Claims Processing Manual

Mercy Care Plan
Mercy Care Plan Long Term Care
Mercy Care Advantage
Division of Developmental Disabilities
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1.0 – Mercy Care Plan and Mercy Care Advantage Websites
Mercy Care Plan’s website is available at www.MercyCarePlan.com. Mercy Care Advantage’s website is available at www.MercyCareAdvantage.com. The website contains valuable information for both providers and members. Some of the key information for our providers includes the following:

Mercy Care Plan Manuals
Mercy Care Plan has three provider manuals available on our website for your review:
- Mercy Care Plan Provider Manual
- Mercy Care Plan Long Term Care Provider Manual
- Mercy Care Advantage Provider Manual

The Mercy Care Provider Manuals all contain valuable information regarding details about the plans, as well as provider responsibilities.

Provider Notifications
Provider Notifications contain recent changes that we want to alert providers to. These could include new regulatory changes, new processes we have established, additional provider education, etc. Provider Notifications are available by clicking on the below links:
- Mercy Care Plan Provider Notifications
- Mercy Care Plan Long Term Care Provider Notifications
- Mercy Care Advantage Provider Notifications

Provider Forms
The Mercy Care website contains plan specific provider forms that are available for your use. These may be accessed by clicking on the below links:
- Mercy Care Plan Forms
- Mercy Care Plan Long Term Care Forms
- Mercy Care Advantage Forms

Provider Newsletters
Provider Newsletters are posted quarterly to our website. Please click on the link to view available Provider Newsletters.

News and Events
The News and Events section of our website include information from outside agencies that you may want to be aware of. Please click on the link to view the News and Events section of the website.
Reference Material and Guides

The Mercy Care website contains plan specific Reference Material and Guides that are available for your use. These may be accessed by clicking on the below links:

- Mercy Care Plan Reference Material and Guides
- Mercy Care Plan Long Term Care Reference Material and Guides
- Mercy Care Advantage Reference Material and Guides

1.1 – Claims Mailing Addresses, Electronic Vendors and Contact Information

**Paper Claim Submissions**

<table>
<thead>
<tr>
<th>Claims</th>
<th>Mail To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Mercy Care Plan or Mercy Care Advantage</td>
</tr>
<tr>
<td></td>
<td>Claims Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52089</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85072-2089</td>
</tr>
<tr>
<td>Dental</td>
<td>DentaQuest of Arizona, LLC</td>
</tr>
<tr>
<td></td>
<td>Attention: Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2906</td>
</tr>
<tr>
<td></td>
<td>Milwaukee, WI 53201-2906</td>
</tr>
<tr>
<td>Refunds</td>
<td>Mercy Care Plan</td>
</tr>
<tr>
<td></td>
<td>Attention: Finance Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52089</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85072-2089</td>
</tr>
</tbody>
</table>

When mailing in a paper claim, a completed claim form needs to be filled out. Complete instructions for filling out a UB-04 claims or a CMS 1500 is included in section 1.2 – Form Types and Instructions.

- 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.
- The claim form may be returned unprocessed (unaccepted) if ineligible or poor quality copies are submitted or required documentation is missing. This could result in the claim being voided in our system. A clean claim submission will need to be made within timely filing guidelines in order to prevent the claim from being denied.
**Electronic Claim Submissions**

Please refer to section **1.3 – Electronic Tools and MercyOneSource** for vendor information on submitting your electronic claims.

**Family Planning Questions**

Please refer to section **2.14 - Family Planning Claims** for additional information regarding family planning. 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

**Calling the Claims Inquiry Claims Research (CICR) Department**

You may contact the CICR Department by calling **602-263-3000** or **800-624-3879** toll-free, Express Service Code **626** for direct access.

CICR is available to:

- Answer general questions about claims.
- Assist in resolving problems or issues with a claim, including an incorrect payment amount.
- Assist with claim denials.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim, including conducting a check tracer.
- Correct errors in claims processing.
- Assist with coordination of benefits questions.
- Assist with data entry errors.
- Assist with remittance advice or negative balance questions.
- Assist in answering general eligibility questions affecting claims, however, providers must call our Member Services Department at **602-263-3000** or **800-624-3879** toll-free, Express Service Code **629** in order to have eligibility corrected.
- Assist in answering general prior authorization questions affecting claims, however, providers must call our Prior Authorization Department at **602-263-3000** or **800-624-3879** toll-free, Express Service Code **622** in order to have a prior authorization corrected.
- Assist in answering general provider set-up questions, including pay to issues affecting a claim, however, providers must call our Provider Relations Department at **602-263-3000** or **800-624-3879** toll-free, Express Service Code **631** to correct a provider record.
- Assist with claim status questions. We strongly encourage our providers to use our secure web portal, MercyOneSource, for status of claims. It is convenient as there are no wait times if you call CICR during peak hours and you can use it at any time, even during off hours. Using MercyOneSource will make better use of your time and allow us to focus on more complex claim questions for both you and other providers calling in. Please refer to section **1.3 – Electronic Tools and MercyOneSource**, for more tools available to you.
Please be prepared to give the CICR Customer Service Representative the following information:

- Organization Name
- Phone number
- NPI/TIN/PIN
- Claim number (if available)

Additionally, in order to meet HIPAA standards our CICR Department is required to validate three pieces of information on the member you are calling about. If the caller is unable to verify the required information, the CICR Customer Service Representative will only provide general information such as the claim billing address, etc. Information required is as follows:

- Member name and AHCCCS member identification number
- Member’s date of birth
- Date of service

**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 Mercy Care Plan’s telephone number at **602-263-3000** or **800-624-3879** toll-free.
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.

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

**Provider Relations Representative Assignment**

Please contact your Provider Relations Representative for questions you have concerning:

- 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 for MercyOneSource
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice
1.2 – Form Types and Instructions
When submitting paper claims, they must be submitted using the correct claim form type. Below please find a listing of appropriate form types to be used by specific provider types.

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Professional Services</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>Family Planning Services – Medical</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>Family Planning Service – Hospital Inpatient</td>
<td>UB-04 (CMS-1450)</td>
</tr>
<tr>
<td>Family Planning Service - Outpatient or</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>Emergency Obstetrical Care</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>Obstetrical Care</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>Hospital Inpatient, Outpatient, Skilled Nursing Facility and Emergency Room Services</td>
<td>UB-04 (CMS-1450)</td>
</tr>
<tr>
<td>Dental Services that are Considered Medical Services</td>
<td>1500 (02-12)</td>
</tr>
<tr>
<td>(Oral Surgery, Anesthesia)</td>
<td></td>
</tr>
</tbody>
</table>

Instructions on how to fill out each claim form type is listed below:

**1500 (02-12) Form Completion Instructions**

**INTRODUCTION**
The 1500 (02-12) claim form is used for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the 1500 (02-12).

- CPT and HCPCS procedure codes must be used to identify all services.
- ICD-10 diagnosis codes are required as of October 1, 2015. Dates of service September 30, 2015 and prior must be billed with ICD-9 codes. It is important to use the correct ICD Indicator. Please refer to section 1.15 - ICD-10 Implementation for additional information regarding ICD-10.
- DSM-4 diagnosis codes are not accepted and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- Total charges of claims with more than 6 lines should only be billed on the last page when billing a paper claim.

**COMPLETING THE REVISED CMS 1500 CLAIM FORM (02/12)**
The following instructions explain how to complete the paper 1500 (02-12) claim form and whether a field is “Required,” “Required if applicable,” or “Not required.”

**NOTE:** This instruction applies to paper 1500 (02-14) claims submitted to Mercy Care Plan, Mercy Care Long Term Care and Mercy Care Advantage and mirrors both AHCCCS and CMS requirements.
In the white, open carrier area please provide the name and address of Mercy Care, i.e., Mercy Care Plan or Mercy Care Advantage. Enter the name and address information in the following format:

1st Line – Name  
2nd Line – First line of address  
3rd Line – Second line of address, if necessary (if not, leave blank)  
4th Line – City State (2 characters) and zip code

Do not use punctuation except for the 9-digit zip code (include the hyphen).

- **Program Block - Required**
  Check the first box labeled “Medicare” for Mercy Care Advantage claims. Check the second box labeled “Medicaid” for Mercy Care Plan claims.

1a. **Insured’s ID Number - Required**
Enter the recipient’s **AHCCCS ID number**. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit or check eligibility on Mercy Care’s secure web portal, **MercyOneSource**. Behavioral health providers must be sure to enter the member’s AHCCCS ID number, not the member’s BHS number.

2. **Patient’s Name - Required**
Enter member’s last name, first name, and middle initial as shown on the AHCCCS ID card. Commas can be used to separate last name, first name and middle initial but do not use periods.

3. **Patient’s Date of Birth and Sex - Required**
Enter the member’s date of birth. Check the appropriate box to indicate the patient’s gender.

4. **Insured’s Name - Not Required**

5. **Patient Address – Not Required**
6. **Patient Relationship to Insured - Not Required**

7. **Insured’s Address - Not Required**

8. **Reserved for NUCC Use - Not Required**

9. **Other Insured's Name - Required if Applicable**
   If the member has no coverage other than Mercy Care Plan, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the member, enter “Same”.

<table>
<thead>
<tr>
<th>9a. <strong>Other Insured’s Policy or Group Number - Required if Applicable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the group number of the other insurance.</td>
</tr>
</tbody>
</table>

| 9b. **Reserved for NUCC Use - Not Required** |
| 9c. **Reserved for NUCC Use - Not Required** |

<table>
<thead>
<tr>
<th>9d. <strong>Insurance Plan Name or Program Name - Required if Applicable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter name of insurance company or program name that provides the insurance coverage.</td>
</tr>
</tbody>
</table>

10. **Is Patient’s Condition Related to: - Required if Applicable**
    Check "YES" or "NO" to indicate whether the patient’s condition is related to employment, an auto accident, or other accident. If the patient’s condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

<table>
<thead>
<tr>
<th>10d. <strong>Claim Codes (Designated by NUCC) - Not Required</strong></th>
</tr>
</thead>
</table>

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11. Insured's Group Policy or FECA Number - Required if Applicable

<table>
<thead>
<tr>
<th>OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>IS PATIENT'S CONDITION RELATED TO:</th>
<th>INSURED'S POLICY GROUP OR FECA NUMBER</th>
</tr>
</thead>
</table>

11a. Insured’s Date of Birth and Sex - Required if Applicable

<table>
<thead>
<tr>
<th>OTHER INSURED'S POLICY OR GROUP NUMBER</th>
<th>EMPLOYMENT? (Current or Previous)</th>
<th>INSURED'S DATE OF BIRTH</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td>MM</td>
</tr>
</tbody>
</table>

11b. Other Claim ID (Designated by NUCC) - Not Required

11c. Insurance Plan Name or Program Name - Required if Applicable

<table>
<thead>
<tr>
<th>INSURANCE PLAN NAME OR PROGRAM NAME</th>
<th>CLAIM CODES (Designated by NUCC)</th>
<th>IS THERE ANOTHER HEALTH BENEFIT PLAN?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

11d. Is There Another Health Benefit Plan - Required if Applicable

Check the appropriate box to indicate coverage other than Mercy Care. If “Yes” is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature - Not Required

13. Insured’s or Authorized Person's Signature - Not Required

14. Date of Illness or Injury - Required if Applicable

<table>
<thead>
<tr>
<th>DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)</th>
<th>OTHER DATE</th>
<th>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>DD</td>
<td>YY</td>
</tr>
</tbody>
</table>

15. Other Date - Not Required

16. Dates Patient Unable to Work in Current Occupation - Not Required

17. Name of Referring Provider or Other Source - Required if Applicable

Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. Do not use periods or commas.
The ordering provider is required for:

- Laboratory       Drugs (J-codes)
- Radiology       Temporary K and Q codes
- Medical and surgical supplies    Orthotics
- Respiratory       DME Prosthetics
- Enteral and Parenteral Therapy    Vision codes (V-codes)
- Durable Medical Equipment     97001 – 97546

Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17a. ID Number of Referring Provider - Not Required

17b. NPI # of Referring Provider - Required if Applicable

18. Hospitalization Dates Related to Current Services - Not Required

19. Reserved for Local Use - Not Required

20. Outside Lab and ($) Charges - Not Required

21. Diagnosis Codes - Required

ICD Ind – Enter the applicable ICD indicator to identify which version of ICD code(s) is (are) being reported:

- 9 - ICD-9 (prior 10/1/15)
- 0 - ICD-10 (required as of 10/1/2015)

Enter at least one ICD-9 diagnosis code or ICD-10 diagnosis code describing the recipient’s condition. Behavioral health providers must not use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary diagnosis, secondary diagnosis, etc.) may be entered.

Relate diagnosis lines A – L to the lines of service in 24E by letter.

22. Medicaid Resubmission Code – Not Required
23. Prior Authorization Number - Not Required
The claims system automatically searches for the appropriate authorization for services that require authorization.

24. The shaded area is supplemental information and it can only be entered with a corresponding, completed service line.

<table>
<thead>
<tr>
<th>Column A</th>
<th>Date(s) of Service</th>
<th>Service Line</th>
<th>Diagnosis Pointer</th>
<th>Other Charges</th>
<th>Other Information</th>
<th>Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<td>3</td>
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</tr>
</tbody>
</table>

24A. Date(s) of Service - Required
Enter the beginning and ending service dates.

