.
- **Facilities** – In the Bill Type field, the last number of the 3 digit code should be a 7.

If you need to submit attachments to your resubmission claims, please submit by paper, as we currently do not accept attachments. This is currently under testing and we will let you know when it is available.

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

17.20 Overpayments

Under **Section 6402 of the Patient Protection and Affordable Care Act** it states:

“Section 6402 of the Patient Protection and Affordable Care Act (PPACA) amends the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions that enhance the federal government’s ability to discover and prosecute provider fraud, waste, and abuse. Among the provisions that may have a significant impact on States are newly imposed requirements for health care providers to report any overpayments from Medicaid and Medicare.

Under a new Section 1128J(d) of the SSA, any provider of services or supplies under Medicaid or Medicare must report and return “overpayments,” which the statute defines as “any funds that a person receives or retains under either program “to which the person, after applicable reconciliation, was not entitled[.]” A “person” is defined as “a provider of services, supplier, Medicaid managed care organization..., Medicare Advantage organization..., or [Medicare Part D Prescription Drug Plan] sponsor[.]” PPACA § 6402(a). It does not include a beneficiary.

The overpayment must be returned within 60 days from the date the overpayment was “identified,” or by the date any corresponding cost report was due, whichever is later. This provision of the law became effective May 22, 2010.

In order to properly return an overpayment, the individual who has received an overpayment must:

return the payment to the Secretary of the Department of Health and Human Services (Secretary), the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned the reason for the overpayment in writing.

Failure to return an overpayment has severe consequences. *If an overpayment is retained beyond the 60-day deadline, PPACA Section 6402 makes clear that it will be considered an “obligation” under the FCA. As amended by the Fraud Enforcement Recovery Act of 2009 (FERA), the FCA subjects a person to a fine and treble damages if he or she knowingly conceals or knowingly and improperly avoids or decreases an “obligation” to pay money to the federal government. PPACA treats Medicaid and Medicare overpayments alike in stating that failing to refund an overpayment will be considered an “obligation” under the FCA.”*

Whether an overpayment is identified directly by the provider or an overpayment request letter is sent to the provider by MCP, the refund along with any supporting documentation should be sent to:

Mercy Care Plan
Attention: Finance Department
P.O. Box 52089
Phoenix, AZ 85072-2089

[Instruction for Specific Claims Types](#)

[17.21 - MCP General Claims Payment Information](#)

MCP 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 AHCCCS processing rules.

[17.22 – Inpatient Claims](#)

Effective October 1, 2014, MCP has changed their pricing mechanism for inpatient claims to APR-DRG in accordance with AHCCCS requirements. Please refer to our provider notification, **[DRG Transition October 1, 2014 – Detailed Information](#)**, for additional detail.

[17.23 – Federally Qualified Health Centers \(FQHCs\)](#)

Effective 4/1/15, special billing rules apply to FQHCs. Claims prior to 4/1/15 will be paid at fee for service. For claims with dates of service on or after 4/1/15, please refer to our provider notification, **[Federally Qualified Health Centers \(FQHCs\) Prospective Payment System Implementation](#)**, for detailed billing instructions.

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

Providers submitting claims for SNFs should use the **[CMS UB-04 Form](#)**.

Please refer to the **[Skilled Nursing Facilities \(SNF\) Reference Guide](#)** on Mercy Care's website.

Therapy (occupational, physical, or speech) services performed in a SNF for Subacute Care Levels II and III (Codes 193 and 194) and Bariatric Level (Code 0070) are included in the per diem. The SNF may be reimbursed for therapy services for the Custodial Level (codes 0081, 0082 and 0083) of stay and all other levels. The therapy services must be billed on the UB-04 along with the Custodial Level.

<u>Care Level</u>	<u>Codes</u>	<u>Therapy Service Coverage</u>
Subacute Care Levels II and III	0193, 0194	Included in the SNF per diem

Bariatric Level	0070	Included in the SNF per diem
Custodial Level	0081, 0082, 0083	SNF may be reimbursed if billed separately and authorized

ALTCS recipients are required to contribute toward the cost of their care. This is called Share of Cost (SOC). When a recipient's eligibility for ALTCS is approved, a notice is generated which identifies the amount of SOC the recipient owes. SOC change notices are sent to nursing facilities for any change that might occur to the SOC amount due. The identified SOC provided by AHCCCS is deducted from the payment owed for the claim. If a patient transfers from one facility to another in a month's time and the total SOC could not be applied to the first facility, the remainder will be carried over to the second facility's claim.

Customized Durable Medical Equipment (DME), including customized wheelchairs and specialty beds such as Clinitron bed, may be covered by Medicaid in a SNF when prior authorized. Alternating pressure mattresses and pumps are included in the per diem.