<table>
<thead>
<tr>
<th>Column A</th>
<th>Date(s) of Service</th>
<th>Service Line</th>
<th>Diagnosis Pointer</th>
<th>Other Charges</th>
<th>Other Information</th>
<th>Rendering Provider ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
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</tr>
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<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
<td></td>
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</tr>
</tbody>
</table>
### 24B. Place of Service - Required
Enter the two-digit code that describes the place of service.  

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Outpatient</td>
</tr>
<tr>
<td>22</td>
<td>Inpatient</td>
</tr>
<tr>
<td>44</td>
<td>Homecare</td>
</tr>
<tr>
<td>45</td>
<td>Other</td>
</tr>
</tbody>
</table>

### 24C. EMG – Emergency Indicator - Required if Applicable
Mark this box with a “✓,” an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Emergency</td>
</tr>
<tr>
<td>X</td>
<td>Emergency</td>
</tr>
<tr>
<td>Y</td>
<td>Emergency</td>
</tr>
</tbody>
</table>

### 24D. Procedures, Services, or Supplies - Required
Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC</td>
<td>Service</td>
<td>10</td>
</tr>
<tr>
<td>DEF</td>
<td>Service</td>
<td>5</td>
</tr>
</tbody>
</table>
For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

### 24E. Diagnosis Pointer - Required

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, they should be in descending order of importance. This field allows for the entry of 4 characters and no punctuation should be used.
### 24F. $ Charges - Required
Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G. Dollar Amount should be right justified.

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### 24G. Units - Required
Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS coding manuals.

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### 24H. EPSDT/Family Planning - Not Required
24I. ID Qualifier - Required if Applicable
Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

The NUCC defines the following qualifiers used in 5010A1:

- 0B - State License Number
- 1G - Provider UPIN Number
- G2 - Provider Commercial Number
- LU - Location Number
- ZZ - Provider Taxonomy

24J. (SHADED AREA) – Use for COB INFORMATION - Required if Applicable
Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a member’s deductible has been met, enter zero (0) for the Deductible amount.

For members and service covered by a third party payer, enter only the amount paid.

Always attach a copy of the Medicare or other insurer’s EOB to the claim.
If the member has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should “zero fill” Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # - Required
Rendering Provider’s NPI is required for all providers that are mandated to maintain NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

25. Federal Tax ID Number - Required
Enter the tax ID number and check the box labeled “EIN”. If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN”.
26. **Patient Account Number - Required if Applicable**  
This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. Mercy Care will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the claim and the provider’s own accounting or tracking system.

27. **Accept Assignment - Not Required**

28. **Total Charge - Required**  
Enter the total for all charges for all lines on the claim. If your claim contains more than 6 lines of service, please only list the total charge on the last page of the form.

29. **Amount Paid - Required if Applicable**  
Enter the total amount that the provider has been paid for this claim by all sources *other than Mercy Care*. Do not enter any amounts expected to be paid by Mercy Care.

30. **Reserved for NUCC Use - Not Required**

31. **Signature and Date - Required**  
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.
32. Service Facility Location Information - Required if Applicable
Enter the name, address, city, state and ZIP code of the LOCATION WHERE THE SERVICES WERE RENDERED.

32a. Service Facility NPI # - Required if Applicable

32b. Service Facility AHCCCS ID # (Shaded Area) - Required if Applicable

33. Billing Provider Name, Address and Phone # - Required
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # - Required if Applicable

33b. Other ID – AHCCCS ID # (Shaded Area) - Required if Applicable
**UB-04 (CMS-1450) Form Completion Instructions**

**INTRODUCTION**
The UB-04 (CMS-1450) claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04 (CMS-1450). Key information is as follows:

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
  - For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 (CMS-1450) with a bill type 81X-82X (Special Facility Hospice).
  - If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.
- ICD-10 diagnosis codes are required for services from 10/1/15 and after.
- AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ICD-10 procedure codes must be used to identify surgical procedures billed on the UB-04 for dates of service 10/1/15 and after.
- CPT/HCPCS and modifiers must be used to identify other services rendered.

**COMPLETING THE UB-04 CLAIM FORM**
The following instructions explain how to complete the UB-04 (CMS-1450) claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04 (CMS-1450)*.

**NOTE:** This chapter applies to paper UB-04 claims submitted to Mercy Care Plan and Mercy Care Advantage. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the [AHCCCS website](#). The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

**Form Locator Fields:**

1. **Provider Data - Required**
Enter the name, address, and phone number of the provider rendering service.

2. **Unassigned - Not Required**

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3. Patient Control No. - Required if Applicable
This is a number that the facility assigns to uniquely identify a claim in the facility’s records. Mercy Care will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Mercy Care remit and the facility’s accounting or tracking system.

4. Type of Bill - Required
This is a 4 digit number based on facility type (2nd digit), bill classification (3rd digit), and frequency (4th digit). See UB-92 Manual for codes.

Enter the four digit code that identifies the specific type of bill and frequency of submission:

- **1st digit is a leading zero.**
- **2nd digit is submitting facility:**
  - 1 = Hospital
  - 2 = Skilled Nursing
  - 3 = Home Health
  - 4 = Christian Science (Hospital)
  - 5 = Christian Science (Extended Care)
  - 6 = Intermediate Care
  - 7 = Clinic (Use "2nd Digit - Clinics Only" below)
  - 8 = Special Facility (Use "2nd Digit – Special Facilities Only" below)
- **3rd Digit - Bill Classification (Except Clinics and Special Facilities):**
  - 1 = Inpatient (Including Medicare Part A)
  - 2 = Inpatient (Medicare Part B Only)
  - 3 = Outpatient
  - 4 = Other
  - 5 = Intermediate Care - Level I
  - 6 = Intermediate Care - Level II
  - 7 = Intermediate Care - Level III
  - 8 = Swing Beds
- **3rd Digit - Clinics Only**
  - 1 = Rural Health
  - 2 = Hospital Based or Independent Renal Dialysis Center
  - 3 = Free Standing
  - 4 = Outpatient Rehabilitation Facility (ORF)
  - 5 = Comprehensive Outpatient Rehabilitation Facility (CORF)
  - 9 = Other
- **3rd Digit - Special Facilities Only**
1 = Hospice (Non-Hospital Based)
2 = Hospice (Hospital Based)
3 = Ambulatory Surgery Center
4 = Free Standing Birthing Center
9 = Other

4th Digit - Frequency
0 = Non-Payment/Zero Claim
1 = Admit Through Discharge Date (one claim covers entire stay)
2 = First Interim Claim
3 = Continuing Interim Claim
4 = Last Interim Claim
7 = Replacement of Prior Claim
8 = Void/Cancel of Prior Claim

5. Fed Tax No. - Required
Enter the facility’s federal tax identification number.

6. Statement Covers Period - Required
Enter the beginning and ending dates of the billing period.

7. Future Use - Not Required

8. Patient Name/Identifier - Required
Enter the member’s last name, first name, and middle initial as they appear on the member’s AHCCCS ID card.

9. Patient Address - Required
Enter the member’s address.
10. Patient Birth Date - Required
Enter the member’s birth date.

11. Patient Sex - Required
Enter the patient’s sex.

12. Admission Date - Required
Enter the start of care date.

13. Admission Hour - Required if Applicable
Enter the hour (using a two-digit code below) that the patient entered the facility:

- 1:00 a.m. - 01
- 2:00 a.m. - 02
- 3:00 a.m. - 03
- 4:00 a.m. - 04
- 5:00 a.m. - 05
- 6:00 a.m. - 06
- 7:00 a.m. - 07
- 8:00 a.m. - 08
- 9:00 a.m. - 09
- 10:00 a.m. - 10
- 11:00 a.m. - 11
- 12:00 noon - 12
- 1:00 p.m. – 13
- 2:00 p.m. - 14
- 3:00 p.m. - 15
- 4:00 p.m. - 16
- 5:00 p.m. - 17
- 6:00 p.m. - 18
- 7:00 p.m. - 19
- 8:00 p.m. - 20
- 9:00 p.m. - 21
- 10:00 p.m. - 22
- 11:00 p.m. - 23
- 12:00 a.m. - 24/00

14. Priority (type) of Admission/Visit - Required
This field is required for all claims. Enter the code that best describes the recipient’s status for this billing period:

- 1 = Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.
- 2 = Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.
• 3 = Elective: Patient's condition permits time to schedule services.
• 4 = Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.
• 5 = Trauma Center: Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

15. Point of Origin for Admission or Visit - Required
Enter one of the following source of admission codes:
• 1 = Physician Referral
• 2 = Clinic Referral
• 3 = HMO Referral
• 4 = Transfer from Hospital
• 5 = Transfer from SNF
• 6 = Transfer From Another Health Care Facility
• 7 = Emergency Room
• 8 = Court/Law Enforcement
• 9 = Information Not Available
• In the Case of Newborn
  o 1 = Normal Delivery
  o 2 = Premature Delivery
  o 3 = Sick Baby
  o 4 = Extramural Birth

16. Discharge Hour - Required if Applicable
Enter the code which best indicates the recipient's time of discharge. This field is required for inpatient claims when the recipient has been discharged. See Field 13 Admission Hour for coder structure.

17. Patient Discharge Status - Required
Field is required for all claims. Enter the code that best describes the member's status for this billing period:
• 01 Discharged to home or self-care (routine discharge)
• 02 Discharged/Transferred to a short-term general hospital for inpatient care
• 03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care
• 04 Discharge/Transferred to a facility that provides custodial or supportive care
• 05 Discharge/Transferred to a designated cancer center or children’s hospital
• 06 Discharge/Transferred to home under care an organized home health service organization in anticipation of covered skilled care
• 07 Left against medical advice or discontinued care
• 09 Admitted as an inpatient to this hospital
• 20 Expired
• 21 Discharged/Transferred to Court/Law Enforcement
• 30 Still a patient
• 40 Expired at home
• 41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice
• 42 Expired, place unknown (hospice only)
• 43 Discharged/Transferred to a federal health care facility
• 50 Discharged to Hospice -home
• 51 Discharged to Hospice -medical facility (certified) providing hospice level of care
• 61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed
• 62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
• 63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
• 64 Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
• 65 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part/unit of hospital
• 66 Discharges/Transfers to a Critical Access Hospital
• 70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

18-28 Condition Codes - Required if Applicable
Enter the appropriate condition codes that apply to this bill. See UB-04 Manual for codes.

- In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field.
- To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).
- To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.

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<th>29. Accident State - Required if Applicable</th>
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<th>31-34 Occurrence Codes and Dates - Required if Applicable</th>
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<td>Enter the occurrence codes and dates if needed.</td>
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<th>35-36. Occurrence Span Codes and Dates - Required if Applicable</th>
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<td>Enter the occurrence span codes and dates if needed.</td>
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<th>38. Responsible Party Name and Address - Required if Applicable</th>
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<td>Enter the responsible party name and address if needed.</td>
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<th>39-41. Value Codes and Amounts - Required if Applicable</th>
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<tr>
<td>Enter the value codes and amounts if needed.</td>
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42. Revenue Code - Required
Enter the appropriate revenue code(s) that describe the service(s) provided. See UB-04 Manual for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

43. Revenue Code Description/NDC code (effective 7/1/12) - Required/NDC if Applicable
Enter the description of the revenue code billed in Field 42. See UB-04 Manual for description of revenue codes.

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.
The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

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<thead>
<tr>
<th>47 REV. CO.</th>
<th>48 DESCRIPTION</th>
<th>49 HCPCS/DATE/HIPPS CODE</th>
<th>4A TOTAL CHARGES</th>
<th>4B TOTAL UNITS</th>
<th>4C TOTAL CHARGES</th>
<th>4D NON-COVERED CHARGES</th>
<th>4E</th>
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**44. HCPCS/Rates - Required if Applicable**

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
45. Service Date - Required
The dates indicate outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Service Units</th>
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46. Service Units - Required
Number of units for ALL services must be indicated. If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.
Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

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<th>#</th>
<th>Description</th>
<th>HCPCS Code/HCPCS Code</th>
<th>Total Date</th>
<th>Total Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
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47. **Total Charges - Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.
48. **Non-Covered Charges - Required if Applicable**
Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

<table>
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<tr>
<th>REV NO</th>
<th>DESCRIPTION</th>
<th>REV CODE</th>
<th>PAYOR</th>
<th>TOTAL AMT</th>
<th>TOTAL UNITS</th>
<th>TOTAL CHARGES</th>
<th>NON-COVERED CHARGES</th>
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49. **Unlabeled Field - Not Required**

50. **(A–C) Payer - Required**
Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than Mercy Care Plan or Mercy Care Advantage, they should be the last entry. If there are no payers other than Mercy Care Plan or Mercy Care Advantage, those will be the only entry listed.

<table>
<thead>
<tr>
<th>PAYER NAME</th>
<th>HEALTH PLAN ID</th>
<th>REF NO</th>
<th>FACILITY</th>
<th>AMT DUE</th>
<th>AMT PAID</th>
<th>AMT PAYABLE</th>
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51. **(A–C) Healthplan ID - Required**
Enter the facility’s ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility’s six-digit AHCCCS service provider ID number should be listed last. Behavioral health providers must not enter their BHS provider ID number.

<table>
<thead>
<tr>
<th>PAYER NAME</th>
<th>HEALTH PLAN ID</th>
<th>REF NO</th>
<th>FACILITY</th>
<th>AMT DUE</th>
<th>AMT PAID</th>
<th>AMT PAYABLE</th>
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52. **(A–C) Release of Information - Not Required**
53. (A–C) Assignment of Benefits - Not Required

54. (A–C) Prior Payments - Required if applicable
Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer other than Mercy Care Plan or Mercy Care Advantage, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter “Ø.” The “Ø” indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from Mercy Care Plan or Mercy Care Advantage.

55. (A–C) Estimated Amount Due - Not required

56. National Provider Identifier - Billing Provider - Required
Enter the billing provider’s NPI.

57. Other (Billing) Provider Identifier - Required if Applicable
Enter other billing provider NPI if needed.

58. (A–C) Insured’s Name - Not Required

59. (A–C) Patient’s Relationship to Insured - Not Required

60. (A–C) Patient CERT. - SSN – HIC – ID NO. - Not Required

61. (A–C) Group Name - Not Required

62. (A–C) Insurance Group Number - Not Required

63. (A–C) Treatment Authorization - Not Required

64. Document Control Number - Not Required
65. (A–C) Employer Name - Not Required

66. Diagnosis and Procedure Code Qualifier - Required
Enter applicable ICD-9 codes for services prior to 10/1/15 and applicable ICD-10 codes for services 10/1/15 and after.

67. Principal Diagnosis Code - Required
Enter the principal ICD-9 diagnosis code for services prior to 10/1/15 and ICD-10 principal diagnosis code for services 10/1/15 and after. Behavioral health providers must not use DSM-4 diagnosis codes.

69. Admitting Diagnosis - Required
Required for inpatient bills. Enter the ICD-9 diagnosis code (for dates of service prior to 10/1/15) and the ICD-10 diagnosis code (for dates of service 10/1/15 and after) that represents the significant reason for admission.

70. Patient’s Reason for Visit - Not Required

72 E-Codes - Required if applicable
Enter trauma diagnosis code, if applicable.

74. Principal Procedure Code and Dates - Required if Applicable
Enter the principal ICD-9 procedure code (for dates of service prior to 10/1/15) or principal ICD-10 procedure code (for dates of service 10/1/15 and after) and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.
76. Attending Provider Name and identifiers - Required if Applicable
Enter the attending provider name and identifiers if needed.

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<tr>
<th>Code</th>
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77. Operating Physician Name and Identifiers - Required if applicable
Enter the operation physician name and identifiers if needed.

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<th>Code</th>
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78-79. Other Physician - Not Required

80. Remarks - Required if Applicable
Required on resubmissions, adjustments, and voids. Enter the claim number of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write “Resubmission” in this field.

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81. Other Procedure Codes - Required if Applicable
Enter other procedure codes in descending order of importance.

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### 1.3 – Electronic Tools and MercyOneSource
Mercy Care Plan strives to continually improve service to our participating network. One way to help improve service is to offer electronic tools to expedite service to our network.

Mercy Care offers multiple tools to allow the participating network to submit and receive electronic transactions and reports. Electronic transactions and reports reduce the volume of paper and costs associated with such transactions. As a state and federally funded program, Mercy Care and contracted providers have the fiduciary responsibility to reduce costs. We are working closely with providers to encourage utilization of electronic tools.
Currently Mercy Care offers several electronic tools to our participating network to help reduce the administrative burden and costs associated with paper transactions, including:

- Electronic Claims Submission
- Electronic Funds Transfer
- Electronic Remittance Advice

**Electronic Claim Submissions (EDI)**

The benefits of electronic claims submissions include:

- Accurate submission and immediate notification of submission errors (level 2 report)
- Faster processing resulting in prompt payment
- Mercy Care pays transaction costs

In order to submit electronic claims you need the following:

- Agreement with an electronic clearinghouse vendor
- Software in your office or facility to transmit electronic claims

Mercy Care works with the following vendors:

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Payor ID</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Healthcare</td>
<td>86052</td>
<td><a href="http://www.changehealthcare.com">www.changehealthcare.com</a> 1-877-363-3666, Option 1 for Sales</td>
</tr>
</tbody>
</table>

**Electronic Funds Transfer (EFT)**

The benefits of electronic funds transfer include:

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

In order to receive electronic funds transfer you need the following:

- Submit your claims electronically (preferred)
- Bank account number

**1500 (02/12) VENDORS**

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<thead>
<tr>
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<th>Payor ID</th>
<th>Contact Information</th>
</tr>
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<tbody>
<tr>
<td>Change Healthcare</td>
<td>86052</td>
<td><a href="http://www.changehealthcare.com">www.changehealthcare.com</a> 1-877-363-3666, Option 1 for Sales</td>
</tr>
</tbody>
</table>

**UB-04 VENDORS**

<table>
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<tr>
<th>Vendor</th>
<th>Payor ID</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>SSI</td>
<td>99999-0547</td>
<td><a href="http://www.thessigroup.com">www.thessigroup.com</a> 1-800-880-3032</td>
</tr>
<tr>
<td>Change Healthcare</td>
<td>86052</td>
<td><a href="http://www.changehealthcare.com">www.changehealthcare.com</a> 1-877-363-3666, Option 1 for Sales</td>
</tr>
</tbody>
</table>
• A voided check or savings account deposit slip
• A signed Electronic Funds Transfer (EFT) Form enrollment form available on Mercy Care’s website under the Forms section.

Please Note: Mercy Care’s check runs kick off every Friday (with a check date of the following Tuesday of the next week). Electronic Fund Transfers will generally appear in your bank account on Wednesday following the check run. However, on a holiday week when the office is closed on Monday, the money will not appear in your bank statement until Thursday.

Mercy Care Plan Long Term Care’s twice weekly check runs will be scheduled to kick off each Wednesday (with a check date of Saturday) and Friday (with a check date of the following Tuesday) of the week. There may be some weeks that do not have a second check run, primarily when a month has 5 weeks in it. However, on a holiday week when the office is closed on Monday, the money will not appear in your bank statement until Thursday.

Electronic Remittance Advice (ERA)
The benefits of electronic remittance advice include:
• Electronic file of processed claims from Mercy Care
• Electronically post payments to your Practice Management system
• Faster reconciliation of account receivables
• Simplified reconciliation process
• Received day after electronic funds transfer

In order to receive electronic remittance advice you need the following:
• Submit your claims electronically (preferred)
• Receive electronic funds transfer (preferred)
• Ability to accept HIPAA standard 835 electronic remit transactions
• Ability to accept direct receipt of 835 transactions via FTP

In order for providers to be able to access the Change Healthcare 835 electronic remit, the form titled Electronic Remittance Advice (ERA) Form needs to be fully filled out and submitted to the MercyCareProviderRelations@AETNA.com mailbox. The form is available on Mercy Care’s website.

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

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

Process Outline
• Provider submits fully completed form to Mercy Care Provider Relations email box.
The form is forwarded to Change Healthcare for them to load in their system.
Change Healthcare notifies Mercy Care that the form has been loaded into their system.
Mercy Care then gives the OK to Change Healthcare to turn on the 835 to start the process.
Change Healthcare then sends an email to you providing your login information. The provider will need to contact Change Healthcare after they get their login in order to set up a secure password.

It is best to e-mail the form in a PDF format to MercyCareProviderRelations@AETNA.com mailbox. You may choose to fax as well, however, this may cause slight delays.

**MercyOneSource**
Mercy also provides a secure web-based platform that enables MCP 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 our secure web-based 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.
- **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 the following:
- MercyOneSource Provider Web Portal Instructions
- MercyOneSource Add User Process
- MercyOneSource Provider Web Portal Registration Form
- Current and Historical Mercy Care Plan Fee Schedules
For registration information regarding MercyOneSource, please access the **MercyOneSource Provider Web Portal Registration Form** available on the website under the Forms section. Non-participating providers may also register for a login ID. Please e-mail or fax your completed form and the signed Provider Web Portal Agreement to Mercy Care Plan at:

- **E-Mail** – MercyCareProviderRelations@AETNA.com
- **Fax** – 1-860-975-3201

Once you have received your login in you may access MercyOneSource by clicking on the link.

### 1.4 – Clean Claim Definition

**Mercy Care Plan**

Mercy Care Plan follows the AHCCCS regulatory definition of a Clean Claim. A “Clean Claim” is defined as a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.

The receipt date of the claim is included in the Mercy Care claim number assigned and reflects the date the claim was received (Julian Date) through the mail or received electronically through direct electronic submission or received by our designated clearinghouse.

**Mercy Care Advantage**

Mercy Care Advantage follows the CMS regulatory definition of a Clean Claim. A “Clean Claim” is one that does not require Mercy Care Advantage to investigate or develop on a prepayment basis. Clean claims must be filed within the timely filing period.

The following bullets are some examples of what are considered clean claims:
- The claim will pass all edits and be processed electronically;
- The claim does not require external development;
- Claims subject to medical review and complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance Mercy Care Advantage instructions;
- Are developed on a post-payment basis; and,
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation.

The receipt date of the claim is included in the Mercy Care claim number assigned and reflects the date the claim was received (Julian Date) through the mail or received electronically through direct electronic submission or received by our designated clearinghouse.
1.5 – Regulatory Turnaround Times
Both Mercy Care Plan and Mercy Care Advantage are subject to regulatory requirements regarding the turnaround time of claims from the date the claim is originally received by the plan to the date when the claim is adjudicated. These turnaround times are as follows:

**For Mercy Care Plan**
- 95% of all clean claims must be adjudicated within 30 days of receipt of the clean claim for all form types (Professional/Institutional).
- 99% of all clean claims must be adjudicated within 60 days of receipt of the clean claim for all form types (Professional/Institutional).

**For Mercy Care Advantage**
- 95% of all clean claims must be adjudicated within 30 days of receipt of the clean claim for all form types (Professional/Institutional).
- 100% of all clean claims must be adjudicated within 60 days of receipt of the clean claim for all form types (Professional/Institutional).

1.6 – Interest Payments
In the absence of a subcontract specifying other late payment terms, Mercy Care is required to pay interest on late payments as specified below:

**For Mercy Care Plan**
- **Hospital Clean Claims** – Mercy Care Plan is required to pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. §36-2903.01).

- **Long Term Care Clean Claims** - For authorized services submitted by a licensed skilled nursing facility, an assisted living facility/center, Long Term Care provider, or a home and community based Long Term Care provider, Mercy Care is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (A.R.S. §36-2943.D).

- **Non-Hospital Clean Claims** – Mercy Care is required to pay interest on payments made after 45 days of receipt of the clean claim. Interest shall be paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment. The Contractor shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute). Mercy Care shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute date unless additional information is provided as part of the dispute, in which case the clean date is reflective of the
Interest is paid based on the difference between the original paid amount and the additional payment. Interest is reported on your remittance advice.

**For Mercy Care Advantage**

The following applies to all claim types. Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt of the claim. The applicable number of days is also known as the payment ceiling. As an example, a clean claim is received on March 1, 2015, must be paid before the end of business on March 31, 2015. Interest is not payable on the following claims types:

- Claims requiring external investigation or development by Mercy Care Advantage;
- Claims on which no payment is due;
- Full denials;
- Interim claims;
- HH PPS RAPs.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6-month basis, effective every January 1 and July 1. You may access the [Prompt Pay Rates](#) by clicking on the link. Interest is calculated using the following formula:

\[
\text{Payment amount} \times \text{rate} \times \text{days divided by 365 (366 in a leap year)} = \text{interest payment}
\]

The interest period begins on the day after payment is due and ends on the day of payment. Interest is reported on your remittance advice.

For additional information regarding interest payments on non-clean claims, please see the [Medicare Claims Processing Manual, Chapter 1](#), under Section 80.2.2 – Interest Payment on Clean Non-PIP Claims Not Paid Timely.

**1.7 – Prompt Payment Discount**

The prompt payment discount only applies to Mercy Care Plan and Mercy Care Plan Long Term Care and is mandated by regulatory requirement.

In the absence of a subcontract specifying otherwise, Mercy Care Plan and Mercy Care Plan Long Term Care must apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the clean claim was received (A.R.S. §36-2903.01.G). This only applies to in-state hospitals. It does not apply to out of state hospitals.
1.8 – Timely Filing

Unless a contract specifies otherwise, Mercy Care ensures that for each form type (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 as stated in section 1.5 – Regulatory Turnaround Times for both Mercy Care Plan and Mercy Care Advantage.

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 (the 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.

For Mercy Care Advantage:

- Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) states that claims with dates of service on or after January 1, 2010, received later than one year beyond the date of service will be denied by Mercy Care Advantage for timely filing.

1.9 – National Correct Coding Initiative

Mercy Care Plan and Mercy Care Advantage, along with 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 the Correct Coding Initiative, please review the CMS National Correct Coding Initiative Edits web page.

MCP utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors with proper reimbursement, along with i-Health. 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 (Clear Claim) is a web-based stand-alone code auditing reference tool designed to approximate the editing based on national standards and Mercy Care’s comprehensive code auditing solution through ClaimCheck. For further information regarding Clear Claim, please review the disclaimer in the application.

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 through Mercy Care Plan’s website through a secure login in MercyOneSource. Clear Claim coding combinations can be used to review the rationale for editing 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 a claim.