Bariatric products and/or services are covered by Medicaid if they are authorized and it is not a Bariatric Level of stay. All other ancillary services are included in the SNF per diem. Some services can be paid under Medicare Part B.

<u>Ancillary Service</u>	<u>Coverage</u>
Customized DME (including customized Wheelchairs and specialty beds)	May be covered when prior authorized
Alternating pressure mattresses and pumps	Included in the SNF per diem
Bariatric products and/or services	Covered if authorized and it is not a Bariatric level of care
All other Ancillary Services	Included in the SNF per diem

If a member has MCA as primary coverage, providers must bill in accordance with standard Medicare RUGS billing requirement rules for MCA. 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.

17.25 - Dental Claims

- Claims for dental services should be submitted on the standard American Dental Association form [American Dental Association Claim Form](#).
- Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on [Form 1500 \(02/12\)](#).

17.26 - Family Planning Claims

- Claims for medical services will only be accepted on [Form 1500 \(02/12\)](#).
- Inpatient hospitalizations, outpatient surgery and emergency department facility claims should be filed on [CMS UB-04 Form](#).
- See the [Covered Family Planning Services and Appropriate Billing Codes](#) provider notification for additional billing information.
- Family Planning services may be billed with other services on the same claim. When billed on the same claim though, a provider will receive two remits, one for family planning services and one for non-family planning services, as these services are paid out of separate funds.
- Family Planning claims may be submitted electronically.

Providers must submit the following information:

- AHCCCS Provider ID number.
- Family planning service diagnosis (all claims **must** have).
- Explanation of Benefits from other insurance (including Medicare).
- Correctly signed and dated sterilization consent forms.
- The 30-day waiting period can be waived for emergent or medically indicated reasons.
- Operative reports for surgical procedures.
- Use HCPCS "J" codes, and provide the drug administered, NDC code and the dosage for injected substances.
- Payment for IUDs requires a copy of the invoice to establish cost to the provider.
- Anesthesia claims require an ASA code for surgery with the appropriate time reflected in minutes.
- For Family Planning Services Extension Program members, X-ray and lab charges will be paid only if they are related to family planning. There must be a Family Planning Service diagnosis.
- A separate claim must be submitted for each date of service.

Members may request services, such as infertility evaluations and abortions, from providers, whether or not they are registered with AHCCCS, but must sign a release form stating that they understand the service is not covered and that the member is responsible for payment of these services.

If you have authorization or claims questions related to family planning, please call:

Aetna Medicaid Administrators, LLC

602-798-2745: Phoenix
888-836-8147: Outside Phoenix

17.27 - Complete Obstetrical Care Package

Reimbursement for obstetrical care is dependent upon the provider's contract with Mercy Care. Please refer to your contract for further detail. Providers are expected to bill for obstetrical care according to the terms of their contract and should file claims using a [Form 1500 \(02/12\)](#).

Fee for Service

For additional information regarding fee for service billing, please refer to the [Obstetrical Billing](#) provider notification on Mercy Care's website. It is important to note that providers must bill all pre-natal and post-partum visits when submitting a finalized claim. This information is detailed in the above Obstetrical Billing provider notification. This information is required per AHCCES guidelines to increase the data available for calculating Performance Measures as well as to provide an opportunity to improve care, services and outcomes for members. Most providers are currently contracted on a fee for service basis and are paid in accordance with CPT Guidelines.

Global Case Rate

Providers contracted at a global case rate are reimbursed as follows:

Services Included in the Package

Will not be separately reimbursed if billed separately:

- Initial and subsequent prenatal visits, including EPSDT for patients less than 21 years of age
- Treatment of pregnancy related conditions, including hypertension and gestational diabetes
- Treatment of urinary tract infections and pelvic infections
- Routine labs and blood draws
- In-hospital management of threatened premature labor
- In-hospital management of hyperemesis gravidarum
- External cephalic version performed in hospital
- Induction of labor by prostaglandins and/or oxytocin and/or combined
- Amnioinfusion
- Trial of vaginal birth after a cesarean (VBAC)
- Delivery by any method, including cesarean section
- Episiotomy and repair, including 4th degree lacerations
- All routine post-partum care, including follow-up visit
- Any management that would ordinarily be considered part of OB care.

If a provider does not complete all the services in the Global Obstetrical Care Package, this may result in a lesser payment or potential recoupment of payments made.

Services Not Included in the Package

Separate reimbursement will be provided, if medically necessary:

- Amniocentesis
- Obstetrical Ultrasonography
- Non-stress and contraction stress tests
- Coloscopy and/or biopsy for accepted indication
- Return to operating or delivery room for postpartum hemorrhage/curettage
- Non-obstetrical related medical care
- Cerclage.