Further detail on how to use Clear Claim can be found on the application itself by using the help link. Clear Claims Connection can be found after logging in to MercyOneSource. For additional information regarding MercyOneSource, please refer to section 1.3 – Electronic Tools and MercyOneSource.

**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.

**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.

**Coding Resources and Common Modifiers**
Mercy Care follows our regulators’ coding practices and guidelines (both CMS and AHCCCS).
It is important to follow all coding guidelines in order to avoid claim denials.

In conjunction with the Mercy Care Website and Provider Manuals, you should also reference the AHCCCS Website as well as the CMS Website for additional detailed information.

Important resources for your use should include the following:

- ICD-10-CM Manual
- HCPCS Level II Manual

It is important to follow coding guidelines outlined in the above manuals in order to avoid claim denials.

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Mercy Care 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).

In addition there are HCPCS modifiers for selective identification of subsets of Distinct Procedural Services (59 modifier) as follows:

- XE – Separate Encounter
- XS – Separate Structure
- XP – Separate Practitioner
- XU – Unusual, Non-Overlapping Service

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

**Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. Mercy Care follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one line reporting one code with a 50 modifier.
**Modifier 51 – Multiple Procedures** – When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines) are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes. Mercy Care follows multiple surgical reduction rules and it’s important to know when this is needed.

Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51, unless the code is an add-on code.

- The principal procedure is reimbursed at 100% of the provider’s contracted rate or billed charges, whichever is less.
- Each secondary surgical procedure is reimbursed at 50% of the provider’s contracted rate or billed charges, whichever is less.

If a claim is received without modifiers to indicate secondary procedures, Mercy Care’s bundling system, ClaimCheck identifies the first procedure on the claim as the principal procedure.

All other surgical procedures, if identified as part of multiple surgical reduction, will have the 51 modifier appended to it and paid at 50% of the provider’s contracted amount or billed charge, whichever is less.

**Modifier 57 – Decision for Surgery** – This must be attached to an Evaluation and Management code when a decision for surgery has been made. Mercy Care 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 [Chapter 3 – Early Periodic Screening, Diagnostic and Treatment (EPSDT)].
**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 [3.4 – Vaccine For Children Program](#).

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

### 1.10 – Resubmission Process

Providers have 12 months from the date of service to request a resubmission or reconsideration of a claim, otherwise it will be denied for timely filing. 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) must be submitted.
- 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.

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 needs 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.
1.11 – Recoupments
The recoupment of a claim may occur from time to time when needed.

Adjustments to Claims
Any time a claim requires adjustment, our claims system will reverse the original claim and repay on a secondary claim. The difference in payment between these two claims is what you will be paid on your remit. There may be times where the difference in payments results in the provider owing us monies, rather than Mercy Care owing additional monies to the provider. This is referred to as a negative balance. Any negative balances will be carried over to the next check run and offset by new claims that are submitted from the provider. Please always refer to the upper right hand corner summary box of your remit for this important information. The Ending Balance section will be the indicator to let you know that you have a negative balance.

Remits may be accessed through MercyOneSource. Please refer to section 1.3 – Electronic Tools and MercyOneSource in this document for more information.

We recommend that providers wait until all negative balances are recouped before they start to reconcile their AP system.

Recoupment Reasons
Recoupments may occur for the following reasons (this list is not all inclusive but contains most common reasons):

- Encounter errors from AHCCCS requiring a corrected claim from the provider.
- Provider billing errors.
- Claims processing or provider set-up errors in our system.
- Inadequate and untimely notification to Mercy Care of changes by the provider such as:
  - New ownership
If you have a large negative remit and are in agreement with the amounts, it is best to send us a check for the overpayment. Once received, we will credit this in, which will reduce your negative balance back to zero.

1.12 – 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

1.13 – Medical Necessity Reviews
Mercy Care 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. Mercy Care 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.

There may be times where a medical necessity review is requested by the provider following the denial of a claim. In those cases, a request for a medical necessity review, along with appropriate documentation supporting medical necessity should be submitted through the claims resubmission process. The claims will be forwarded to our clinical staff for further review. If medical necessity is established for the claim, the claim will be reprocessed for payment.
1.14 – Claim Disputes

Mercy Care Plan 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, i.e., through the resubmission process.
- The provider should contact the Claims Inquiry Claims Research (CICR) department 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.

Mercy Care 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:

---

QB 1924 Page 54 October 2016
Mercy Care Plan  
Appeals Department  
4350 E. Cotton Center Boulevard, Building D  
Phoenix, AZ 85040

If a provider disagrees with the Mercy Care 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

It’s important to note that once a claim is disputed through this process, it can no longer go through the resubmission process. It must go through the next step, which is for State Fair Hearing.

**Mercy Care Advantage Claim Disputes**

Contracted providers with Mercy Care Advantage do not have Claim Dispute rights. They must submit claims that they are disputing through the resubmission process.

**1.15 – ICD-10 Implementation**

Effective October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures was replaced by ICD-10 code sets.

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). Please note the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

Please feel free to access our Claims Information webpage on our website under the button Tools to Assist with the Transition to ICD-10. Tools available for your use are as follows:

- **ICD-9 and ICD-10 Common Codes by Sonora Quest Laboratories** – Sonora Quest Laboratories has a great reference document regarding ICD-9 and ICD-10 Common Codes. They have allowed us to share this useful information with our providers.

- **ICD-9 to ICD-10 Translator by AAPC** - This tool comes from the National Coding Organization, AAPC, and is based on the General Equivalency Mapping (GEM) files published by CMS. Please keep in mind that while many codes in ICD-9-CM map directly
to codes in ICD-10, in some cases, a clinical analysis may be required to determine which code or codes should be selected for your mapping. Always review mapping results before applying them.

**Please Note:** The online translator tool only converts to ICD-10-CM codes. It does not convert to ICD-10-PCS.

In addition, several resources are available from both CMS and AHCCCS to assist you:

- [CMS Announcement](#) dated July 6, 2015 regarding ICD-10.
- [CMS Guidelines and FAQs](#) are also posted on the CMS website.
- [CMS ICD-10 Information Page](#) contains several resources to assist you in preparation for ICD-10.
- [AHCCCS Frequently Asked Questions (FAQs)](#) is available on their website.
- [AHCCCS ICD-10 Updates, Technical Consortiums and Related Documentation web page](#) is also available for your review.

In regard to claim submissions, ICD-10 implementation is date of service specific. All dates of service from October 1, 2015 and after must have the appropriate ICD-10 diagnosis code on it. Specific examples include:

- **Inpatient claims** – Since the services are discharge date driven due to APR-DRG pricing, if the discharge date is on or after 10/1/15, then the ICD-10 code needs to be used.
- **Outpatient claims** – If an outpatient claim spans September and October, 2015, the claim will need to be split by the provider. Services prior to October 1, 2015 must contain the ICD-9 code. Services on or after October 1, 2015 will need the ICD-10 code.
- **DME** – These claims tend to be sent spanning a month time period. If services happen to span September through October 2015, the last date of service will drive the appropriate diagnosis code, i.e., if the last date of service is on or after October 1, 2015, the ICD-10 diagnosis code must be used.
- **Obstetric Services** – Payment is based on the delivery date. If the delivery date is prior to 10/1/15, ICD-9 should be billed. If the delivery date is 10/1/15 and after, ICD-10 should be billed. Prenatal and postnatal services that are billed for HEDIS purposes with a $0.00 amount will also need to be split by date of service depending on whether ICD-9 or ICD-10 applies.

**Manifestation Codes**

There are certain diagnosis codes, called manifestation codes that cannot be billed as the primary diagnosis. Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and therefore should not be used as a principal diagnosis.
Mercy Care’s system will deny a claim where a manifestation code is billed as the primary diagnosis code. For a listing of specific manifestation codes, please reference the CMS ICD-10 Dx Edit Code Lists document. ICD-10 manifestation codes are listed on page 133 – 137.

1.16 – National Drug Code Claim Requirements
AHCCCS provides an Implementation of the National Drug Code (NDC) Billing Requirements for Medications Administered in an Outpatient Setting to assist you with this requirement. Please click on the link to review in further detail.

Mercy Care follows all AHCCCS guidance regarding the provider’s responsibility to bill NDC as follows:

The billing requirements for drugs administered in outpatient clinical settings are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit the National Drug Code (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims by the use of the Healthcare Common Procedure Coding System (HCPCS) codes.

Background
The Deficit Reduction Act of 2005 (DRA) included new provisions regarding State collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927(a)(7) to the Social Security Act to require States to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, the State must provide collection and submission of utilization data in order to secure rebates. Since there are often several NDCs linked to a single HCPCS code, the Centers for Medicare and Medicaid Services (CMS) deem that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

NDC Definition
The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer. Some packages will display less than 11 digits, but leading “0’s” can be assumed and need to be used when billing. For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX
XXX-XX = XXXXX-0XX-XX

= XXXX-XXXX-XX

= XXXX-XXXX-XX

= XXXX-XXXX-XX

= XXXX-XXXX-XX
The NDC is found on the drug container, i.e. vial, bottle, tube. The NDC submitted to Mercy Care Plan must be the actual NDC number on the package or container from which the medication was administered. Claims may not be submitted for one manufacturer when a different manufacturer’s product was administered. It is considered a fraudulent billing practice to bill using an NDC other than the one assigned to the drug administered.

When submitting a Medicaid claim for administering a drug, providers must submit the 11-digit NDC without dashes or spaces between the numbers. Claims submitted with NDCs in any other configuration may fail.

Providers of “physician-administered” drugs
Providers of “physician-administered” drugs include any AHCCCS registered provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), doctor of osteopathic medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

Exception: IHS /tribally operated 638 facilities reimbursed at the federally the published all-inclusive rate.

HCPSC codes that will require the NDC information on the claim submission
Drugs billed using HCPCS codes include:
  - A, C, J, Q and S codes as applicable.
  - “Not otherwise classified” (NOC) and “Not otherwise specified” (NOS) drug codes (e.g., J3490, J9999, and C9399).
  - CPT codes, 90281-90399 for immune globulins.
  - CPT Codes 90476-90749 for vaccines and toxoids.

In order to comply with this mandate, providers must do the following, effective for the dates of service on or after July 1, 2012:
  - Providers must submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
  - The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area.
**Revenue Center Codes affected**

To support the NDC claims submission requirements, the following Revenue Center Codes may require a CPT or HCPCS code for administration of the drug and reporting of the specific NDC and quantity:

- 0250-259
- 0262
- 0263
- 0331
- 0332
- 0335
- 0634-0637

**NDC quantity to be billed and claims elements required**

NDC units are based on the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered and the unit of measurement is required for billing. If reporting a fraction, use a decimal point. The units of measurement codes are as follows:

- NDC of the drug administered as described above.
- NDC Unit of Measure:
  - **F2** = International Unit.
  - **GR** = Gram - usually for products such as ointments, creams, inhalers, or bulk. This unit of measure is typically used in the retail pharmacy setting.
  - **ML** = Milliliter - for drugs that come in vials which are in liquid form.
  - **UN** = Unit (each) - for unit of use preparations, generally those that must be reconstituted prior to administration.
- Quantity administered equals number of NDC units.

**Note:** Provider must also continue to submit Revenue Codes, HCPCS Codes and related service units in addition to the required NDC information.

**HCPCS to NDC quantity conversion examples:**

**Note:** Payment is based on the quantity of J codes units administered.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>NDC</th>
<th>QUANTITY CONVERSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9305</td>
<td>00002762301</td>
<td>HCPCS code is per 10 mg and the product comes as a dry power injection 500mg. NDC units are “each vial” Dose was 100 mg, for example</td>
</tr>
</tbody>
</table>

HCPCS quantity = 10 and the NDC quantity = 100/500 = 0.2

Enter: N400002762301 UN0.2 on the CMS-1500.
J3110 00002897101  HCPCS code is for 10mcg and the product comes as 250mg/ml

NDC units are ml. Dose was 750 mcg.

HCPCS quantity = 75 and the NDC quantity =3

Enter: N400002897101 ML3 on the CMS-1500.

J1745 57894003001  HCPCS code is for 10 mg and product comes as 100mg powder for injection.

NDC units are “each vial”.

Dose was 200 mg.

HCPCS quantity = 20 (20 X 10mg) = 200mg and the NDC quantity is 2. This is true even if the dry powder was reconstituted to 20 ml.

Enter: N457894003001 UN2 on the CMS-1500.

**Paper Billing Instructions**

All institutional (UB04/837I) and professional (CMS-1500/837P) claims must include the following information:

- NDC and unit of measurement for the drug billed;
- HCPCS/CPT code and units of service for the drug billed; and
- The actual metric decimal quantity administered.

**UB04 Claim Form**

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above).
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

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- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

<table>
<thead>
<tr>
<th></th>
<th>42. REV. CD.</th>
<th>43. DESCRIPTION</th>
<th>44. HCPCS/RATES</th>
<th>46. SERV. UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0250</td>
<td>N400074115278 ML10</td>
<td>J1642</td>
<td>2.00</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CMS-1500 Claim Form**

To report the NDC on the CMS-1500 claim form, enter the following information:

- In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of 4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

**Example of CMS 1500 Paper Claims**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Date(S) OF Service</td>
<td>From MM DD YY To MM DD YY</td>
<td>Place of Service</td>
<td>EMG</td>
<td>PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
</tr>
<tr>
<td>N400074115278 ML10</td>
<td>07 01 12</td>
<td>07 01 12</td>
<td>J1642</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Submission of multiple NDCs per HCPCS is not allowed.
Electronic Billing Instructions

837 Claims Submission for NDC:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Segment</th>
<th>Field Name</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2410</td>
<td>LIN02</td>
<td>Prod/Serv ID Qualifier</td>
<td>A value of “N4” is expected.</td>
</tr>
<tr>
<td>2410</td>
<td>LIN03</td>
<td>Prod/Service ID</td>
<td>An 11-digit NDC number is expected and will be mapped to the CPDNDC Prod/Service ID</td>
</tr>
<tr>
<td>2410/2400</td>
<td>CTP04/ SV104</td>
<td>Quantity</td>
<td>The quantity is expected and will be mapped to CPDNDC quantity. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP04; otherwise map SV104.</td>
</tr>
<tr>
<td>2410/2400</td>
<td>CTP05/ SV103</td>
<td>Composite Unit of Measure</td>
<td>The composite unit of measure is expected and will be mapped to CPDNDC composite unit of measure. If the unit price on segment CTP03 is different than the unit price on the SV203, then map CTP04; otherwise map SV103.</td>
</tr>
</tbody>
</table>

Note: Submission of multiple NDCs per HCPCS is not allowed.

Remittance Advice if NDC is Submitted Incorrectly
If the NDC billing information is missing or invalid, claims may fail. The claim will need to be resubmitted with the required NDC information and/or correct number of units within the time allowed for potential payment.

For Your Information: Vendor software submitters please check with your vendor to ensure your software will be able to capture the criteria necessary to submit the 837 with the required NDC information.

Please Note: Effective for dates of service September 1, 2013 and after, claims lines billed with an inappropriate NDC or no NDC when required will result in a denial from Mercy Care.
CHAPTER 2 – PROFESSIONAL CLAIM TYPES BY SPECIALTY

2.0 – Laboratory
Sonora Quest Laboratories, a subsidiary of Laboratory Sciences of Arizona, is Mercy Care’s only provider of laboratory services for all of our Acute, DDD, Mercy Care Plan Long Term Care (MCPLTC), and Mercy Care Advantage (MCA) membership as of October 1, 2011. If your practice location does not presently have a relationship with Sonora Quest Laboratories, please contact their Sales Support Department at 602-685-5285. Sonora Quest Laboratories will work closely with your practice to assure a smooth transition takes place. Please feel free to contact Sonora Quest’s website at http://www.sonoraquest.com/ to access current laboratory locations.

Additional requirements for labs are as follows:
- ALL genetic testing requests must be authorized in advance. The prior authorization staff will direct you to the appropriate laboratory service provider for the test that you are requesting.
- Please DO NOT send any Mercy Care members or lab specimens drawn in the office to a hospital reference laboratory for services. All laboratory testing can be provided by Sonora Quest Laboratories.
- Since Sonora Quest is Mercy Care Plan’s preferred lab, we only allow the following lab services to be reimbursed in the physician office setting:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81002</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, non-automated, without microscopy</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin; by copper sulfate method, non-automated</td>
</tr>
<tr>
<td>83036 QW</td>
<td>Hemoglobin; glycosylated (A1C)</td>
</tr>
<tr>
<td>83037 QW</td>
<td>Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use</td>
</tr>
<tr>
<td>83655</td>
<td>Lead</td>
</tr>
<tr>
<td>83861 QW</td>
<td>Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun microhematocrit</td>
</tr>
<tr>
<td>85014 QW</td>
<td>Blood count; hematocrit (Hct)</td>
</tr>
</tbody>
</table>
2.2 - Influenza Guidelines

Mercy Care Plan would like to provide you with the latest information regarding influenza vaccine coding for the 2016-2017 flu season.

You can help your patients reduce their risk for contracting seasonal flu and serious complications by using every office visit or encounter as an opportunity to recommend they take advantage of Mercy Care Plan’s coverage of the annual flu shot.

The CPT codes providers should use when billing for the influenza vaccine are listed as follows. Please keep in mind that billable codes can differentiate by Mercy Care Plan versus Mercy Care Advantage based on AHCCCS or CMS rules:

**Mercy Care and Mercy Care Plan Long Term Care Plans**

- **90630** - Influenza virus vaccine, quadrivalent, split virus, preservative free, for intradermal use
- **90653** - Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- **90655** - Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- **90656** - Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
- **90657** - Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
- **90658** - Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years and older, for intramuscular use
- **90660** - Influenza virus vaccine, trivalent, live, for intranasal use
- **90662** - Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- **90672** - Influenza virus vaccine, quadrivalent, live, for intranasal use
- **90673** - Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemaggl
90685 - Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686 - Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90687 - Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90688 - Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
Q2034 - Influenza virus vaccine, split virus, for intramuscular use (Agriflu)

Administration Codes
90460 - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461 - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
90471 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473 - Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474 - Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
G0008 – Administration of influenza virus vaccine (Not to be used for VFC Claims)

Mercy Care Advantage
90630 - Influenza virus vaccine, quadrivalent, split virus, preservative free, for intradermal use
90653 - Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
90654 - Influenza virus vaccine, trivalent, split virus, preservative-free, for intramuscular use
90655 - Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656 - Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657 - Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

Influenza virus vaccine, quadrivalent, live, for intranasal use

Influenza virus vaccine, trivalent, derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

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

Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use

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

Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use

Q2035 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)

Q2036 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)

Q2037 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)

Q2038 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)

Q2039 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

Administration Code

G0008 – Administration of influenza virus vaccine

IMPORTANT NOTE: If the flu vaccine is given as part of the Vaccine for Children’s Program, an SL modifier must be appended to the vaccine code. In addition, administration codes should be billed with 90460-90461 or 90471-90474 codes, not G0008.

For additional information concerning influenza vaccines, please feel free to refer to the MLN Matters article on the CMS website titled 2016-2017 Influenza (Flu) Resources for Health Care Professionals.

Arizona Vaccine News is also available from the Arizona Department of Health Services (ADHS).

Other influenza reference materials are available on Mercy Care’s web page under Influenza Updates under News and Events for your review.
Mercy Care and Mercy Care Advantage members have been informed there are several ways they can get their flu shot:

- Visit their PCP.
- Visit a participating pharmacy that offers the flu vaccine, i.e., CVS, Walgreens, Walmart, etc.
- Visit an urgent care facility.
- If the member resides in a Skilled Nursing Facility, the flu shot will be provided directly to them.
- Or call their case manager.

### 2.2 – Synagis Guidelines

Respiratory syncytial virus (RSV) season typically begins on November 1st of each year and continues through March of the following year. Synagis (palivizumab) injections to prevent RSV are coordinated and administered by Los Ninos Synagis Clinic for Mercy Care Plan and submitted with CPT Code **90378 - Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each.**

Mercy Care’s Medical Management department provides guidelines to providers regarding requests for Synagis. Please refer to our provider notification titled, *Synagis® - Information for 2016 - 2017.* The authorization request form titled, *MCP Synagis™ (palivizumab) Authorization Form 2016-2017 Season* is also available for any members who require Synagis.

### 2.3 – Anesthesia

Anesthesia claims are billed on a 1500 (02-12) form and must include the start and stop time for anesthesia administration, with the total time indicated in the units’ field.

**Anesthesia Services Provided in a Physician’s Office**

All services provided by a non-participating provider require prior authorization from Mercy Care. This includes anesthesia services provided in an office by a non-participating anesthesiologist. While the office where services are rendered may be a participating provider, the non-participating anesthesiologist providing anesthesia services requires prior authorization.

**Anesthesia Services Provided in an Inpatient or Outpatient Facility**

Anesthesia services are included under the authorization for an inpatient facility or outpatient facility authorization. A separate authorization is not required. If a surgical procedure requiring authorization is not authorized, services will be denied for anesthesia as well.

### 2.4 – Radiology

Effective November 1, 2014, eviCore healthcare 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

Please refer to Mercy Care’s Participating Provider Authorization Requirement Search Tool (ProPat) available in MercyOneSource for the ability to review which services require authorization and which do not. You must have a MercyOneSource login to access this tool.

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 eviCore healthcare, please submit your request online, by phone or by fax to:

- Log onto the [eviCore healthcare Online Web Portal](#).
- Call eviCore healthcare at 888-693-3211.
- Fax an [eviCore healthcare Request Form](#) (available online at the eviCore healthcare 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 eviCore healthcare’s toll-free number for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

eviCore healthcare recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. eviCore healthcare 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 eviCore healthcare for review and authorization prior to claim submission. If not done, this could result in claim denials.

### 2.5 - Obstetrical Billing

**Referrals**
As outlined in the Provider Manual, a woman may self-refer to an OB/GYN for obstetrical care and serves as the member’s PCP while pregnant. A member may also self-refer for gynecological services as well.

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

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

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:
- Coordinate the member’s 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 – once 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.

Prior Period Coverage (PPC)
Mercy Care is responsible for reimbursing providers for covered services rendered to recipients during the Prior Period Coverage (PPC) time frame. The PPC is the period between the recipients starting date of AHCCCS eligibility and the date of enrollment with a contractor. If the Total OB Package falls within the prior period coverage timeframe, then it is applicable to the Total OB Package reimbursement rules.

Payment of TOB Package
Mercy Care will reimburse Obstetrics services on a fee for services basis, unless specifically contracted in a different manner. Billing should be in accordance with Current Procedural Terminology (CPT®) rules.

The services normally provided in uncomplicated maternity case include antepartum care, delivery and postpartum care. A TOB would normally be billed when a member sees only one OB provider group through the pregnancy and has the same insurance coverage.

A TOB initially starts after a pregnancy diagnosis has been established. Per the American Congress of Obstetricians and Gynecologists (ACOG), as an example, if a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level E/M CPT code. However, if the OB record is initiated at this visit, then the visit becomes part of the TOB package and is not billed separately. If the pregnancy has been confirmed by another physician, you would not bill a confirmation of pregnancy visit.

The confirmation of pregnancy visit is typically a minimal visit that may not involve face to face contact with the physician (for an established patient). The physician may draw blood and
prescribe prenatal vitamins during this initial visit and still report it as a separate E/M service as long as the OB record is not started.

CPT codes used for the TOB package include:

- **59400** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care*
- **59510** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*
- **59610** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery*
- **59618** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery*

**Descriptions of Service**

The following descriptions of service and inclusive services come from CPT:

- **Antepartum Care** - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

- **Delivery Services** - includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only service (CPT codes 59410, 59515, 59614, or 59622) include delivery services and all inpatient and outpatient postpartum services.

- **Medical Problems** – medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and Evaluation and Management Services section in CPT, in addition to codes for maternity care.

Medical complications of pregnancy could include:

- Cardiac problems
- Diabetes
- Hyperemesis
- Hypertension
- Neurological problems
- Premature rupture of membranes
- Pre-term labor
- Toxemia
- Other medical problems complicating labor and delivery
Surgical complications of pregnancy could include:

- Appendectomy
- Bartholin cyst
- Hernia
- Ovarian Cyst

Other medical complications, i.e., drug abuse

- **Postpartum Care Only Services (59430)** - include office or other outpatient visits following vaginal or cesarean section delivery.

**Multiple Births**

The initial delivery of the first baby will be payable at the appropriate fee for service rate and should be billed with the appropriate CPT delivery code that applies.

Subsequent delivery of each additional baby should be billed with appropriate **delivery only** code with a 51 modifier appended to each. Those CPT codes are as follows:

- **59409** – Vaginal delivery only (with or without episiotomy and/or forceps)
- **59612** – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- **59514** – Cesarean delivery only
- **59620** – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

The rate payable for each subsequent delivery will be 50% of the allowable amount for the above codes. The only exception to the above is if the provider’s contract specifically addresses a different reimbursement methodology.

**Billing for Multiple Fetal Non-Stress Tests (CPT Code 59025)**

Fetal non-stress tests can be billed with a maximum of two units per visit. AHCCCS does not allow any more than 2 separate fetal non-stress tests per day per fetus. Appropriate billing when 2 separate fetal non-stress tests are required is listed below:

- Single pregnancy – no more than 2 units per day
- Twins – no more than 4 units per day
- Triplets – no more than 6 units per day
- Etc.

CPT codes should be billed in the following manner for multiple births to alleviate services being denied as a duplicate (example provided is for twins):

1. Claim line one – **59025** – 1 or 2 (maximum) units
2. Claim line two – **59025** – 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional) – 1 or 2 (maximum) units

Or
2. Claim line one – 59025 – 1 or 2 (maximum) units
   Claim line two – 59025 – 77 (Repeat Procedure by Another Physician or Other Qualified Health Care Professional) – 1 or 2 (maximum) units

   Total maximum units for the day could be:
   - 2 units per line with a total of 4 units per day for twins
   - 3 units per line with a total of 6 units per day for triplets
   - Etc.

   **PLEASE NOTE:** Claims billing must match medical records. While AHCCCS allows a maximum of 2 units per day, if a physician only performed 1 unit per day per fetus, it must be billed in accordance with services provided by physician.