17.28 - Trimester of Entry into Prenatal Care

Claims for obstetrical services are submitted on [Form 1500 \(02-12\)](#). Health providers must in accordance with the provider notification titled [Obstetrical Billing](#).

While the goals of early entry into prenatal care and regular care during pregnancy have not changed, HEDIS guidelines will be followed to determine trimester of entry into prenatal care. Entry into prenatal care and the number of prenatal visits are measured and monitored by MCP and AHCCCS as part of the Quality Management Program.

17.29 - Provider Remittance Advice

MCP 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 Provider Relations representative if you are interested in receiving electronic remittance advices. Additional information can be attained by accessing the provider notification titled [Electronic Tools](#).

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:
 - Member/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 Provider Tools or by clicking on the form listed below:

- [Mercy Care Plan Remit Format for Check](#)
- [Mercy Care Plan Remit Format for EFT](#)

- [SA FPS Remit Format for Check](#)
- [SA FPS Remit Format for EFT](#)

More information is available in this Provider Manual under section [5.39 - MercyOneSource](#) regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. In order 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 have the ability to 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 Provider Relations representative to assist you with this process.

CHAPTER 18 – GRIEVANCES, APPEALS AND CLAIM DISPUTES

18.0 - Grievances

A grievance is an expression of dissatisfaction about any matter other than an action. A grievance is not related to a denial of claims payment or claims reimbursement. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

A provider is permitted to file a grievance with a contractor at the contractor's discretion. A provider may file a grievance in writing to:

Mercy Care Plan
Member Services Department
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040

18.1 - Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A provider may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

Before a provider initiates a claims dispute, the following needs to occur:

- The claim dispute process should only be used after other attempts to resolve the matter have failed.
- The provider should contact MCP Claims and/or Provider Relations to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor:
 - Within 12 months after the date of service.
 - Within 12 months after the date that eligibility is posted.
 - Or within 60 days after the date of the denial of a timely claim submission, whichever is later.

You may submit your claim dispute in writing through the mail or send electronically to us through fax. Not only do we now have the ability to receive disputes by fax, but we can also respond back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to (602) 431-7443, (602) 453-6098 or Toll Free (800) 624-3879.

Written claim disputes must be submitted to the MCP Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the relief requested, along with copies of any supporting documentation, such as remittance advice(s), medical records or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

MCP will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MCP may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:

Mercy Care Plan
Appeals Department
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040

If a provider disagrees with the MCP Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision. Please clearly state "State Fair Hearing Request" on your correspondence. All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040
602-351-2300 (fax)

18.2 - Appeals

An appeal is a request for review of an action by an enrollee (member) or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

Standard Appeals - An appeal must be filed either orally or in writing with MCP within 60 days after the date of the Notice of Action. A provider may assist a member in filing an appeal. MCP does not restrict or prohibit a provider from advocating on behalf of a member.

Standard Appeal Resolution - MCP will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MCP receives the appeal.

Expedited Appeals - If a provider believes that the time for a standard resolution appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the provider can submit a request for an Expedited Appeal, with the member's written consent, along with supporting documentation to MCP. MCP will acknowledge an expedited appeal within one working day of receipt.

Expedited Appeal Resolution

MCP will resolve the appeal and mail a written Notice of Appeal Resolution to the member within 3 working days after MCP receives the Expedited Appeal. MCP will also make reasonable efforts to provide prompt oral notification to the member. This timeframe may be extended if MCP needs additional information and the extension is in the best interest of the member. If the request for an Expedited Appeal is denied, MCP will decide the appeal within the standard timeframe (30 days from the day MCP receives the Expedited Appeal).

Each appeal should be filed separately. In order to file an appeal, please submit in writing, along with all substantiating documentation to:

Mercy Care Plan
Appeals Department
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040
602-351-2300 (FAX)

A member may also file an Appeal orally by contacting:

Mercy Care Plan
Appeals Department
Phone: 602-453-6098
Toll Free: 800-624-3879

An authorized representative, including a provider, acting on behalf of the member, with the member's written consent, may request a State Fair Hearing on behalf of the member. The

request for State Fair Hearing must be in writing, submitted to and received by MCP, no later than 30 days after the date the member receives the Notice of Appeal Resolution.

All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040
602-351-2300 (fax)

CHAPTER 19 – FRAUD AND ABUSE

19.0 - Fraud and Abuse Overview

MCP supports efforts to detect, prevent and report fraud and abuse within the Medicaid 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 members as possible.

Examples of actions that are reportable to the state's investigative agencies include:

- Physical or sexual abuse of members.
- Improper billing and coding of claims.
- Pass through billing.
- Billing for services not rendered.
- Raising fees for Medicaid patients to allowable amounts if these fees are not billed to other patients.
- Unbundling and up coding may be construed as fraud if a pattern is found to exist.