   **Broken TOB Package**
   There may be times when a transfer of care may occur from one provider to another during the course of a pregnancy. If a physician or physician group provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to a referral to another physician or physician group for delivery, this would be considered a broken TOB package. Those cases require special billing and follow CPT code guidelines as follows:
   - For 1 – 3 antepartum care visits, use appropriate E&M CPT code, i.e. 99201 - 99215.
   - For 4 – 6 antepartum care visits, use CPT code 59425 – Antepartum care only; 4-6 visits.
   - For 7 or more antepartum care visits, use CPT code 59426 – Antepartum care only; 7 or more visits.
   - Providers in group practices may not unbundle the global delivery code when a recipient receives OB services from more than one provider in the same group and delivery is performed by a provider in the same group.

   Other codes available in CPT that represent broken TOB package include:

   **Delivery Only CPT Codes that Include Postpartum Care**
   Delivery codes including postpartum care CPT codes are as follows:
   - 59410 – Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care.
   - 59515 – Cesarean delivery only; including postpartum care.
   - 59614 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care.
   - 59622 – Cesarean delivery only, following attempted vaginal deliver after previous cesarean delivery; including postpartum care

   **Delivery Only CPT Codes**
   The following CPT codes will be billed, if provider is only billing for delivery services:
• **59409** – Vaginal delivery only (with or without episiotomy and/or forceps).
• **59514** – Cesarean delivery only.
• **59612** – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).
• **59620** – Cesarean delivery only following attempted vaginal delivery after previous cesarean delivery.
**Postpartum Care Only CPT Code**

A provider billing for postpartum care only should bill code **59430** – *Postpartum care only (separate procedure).*

If the provider only billed a portion of the global routine obstetric care, the service is reported with codes that describe that portion of the service as delivery only or postpartum care only, based on the delivery method.

Authorization is no longer required for the TOB package.

Please refer to Mercy Care’s secure web portal, [MercyOneSource](#), under *Mercy Care PA Search Tool* for additional prior authorization guidelines for each plan.

**Appropriate Claim Billing Examples**

A change was made to AHCCCS Medical Policy Manual under Chapter 400 under the section titled Maternity Care Provider Requirements that requires a change in how providers bill their services on a claim. The change states:

> “3. All maternity care providers will ensure that:
>  
>  f. All prenatal and postpartum visits are recorded on claims forms to the Contractor regardless of the payment methodology used.”

Based on this, Mercy Care will require that you bill in the following manner:
**Example 1: TOB Package Claims**

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies</th>
<th>$ Charges</th>
<th>Days or Units</th>
</tr>
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</table>

All pre- and post-natal care information is necessary in order for Mercy Care to report these required statistics to AHCCCS. No dollar amount is billed for the pre- and post-natal dates, as payment is included in the delivery. Only the delivery CPT code would have a billed amount.

**Please Note:** Mercy Care will pay obstetrical claims upon receipt of claim after delivery and will not postpone payment for inclusion of the postpartum visit. Postpartum services must be provided to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.
**Example 2: Broken OB Package Claims**

*Initial Provider* – Services provided for greater than 7 visits for antepartum care.

<table>
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<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies</th>
<th>$ Charges</th>
<th>Days or Units</th>
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</table>

*Second Provider* – Patient was out of town and a different doctor not in the same practice delivered the baby and is providing postpartum care.

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies</th>
<th>$ Charges</th>
<th>Days or Units</th>
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</tbody>
</table>

All pre- and post-natal care information is necessary in order for Mercy Care to report these required statistics to AHCCCS. No dollar amount is billed for the pre- and post-natal dates, as
payment is included in the specific CPT code. Only the CPT code for the type of OB package being billed would have a billed amount.

In every broken OB package type, both post-and pre-natal care information needs to be billed in the same manner as the above examples.

Please Note: Mercy Care will pay obstetrical claims upon receipt of claim after delivery and will not postpone payment for inclusion of the postpartum visit. Postpartum services must be provided to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.

Important Note: When billing via a paper claim, the total amount of the claim should be listed on the last page, along with the service that generates payment.

Maternal/Fetal – High Risk Pregnancy

A member may be referred to a maternal/fetal specialist at any time either due to a high risk pregnancy or as a high risk medical complication of pregnancy develops. All services provided by a maternal/fetal specialist are paid on a fee for service basis outside of the TOB.

2.6 – Physical, Occupational and Speech Therapy

Physical Therapy

Physical therapy (PT) is a covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function. Services must be medically necessary PT services and are covered for members in an inpatient or outpatient setting, when services are ordered by the member’s PCP/Attending physician as follows:

Inpatient

Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility) for both Mercy Care Plan and Mercy Care Advantage.

Outpatient

- Outpatient PT services are covered for EPSDT and KidsCare members when medically necessary.
- Outpatient PT services are covered for adult members, 21 years of age and older for Mercy Care Plan, Mercy Care Plan Long Term Care and Mercy Care Advantage:
  - For Mercy Care Plan and Mercy Care Plan Long Term Care - In accordance with a recent AHCCCS benefit change notification, effective with dates of service March 1, 2014 and forward, Mercy Care will add a new outpatient physical therapy benefit for adult members 21 years of age or older. This new benefit will cover 15 additional outpatient physical therapy visits when they are needed to keep a level of function or help get to a level of function. Prior to this, all AHCCCS adult members received up to 15 outpatient physical therapy visits to restore a level of function, but no
additional visits to keep or get to a level of function. The benefit will renew at the start of the new benefit year.

- For Mercy Care Advantage, outpatient claims are subject to Medicare cost sharing and are applied to the maximum out of pocket limit.
- A visit is considered to be PT services received in one day. Outpatient settings include, but are not limited to: physical therapy clinics, outpatient hospitals units, FQHCs, and physicians’ offices. Nursing facilities, nursing homes and custodial care facilities are excluded from the visit limitations. PT services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners or a Physical Therapy Assistant (under the supervision of the Physical Therapist), certified by the Arizona Physical Therapy Board of Examiners. Physical therapists who provide services to members outside the State of Arizona must meet the applicable State and/or Federal requirements.
- Outpatient physical therapy is not covered as a maintenance regimen.
- Authorized treatment services include, but are not limited to:
  - The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member’s treatment;
  - The administration, evaluation and modification of treatment methodologies and instruction; and
  - The provision of instruction or education, consultation and other advisory services.

**Occupational Therapy**

Occupational therapy (OT) services are medically ordered treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury. OT is intended to improve the member’s ability to perform those tasks required for independent functioning. OT services must be medically necessary and are covered for members in an inpatient or outpatient setting, when services are ordered by the member’s PCP/attending physician as follows:

- Medically necessary OT service are covered when provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member’s PCP/attending physician. Inpatient OT consists of evaluation and therapy.
- Outpatient OT services are covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, KidsCare members and MCPLTC members. Adult acute members are not covered.
- For Mercy Care Advantage, outpatient claims are subject to Medicare cost sharing and are applied to the maximum out of pocket limit.
- OT services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of
Occupational Therapy: Occupational therapists who provide services to members outside the State of Arizona must meet the applicable State and/or Federal requirements.

- Therapy services may include, but are not limited to:
  - Cognitive training
  - Exercise modalities
  - Hand dexterity
  - Hydrotherapy
  - Joint protection
  - Manual exercise
  - Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
  - Perceptual motor testing and training
  - Reality orientation
  - Restoration of activities of daily living
  - Sensory reeducation, and
  - Work simplification and/or energy conservation.

Speech Therapy:

Speech therapy is the medically ordered provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

- Mercy Care covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members.
- Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and MCPLTC members. Adult acute members are not covered.
- For Mercy Care Advantage, outpatient claims are subject to Medicare cost sharing and are applied to the maximum out of pocket limit.
- Speech-language pathologists providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.
- ST may be provided by the following professionals within their scope of practice:
  - A qualified speech-language pathologist (SLP) licensed by the Arizona Department of Health Services (ADHS); or
  - A speech-language pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified speech-language pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed at that time; or
  - A qualified SPL assistant (under the supervision of the speech-language pathologist) licensed by the Arizona Department of Health Services. The SLPA
must be identified as the treating provider and bill for services under his or her individual NPI number (a group ID number may be utilized to direct payment).

- Speech therapy by qualified professionals may include the list below. It is incumbent upon each professional to assure they are acting within the scope of their license. SLPAs may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.
  - Articulation training
  - Auditory training
  - Cognitive training
  - Esophageal speech training
  - Fluency training
  - Language treatment
  - Lip reading
  - Non-oral language training
  - Oral-motor development, and
  - Swallowing training.

### 2.7 – Home Health Claims

Mercy Care covers medically necessary home health services provided in the recipient's place of residence in lieu of hospitalization. Mercy Care also covers home health services for elderly and physically disabled and developmentally disabled Mercy Care Plan Long Term Care (MCPLTC) recipients under Home and Community Based Services.

Covered services include:
- Home health nursing visits
- Home health aide services
- Medically necessary supplies
- Therapy services within certain limits

Home health nursing and home health aide services must be provided on an intermittent basis and ordered by a physician.

Outpatient speech and occupational therapy services are covered for EPSDT and MCPLTC recipients only. It is also covered under Mercy Care Advantage. For additional information please refer to the section **2.6 – Physical, Occupational and Speech Therapy** in this manual.

**Billing for Services**

All home health services require prior authorization from Mercy Care or the Mercy Care Plan Long Term Care’s case manager.

All home health agencies must bill for services on a CMS 1500 claim form.
**Home health nursing services**
Home health nursing services must be billed with the following codes:
- **S9123** - Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)
- **S9124** - Nursing care, in the home; by licensed practical nurse, per hour

**Private duty nursing services (RN or LPN)**
Private duty nursing services (RN or LPN) for ventilator dependent individuals at home who require more care than is defined as part-time or intermittent must be billed as follows:

Registered nurse (RN) services must be billed with the following code and modifier:
- **S9123** billed with **TG** modifier – Nursing care, in the home; by registered nurse, per hour (complex/high level of care)

Licensed Practical Nurse (LPN) services must be billed with the following code and modifier:
- **S9124** billed with **TG** modifier – Nursing care, in the home; by licensed practical nurse, per hour (complex/high level of care)

**Respiratory therapy services**
Respiratory therapists must bill with the following code:
- **S5180** - Home health respiratory therapy, initial evaluation

Respiratory therapists may not use the ventilator management codes 94002 – 94005 CPT codes. Physicians and hospitals will continue to use CPT codes 94002 - 94005.

**Mercy Care Advantage Claims**
Claims submitted for Mercy Care Advantage are paid based on the terms of the provider’s contract for fee for service reimbursement.

For Mercy Care Advantage, participating home health agencies must bill for services on a CMS 1500 claim form, the same as Mercy Care Plan.

Non-participating home health agencies must bill in the same manner as they would Medicare.

**2.8 - Well Visits**

**Mercy Care Plan and Mercy Care Plan Long Term Care**
Mercy Care Plan and Mercy Care Plan Long Term Care covers adult well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams. These are covered for members 21 years of age and older. Most well visits include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations.
In addition, female members will have direct access to preventive and well care services from a gynecologist within Mercy Care’s network, without a referral from a primary care provider.

**Mercy Care Advantage Initial Preventive Physical Examination (IPPE)**

The Initial Preventive Physical Examination (IPPE) is also known as the “Welcome to Medicare Preventive Visit.” The goals of the IPPE are health promotion and disease prevention and detection. Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary’s first Medicare Part B coverage period. This service must be billed with CPT code:

**G0402** - *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*

For additional information regarding the IPPE, please click on the following link from CMS:


**Mercy Care Advantage Annual Wellness Visit (AWV)**

Per CMS guidelines for the Annual Wellness Visit (AWV): *When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury or to improve the functioning of a malformed body member.*

Below are the appropriate CPT billing codes for the Annual Wellness Exams:

**G0438** - *Annual Wellness Visit including a personalized prevention plan of service (initial visit)*

**G0439** - *Annual wellness visit including a personalized prevention plan of service (subsequent visit)*

The following links will take you to the CMS MLN Network and documents that further explain all components of the AWV and the IPPE:


### 2.9 – Hospice

**Mercy Care Plan and Mercy Care Plan Long Term Care**

Hospice services provide palliative and supportive care for all terminally ill members, as well as their families or caregivers. A physician must certify that the member is terminally ill. Hospice
care is limited to those members who are in the final stages of a terminal illness (i.e., members who have a prognosis of death within six months).

The initial physician certification is effective for 90 days. If the member continues to need services, the physician must re-certify for a second 90-day period. Subsequent re-certifications for 60-day periods are required if the member continues to require hospice services.

A hospice uses a medically directed interdisciplinary care team of professionals and volunteers to meet the physical, psychological, social, spiritual, and other special needs which are experienced during the final stages of illness, during dying, and bereavement.

Hospice services include:
- Nursing services
- Respite care
- Bereavement services
- On-call availability for reassurance
- Information and referral for members and families
- Social services
- Pastoral/counseling services
- Dietary services
- Homemaker services
- Home health aide services
- Therapies
- Medical supplies, appliances, and DME
- Pharmaceuticals

Hospice services may be provided in the member's home (a nursing facility can be considered a member's home) or in an inpatient setting.

Home care may be provided on an intermittent, regularly scheduled, and/or an on-call, around-the-clock basis according to member and family needs.

Non-institutional hospice services may be provided in the member's home as long as the member's condition remains stable enough for the member to remain at home.

**Billing and Authorization Requirements**
Hospice services require authorization for all lines of business.

Hospice providers must bill for services on the UB-92 claim form using bill types 081X - 082X. The last digit must be 1 through 4 or 6 through 8.
Payment is made to a hospice provider for only one of four revenue codes. Mercy Care’s reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication, and other health care services (physician) related to the recipient's terminal illness.

Recipients requiring medical services not related to the terminal illness may receive them without having payment for these services included in the all-inclusive rate. Acute medical care services in this instance are non-inpatient services provided to ALTCS eligible recipients who are not covered by Medicare. Acute medical care services must be coordinated between the primary care physician and the case manager.

The following revenue codes may be billed to Mercy Care. (NOTE: Medicare claims with A, B, C, or D in the third digit cannot be processed. They refer only to the Notice of Election for Medicare.)

Revenue Code 651 (Routine Home Care Day)
- A routine home care day is a day during which a recipient is at home (or in a nursing facility) and not receiving continuous care.
- Reimbursement is the lesser of the hourly rate multiplied by the hours billed or the per diem rate.
- When hospice care is furnished to a fee-for-service recipient in a nursing facility, the hospice should bill only for the routine home care rate.
- The nursing facility is reimbursed directly by Mercy Care for the room and board and other services furnished by the facility.

Revenue Code 652 (Continuous Home Care Day)
- A continuous home care day is a day during which a recipient receives services consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis as necessary to maintain terminally ill recipients at their places of residence. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
- Home health aide, homemaker services, or both may also be provided on a continuous basis.
- Continuous home care is not available to nursing facility residents.
- Reimbursement is the lesser of the billed charge or the Mercy Care hourly rate multiplied by the number of hours billed.

Revenue Code 655 (Inpatient Respite Care Day)
- An inpatient respite care day is a day during which a recipient receives care in an approved facility on a short-term basis. Institutional (inpatient hospice) services may be delivered at the provider’s site or through subcontracted beds in an institutional setting.
such as a hospital or nursing facility when the recipient's condition is such that care can no longer be rendered in the recipient's home.

- The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
- For the date of discharge, the appropriate home care rate is paid.
- If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
- Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

Revenue Code 656 (General Inpatient Care Day)

- A general inpatient care day is a day on which a recipient receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings.
- The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
- For the date of discharge, the appropriate home care rate is paid.
- If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.

**Mercy Care Advantage**

According to the Medicare Managed Care Manual, published by CMS, under **Chapter 4 – Benefits and Beneficiary Protections**, it states the following:

“10.2.1 – Exceptions to Requirement for MA plans to Cover FFS Benefits
(Rev. 115, Issued: 08-23-13, Effective: 08-23-13, Implementation: 08-23-13)

The following circumstances are exceptions to the rule that MAOs must cover the costs of Original Medicare benefits:

**Hospice:** Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. For detailed information about services furnished to an enrollee who has elected hospice care, see section 10.4 below.

10.4 - Hospice Coverage
(Rev. 115, Issued: 08-23-13, Effective: 08-23-13, Implementation: 08-23-13)

As defined in 42 CFR § 422.320, an MAO must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare hospice program is located within the plan's service area; or (2) it is common practice to refer patients to hospice programs outside the organization’s service area.

An MA enrollee who elects hospice care but chooses not to dis-enroll from the plan is entitled to continue to receive through the MA plan any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for
hospice care furnished to the enrollee and the MAO, providers, and suppliers for other Medicare-covered services furnished to the enrollee.

Table I summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>Enrollee Coverage</th>
<th>Enrollee Cost-Sharing</th>
<th>Payments to Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice program</td>
<td>Hospice program</td>
<td>Original Medicare cost-sharing</td>
<td>Original Medicare</td>
</tr>
<tr>
<td>Non-hospice(^1), Parts A &amp; B</td>
<td>MA plan or Original Medicare</td>
<td>MA plan cost-sharing, if enrollee follows MA plan rules(^3)</td>
<td>Original Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Original Medicare cost-sharing, if enrollee does not follow MA plan rules(^3)</td>
<td>Original Medicare</td>
</tr>
<tr>
<td>Non-hospice(^1), Part D Supplemental</td>
<td>MA plan (if applicable)</td>
<td>MA plan cost-sharing</td>
<td>MAO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MA plan cost-sharing</td>
<td>MAO</td>
</tr>
</tbody>
</table>

Notes:
1) The term ‘hospice care’ refers to Original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term ‘non-hospice care’ refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

2) If the enrollee chooses to go to Original Medicare for non-hospice, Original Medicare services, and also follows plan requirements, then, as indicated, the enrollee pays plan cost-sharing and Original Medicare pays the provider. The MA plan must pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable.

3) Note: An HMO enrollee who chose to receive services out of network has not followed plan rules and therefore pays FFS cost sharing; a PPO enrollee who receives services out of network has followed plan rules and is only responsible for plan cost sharing. The enrollee need not communicate to the plan in advance his/her choice of where services are obtained.

Please see the following resources for additional information:
• The Social Security Act, Section 1853(h)(2)(B); and
• The Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims, Section 30.4”

The only claims payable during the hospice election period by MCA would be additional benefits covered under MCA that would not normally be covered under traditional Medicare-
covered services. Please refer to the MCA website under MCA Additional Benefits for a listing of these additional benefits.

Per CMS guidelines, MCA is not responsible for a hospice member’s claims while receiving a reduced CMS capitation payment, which may include dates after a member has revoked their hospice election. This following information is found in the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance:

“20.2 – Election, Revocation, and Change of Hospice
(Rev. 141, Issue: 03-02-11, Effective: 01-01-11, Implementation: 03-23-11)
Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked. As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries.”

While a hospice election is in effect, all Medicare Part A and B services furnished from the election’s effective date to revocation or expiration of the enrollee’s hospice election should be submitted directly to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, until the first day of the month following the month in which hospice was revoked.

CMS provides notification of hospice election through eligibility files sent to MCA. In certain cases, MCA may be notified of a retro-election of hospice coverage by CMS, which may require recoupment of claims originally paid by MCA that should have been paid by a fee-for-service contractor of CMS. Recoupments will only be made within 365 days (1 year) from the date the claim is received by MCA or eligibility posting deadline, whichever is later. The claim should then be submitted to the appropriate CMS fee-for-service contractor for consideration.

2.10 – Transportation Claims

Mercy Care follows regulatory guidelines for billing transportation claims. Please refer to AHCCCS Fee For Service Manual - Chapter 14 – Transportation or the Medicare Claims Processing Manual – Chapter 15 - Ambulance for additional detail.
Mercy Care Plan and Mercy Care Plan Long Term Care

- Emergency Transportation
  - All members are covered for emergency transportation without prior authorization.

- Non-Emergency Transportation
  - MCP members are eligible to receive medically necessary non-emergency transportation when there is no other means of transportation available. Transportation services include bus tickets, taxis, stretcher vans or wheelchair vans and non-emergency ambulances.
  - Providers may arrange medically necessary non-emergent transportation for MCP members by calling Member Services at 602-263-3000 or 800-624-3879, Express Service Code 630.

Mercy Care Advantage

- Emergency Transportation
  - All members are covered for emergency transportation without prior authorization.
  - MCA enrollees are not eligible for non-routine, non-medically necessary transportation, as it is not a Medicare covered benefit. MCA enrollees with either MCPLTC or MCP Acute are eligible for non-emergency transportation under their MCPLTC coverage. This benefit will be paid under MCPLTC/MCP Acute as the primary payer.

2.11 – Dental Claims

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

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

MCP will administer the following for our members:

- Grievances or Appeals
- Customer Service Calls from Members

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
P.O. Box 2906
Milwaukee, WI  53201-2906

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

- Change Healthcare (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 payor and claim mailing address on your electronic claims. 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 Payor 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.

2.12 – Oral Surgery Claims
Oral surgery claims are considered medical in nature and need to be submitted to Mercy Care Plan or Mercy Care Advantage for claims processing. The claim should be submitted on a CMS 1500 (02/12) Form.

2.13 - Behavioral Health Claims

General Information
Effective October 1, 2015, acute members with Medicare Prime plans or Mercy Care Advantage as their primary payor will be realigned for General Mental Health/Substance Abuse (GMH/SA) benefits from their Regional Behavioral Health Authority (RBHA) to Mercy Care Plan. Prior to October 1, 2015, this coverage was facilitated by the RBHA (Mercy Maricopa Integrated Care in Maricopa county and CPSA in Pima county).

Please refer to Chapter 7 of the Mercy Care Plan Provider Manual which provides detailed information regarding all aspects of Behavioral Health.
Members with Acute Care – Non-Medicare Primary Plans or DDD Programs

Comprehensive mental health and substance abuse (behavioral health) services are available to MCP members. If a member is enrolled in MCP’s Acute Care or DDD programs and the member does not have a Medicare Prime plan or Mercy Care Advantage as their primary payor, the Regional Behavioral Health Authority (RBHA) delivers behavioral health (mental health and substance abuse) services for these members.

Additionally, behavioral health services in the prior period are also the responsibility of the RBHA.

For more information related to the AHCCCS Behavioral Health Program, please review the AHCCCS Behavioral Health Services Guide.

Behavioral Health Emergency Services

When a member is part of the RBHA and they present in an emergency room setting, MCP is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. In addition, MCP is responsible to ensure the member does not run out of medication prior to the member’s initial first appointment with RBHA. ADHS/RBHA is responsible for medically necessary psychiatric consultations in emergency room settings or inpatient settings. The RBHA is also responsible for reimbursement of both the inpatient facility services and the professional behavioral health services for hospitalized members with primary behavioral health diagnoses unrelated to the bed or floor where the member is placed.

MCP is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member. The RBHA is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member who requires behavioral services after medical stabilization.

Reimbursement for court ordered screening and evaluation services is not the responsibility of MCP and is instead the responsibility of the county pursuant to A.R.S. 36-545.

Plan Determination – Claim with Behavioral Health and Physical Health Diagnoses

When determining financial responsibility for a claim that contains both behavioral health diagnoses and medical diagnoses, Mercy Care Plan, in accordance with AHCCCS guidelines, determines financial responsibility by the primary diagnosis that appears on a claim. This is defined as the principal diagnosis on a UB-04 claim from a facility or the first-listed diagnosis on a 1500 (02/12) claim from a physician. A listing of principal behavioral health diagnoses is available in the Covered Behavioral Health Services Guide under Appendix B-3 – Encounter/Claims Principal Behavioral Health ICD-9 Diagnostic Codes.

There may be times where a facility or physician claim may have a combination of both medical and behavioral health services listed on the claim. Mercy Care’s determination of plan responsibility when the claim is initially submitted is as follows:
• If the primary diagnosis listed is a medical diagnosis, the financial responsibility to process the claim would be Mercy Care Plan or Mercy Care Plan Long Term Care.
• If the primary diagnosis listed is a behavioral health diagnosis and the Acute or Long Term Care member has a Medicare Prime plan or Mercy Care Advantage, the financial responsibility to process the claim would be Mercy Care Plan or Mercy Care Plan Long Term Care.
• If the primary diagnosis listed is a behavioral health diagnosis and the member does not have a Medicare Prime plan or Mercy Care Advantage, the financial responsibility to process the claim would be the Regional Behavioral Health Authority’s (RBHA).

**Medication Management**
PCPs may provide medication management (prescription of behavioral health medications, monitoring visits, associated laboratory tests) for MCP acute care and DDD members with attention deficit hyperactivity disorder (ADHD), anxiety, or depression. PCPs that provide treatment and medication management for these diagnoses must follow Clinical Guidelines adopted by MCP for those conditions. The guidelines are kept current and are available on the MCP website. MCP’s behavioral health coordinators and behavioral health medical director are available for consultation regarding the guidelines.

- MCP covers prescriptions of these four behavioral health conditions when on the Preferred Drug List. Prior authorization is required for medications not on the preferred drug list.
- Prescriptions can be filled at any contracted MCP pharmacy.

Any member who has a behavioral health condition other than the four disorders listed above, will be covered through the RBHA for medication management and treatment.