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

- Use of another member's identification to obtain services.
- Fraudulent application for eligibility.
- Sale of durable medical equipment while on loan to members.
- Prescription fraud.

MCP is required to report cases of suspected fraud or abuse to the AHCCCS Office of Inspector General. Other agencies may have involvement in cases of criminal activity or abuse. The AHCCCS Office of Inspector General is responsible for determining if suspected fraud or abuse cases warrant referral to the State Attorney General's office. The AHCCCS Office of Inspector General has the authority to levy civil monetary penalties, issue recoupment letters, and utilize other types of sanctions if fraud, waste or abuse is substantiated.

Anyone who suspects member or provider fraud or abuse may report it either to the MCP hotline number at 800-810-6544 or directly to the State hotline at:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686.

AHCCCS has published to its website an e-learning seminar entitled "Fraud Awareness for Providers" that discusses provider and member fraud. This seminar is available at the following website:

<http://www.azahcccs.gov/fraud/>

MCP would like to inform you of this valuable seminar's availability and would like to encourage our providers and their office staff to review/listen to this short seminar for additional information regarding fraud awareness.

Per the AHCCCS website, the chief goal of the AHCCCS Office of Inspector General is to ensure that AHCCCS (Medicaid) funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Every dollar lost to the misuse of AHCCCS benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents. The Office of Inspector General audits and investigates providers and members who are suspected of defrauding the AHCCCS program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal prosecution. You are encouraged to immediately report matters involving fraud, waste and abuse.

19.1 - Deficit Reduction Act and False Claims Act Compliance Requirements

Each Provider Agreement requires all providers to adhere to Deficit Reduction Act (DRA) requirements. The DRA requires that any entity (which receives or makes payments, under a state plan approved under Title XIX or under any waiver of such plan, totaling at least \$5 million annually) must establish written policies for its employees, management, contractors and agents regarding the False Claims Act (FCA). The FCA applies to claims presented for payment by federal health care programs. The FCA allows private persons to bring a civil action against those who knowingly submit false claims upon the government.

Activities for which one may be liable under the FCA:

- Knowingly presenting to an officer or employee of the United States government a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting false or fraudulent claims allowed or paid.
- Having possession, custody, or control of property or money used, or to be used by the government and, intending to defraud the government by willfully concealing property, delivering, or causing to be delivered less property than the amount for which the person receives.
- Authorizing to make or deliver a document, certifying receipt of property used by the government and intending to defraud the government and making or delivering a receipt without completely knowing that the information on the receipt is true;

- Knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
 - Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
 - The definition of “knowing” and “knowingly” as it relates to the FCA includes actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, and/or acting in reckless disregard of the truth or falsity of the information. Proof of specific intent to “defraud” is not required for reporting potential violations of the law.

19.2 - False Claims Training Requirements

As required by MCP’s contract with AHCCCS Administration, providers must train their staff on the following:

- The administrative remedies for false claims and statements.
- Any state laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower (or relater) protections under such laws.

19.3 - Administrative Remedies for False Claims and Statements

The United States Government (government) has administrative remedies available to it in cases that have resulted in FCA violations. The administrative remedy for violating the FCA is three times the dollar amount that the government is defrauded and civil penalties of \$5,500 to \$11,000 for each false claim by the party responsible for the claim. If there is a recovery in the case brought under the FCA, the person bringing suit (relater) may receive a percentage of the recovery against the party that had responsibility for the false claim. For the party that had responsibility for the false claim, the government may seek to exclude it from future participation in federally funded health care programs or impose integrity obligations against it.

19.4 - State Laws Relating To Civil or Criminal Penalties or False Claims and Statements

To prevent and detect fraud, waste, and abuse, many states have enacted laws similar to the FCA but with state-specific requirements, including administrative remedies and relater rights. Those laws generally prohibit the same types of false or fraudulent claims for payments for health care related goods or services as are addressed by the federal FCA. For further information on specific state law requirements, contact MCP’s Compliance Office.

Additional information on the DRA and FCA is available on the following websites:

- Deficit Reduction Act – Public Law 109-171:
<http://azahcccs.gov/DRA/Downloads/DRAPolicy.pdf>

- Arizona Revised Statutes (ARS):
<http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp>
 - ARS 13-1802: Theft
 - ARS 13-2002: Forgery
 - ARS 13-2310: Fraudulent schemes and artifices
 - ARS 13-2311: Fraudulent schemes and practices; willful concealment
 - ARS 36-2918: Duty to report fraud
 - AAC R9-22-1101, et seq.: Civil Monetary Penalties and Assessments