The following ICD-10 codes cover the diagnoses that may be treated by a PCP through treatment and medication management:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.30</td>
<td>Mood disorder due to known physiological condition, unspecified</td>
</tr>
<tr>
<td>F06.31</td>
<td>Mood disorder due to known physiological condition with depressive features</td>
</tr>
<tr>
<td>F06.32</td>
<td>Mood disorder due to known physiological condition with major depressive-like episode</td>
</tr>
<tr>
<td>F06.34</td>
<td>Mood disorder due to known physiological condition with mixed features</td>
</tr>
<tr>
<td>F06.4</td>
<td>Anxiety disorder due to known physiological condition</td>
</tr>
<tr>
<td>F17.200</td>
<td>Nicotine dependence, unspecified, uncomplicated</td>
</tr>
<tr>
<td>F17.201</td>
<td>Nicotine dependence, unspecified, in remission</td>
</tr>
<tr>
<td>F17.203</td>
<td>Nicotine dependence, unspecified, with withdrawal</td>
</tr>
<tr>
<td>F17.208</td>
<td>Nicotine dependence, unspecified, with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.209</td>
<td>Nicotine dependence, unspecified, with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F17.210</td>
<td>Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
<tr>
<td>F17.211</td>
<td>Nicotine dependence, cigarettes, in remission</td>
</tr>
<tr>
<td>F17.213</td>
<td>Nicotine dependence, cigarettes, with withdrawal</td>
</tr>
<tr>
<td>F17.218</td>
<td>Nicotine dependence, cigarettes, with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.219</td>
<td>Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.220</td>
<td>Nicotine dependence, chewing tobacco, uncomplicated</td>
</tr>
<tr>
<td>F17.221</td>
<td>Nicotine dependence, chewing tobacco, in remission</td>
</tr>
<tr>
<td>F17.223</td>
<td>Nicotine dependence, chewing tobacco, with withdrawal</td>
</tr>
<tr>
<td>F17.228</td>
<td>Nicotine dependence, chewing tobacco, with other nicotine-induced disorders</td>
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<tr>
<td>F17.229</td>
<td>Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.290</td>
<td>Nicotine dependence, other tobacco product, uncomplicated</td>
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<tr>
<td>F17.291</td>
<td>Nicotine dependence, other tobacco product, in remission</td>
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<tr>
<td>F17.293</td>
<td>Nicotine dependence, other tobacco product, with withdrawal</td>
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<td>F17.298</td>
<td>Nicotine dependence, other tobacco product, with other nicotine-induced disorders</td>
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<td>F17.299</td>
<td>Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders</td>
</tr>
<tr>
<td>F32.0</td>
<td>Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td>F32.1</td>
<td>Major depressive disorder, single episode, moderate</td>
</tr>
<tr>
<td>F32.2</td>
<td>Major depressive disorder, single episode, severe without psychotic features</td>
</tr>
<tr>
<td>F32.4</td>
<td>Major depressive disorder, single episode, in partial remission</td>
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<tr>
<td>F32.5</td>
<td>Major depressive disorder, single episode, in full remission</td>
</tr>
<tr>
<td>F32.8</td>
<td>Other depressive episodes</td>
</tr>
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<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
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<td>Major depressive disorder, recurrent, mild</td>
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<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
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<tr>
<td>F33.2</td>
<td>Major depressive disorder, recurrent, severe without psychotic features</td>
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<tr>
<td>F33.40</td>
<td>Major depressive disorder, recurrent, in remission, unspecified</td>
</tr>
<tr>
<td>F33.41</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
</tr>
<tr>
<td>F33.42</td>
<td>Major depressive disorder, recurrent, in full remission</td>
</tr>
<tr>
<td>F33.8</td>
<td>Other recurrent depressive disorders</td>
</tr>
<tr>
<td>F33.9</td>
<td>Major depressive disorder, recurrent, unspecified</td>
</tr>
<tr>
<td>F34.1</td>
<td>Dysthymic disorder</td>
</tr>
<tr>
<td>F40.00</td>
<td>Agoraphobia, unspecified</td>
</tr>
<tr>
<td>F40.01</td>
<td>Agoraphobia with panic disorder</td>
</tr>
<tr>
<td>F40.02</td>
<td>Agoraphobia without panic disorder</td>
</tr>
<tr>
<td>F40.10</td>
<td>Social phobia, unspecified</td>
</tr>
<tr>
<td>F40.11</td>
<td>Social phobia, generalized</td>
</tr>
<tr>
<td>F40.210</td>
<td>Arachnophobia</td>
</tr>
<tr>
<td>F40.218</td>
<td>Other animal type phobia</td>
</tr>
<tr>
<td>F40.220</td>
<td>Fear of thunderstorms</td>
</tr>
<tr>
<td>F40.228</td>
<td>Other natural environment type phobia</td>
</tr>
</tbody>
</table>
F40.230 Fear of blood
F40.231 Fear of injections and transfusions
F40.232 Fear of other medical care
F40.233 Fear of injury
F40.240 Claustrophobia
F40.241 Acrophobia
F40.242 Fear of bridges
F40.243 Fear of flying
F40.248 Other situational type phobia
F40.290 Androphobia
F40.291 Gynephobia
F40.298 Other specified phobia
F40.8 Other phobic anxiety disorders
F40.9 Phobic anxiety disorder, unspecified
F41.0 Panic disorder [episodic paroxysmal anxiety] without agoraphobia
F41.1 Generalized anxiety disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified
F43.0 Acute stress reaction
F48.8 Other specified nonpsychotic mental disorders
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual abilities
F73 Profound intellectual disabilities
F78 Other intellectual disabilities
F79 Unspecified intellectual disabilities
F84.0 Autistic Disorder
F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2 Attention-deficit hyperactivity disorder, combined type
F90.8 Attention-deficit hyperactivity disorder, other type
F90.9 Attention-deficit hyperactivity disorder, unspecified type
F98.0 Enuresis not due to a substance or known physiological condition
F98.1 Enuresis not due to a substance or known physiological condition

**Acute Members with Medicare Prime Plans or Mercy Care Advantage**
MCP covers behavioral health emergency services for Acute and Long Term Care members with Medicare Prime Plans or Mercy Care Advantage members. If a member is experiencing a behavioral health crisis, please contact the MCP Behavioral Health Hotline at 1-800-876-5835.

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 MCP.

Mercy Maricopa Integrated Services (MMIC) maintains eligibility for all GMHSA dual eligible members, as payment responsibility for crisis claims is MMIC’s. Crisis claims are the only exception. Everything else is paid by Medicare primary and MCP secondary.

MCP is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member.

**Authorization Requirements**
MCP requires prior authorization for outpatient behavioral health services and hospital admissions to assure medical necessity for Acute or Long Term Care members with Medicare Prime Plans or Mercy Care Advantage. 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 Mercy Care’s Prior Authorization Department for prior authorization prior to delivery of services.
- Explain to the Prior Authorization representative the type of services to be delivered, frequency of services to be delivered, and duration of services provided.

**Coordination of Benefits**
- If a member has Mercy Care Advantage as their primary payor, we will coordinate benefits automatically with Mercy Care Plan.
- If a member has Mercy Care Advantage as their primary payor and the service is something not normally covered by the plan, the claim will be paid automatically under the Mercy Care Plan.
- If a member has traditional Medicare or another Medicare Advantage plan and the service is covered by that plan, the claim will need to be sent to them primarily for payment. Once you receive the Medicare Explanation of Benefits (EOMB), submit the claim and EOMB to Mercy Care Plan to coordinate.

**2.14 - Family Planning Claims**
Family planning services are funded and contracted through Aetna Medicaid Family Planning for Mercy Care Plan. In order to pay family planning services through the Aetna Medicaid Family Planning fund, the following rules will apply:
- Any service billed with the following primary ICD-10 diagnoses will be paid as family planning:
  - Z30.011 – Encounter for initial prescription of contraceptive pills
- Z30.012 – Encounter for prescription of emergency contraception
- Z30.013 – Encounter for initial prescription of injectable contraception
- Z30.014 – Encounter for initial prescription of uterine contraception
- Z30.018 – Encounter for prescription of other contraceptives
- Z30.19 – Encounter for initial prescription of contraceptives, unspecified
- Z30.02 – Counseling and instruction in natural family planning to avoid pregnancy.
- Z30.09 – Encounter for other general counseling and advice on contraception
- Z30.40 – Encounter for surveillance of contraceptives, unspecified
- Z30.41 – Encounter for surveillance of contraceptive pills
- Z30.42 – Encounter for surveillance of injectable contraceptive
- Z30.430 – Encounter for insertion of intrauterine contraceptive device
- Z30.432 – Encounter for removal of intrauterine contraceptive device
- Z30.433 – Encounter for removal and reinsertion of intrauterine contraceptive device
- Z30.49 – Encounter for surveillance of other contraceptives
- Z30.8 – Encounter for other contraceptive management
- Z30.9 – Encounter for contraceptive management, unspecified
- Z31.42 – Aftercare following sterilization reversal
- Z31.62 – Encounter for fertility preservation counseling
- Z31.84 – Encounter for fertility preservation procedure

- Any service billed with a modifier of FP will be paid as family planning (if the modifier is valid for the code).
- The following codes will always be paid as family planning regardless of the diagnosis or presence of the FP modifier:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>00851</td>
<td>ANES; TUBAL LIGATION/TRANSECTION</td>
</tr>
<tr>
<td>11976</td>
<td>REMOVAL WITHOUT REINSERTION, IMPLANT</td>
</tr>
<tr>
<td>55250</td>
<td>VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)</td>
</tr>
<tr>
<td>57170</td>
<td>DIAPHRAGM FITTING.WITH INSTRUCTIONS</td>
</tr>
<tr>
<td>58300</td>
<td>INSERT INTRAUTERINE DEVICE</td>
</tr>
<tr>
<td>58301</td>
<td>REMOVE INTRAUTERINE DEVICE</td>
</tr>
<tr>
<td>58565</td>
<td>HYSTEROSCOPY BI TUBE OCCLUSION W/PERM IMPLNTS</td>
</tr>
<tr>
<td>58600</td>
<td>DIVISION OF FALLOPIAN TUBES</td>
</tr>
<tr>
<td>58605</td>
<td>LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR VAGINAL APPROACH, POSTPARTUM, UNILATERAL OR BILATERAL, DURING SAME HOSPITALIZATION (SEPARATE PROCEDURE)</td>
</tr>
<tr>
<td>58611</td>
<td>LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S) WHEN DONE AT THE TIME OF CESAREAN DELIVERY OR INTRA-ABDOMINAL SURGERY (NOT A SEPARATE</td>
</tr>
</tbody>
</table>

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PROCEDURE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

58615 OCCLUSION OF FALLOPIAN TUBE, DEVICE
58661 LAPAROSCOPY, SURGICAL; WITH REMOVAL OF ADNEXAL STRUCTURES
58670 LAPAROSCOPY, TUBAL CAUTERY
58671 LAPAROSCOPY, TUBAL BLOCK
59840 INDUCED ABORTION, BY DILATION AND CURETTAGE
59841 INDUCED ABORTION, BY DILATION AND EVACULATION
59850 INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS
59851 INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS WITH DILATION AND CURETTAGE AND/OR EVACUATION
59852 INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS WITH HYSTEROTOMY
59855 INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES
59856 INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES WITH DILATION AND CURETTAGE AND/OR EVACUATION
59857 INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES WITH HYSTEROTOMY
A4261 CONTRACEPTIVE SUPPLY
A4266 DIAPHRAGM FOR CONTRACEPTIVE USE
A4267 CONTRACEPTIVE SUPPLY
A4268 CONTRACEPTIVE SUPPLY
A4269 CONTRACEPTIVE SUPPLY
J1050 DEPO-PROVERA INJ 1MG
J7297 LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG, 3 YEAR DURATION
J7298 LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG, 5 YEAR DURATION
J7300 INTRAUTERINE COPPER CONTRACEPTIVE
J7301 LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (SKYLA), 13.5 MG
J7302 LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG
J7303 CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH
J7304 CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH
J7306 LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES
J7307 ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES

ALL OTHER CONTRACEPTIVE DRUGS, SUPPLIES, AND ITEMS IDENTIFIED WITH AN NDC CODE

- 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 the [CMS UB-04 Form](#).
- 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.
- 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 as family planning 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. Exceptions for medically necessary abortions are outlined in the [AHCCCS Attestation of Compliance with A.R.S. 35-196.05](#) document.

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

**CHAPTER 3 – EARLY PERIODIC SCREENING AND DEVELOPMENTAL TESTING (EPSDT)**

**3.0 – Early Periodic Screening and Developmental Testing (EPSDT) General Overview**

Providers have several responsibilities regarding Early Periodic Screening and Developmental Testing (EPSDT). These responsibilities are outlined in detail in our provider manuals. Outlined below are general claims billing requirements for EPSDT services.
3.1 – Well Child Visits

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 Codes (effective 10/1/15 and after) based on age appropriateness:

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9-CM Diagnosis Codes for Dates of Service Prior to 10/1/15</th>
<th>ICD-10-CM Diagnosis Codes for Dates of Service After 10/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381, 99382, 99391, 99392, 99461</td>
<td>V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
<td>Z00.121, Z00.129, Z00.110, Z00.111, Z02.89, Z00.8, Z00.70, Z00.71</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9-CM Diagnosis Codes for Dates of Service Prior to 10/1/15</th>
<th>ICD-10-CM Diagnosis Codes for Dates of Service After 10/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>99382, 99383, 99392, 99393</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
<td>Z00.21, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71</td>
</tr>
</tbody>
</table>

**Codes to Identify Well-Care Visits – Adolescents**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9-CM Diagnosis Codes for Dates of Service Prior to 10/1/15</th>
<th>ICD-10-CM Diagnosis Codes for Dates of Service After 10/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>99383-99385, 99393-99395</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
<td>Z00.21, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71</td>
</tr>
</tbody>
</table>
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.

3.2 – 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 appropriate CPT code and modifier – 96110-EP - is billed. Copies of the completed tools must be retained in the medical record.

3.3 – 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.
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 submit a copy of their certificate to CAQH. This certificate will be used in the credentialing process to verify completion of training necessary for reimbursement.

Please use the following CPT code for billing this service:

99188 – Application of topical fluoride varnish by a physician or other qualified health care professional.

3.4 - 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.
AHCCCS has introduced new requirements for submission of claims for vaccine administration with dates of service beginning January 1, 2013. There have been several revisions since January 1, 2013 from AHCCCS and the below reflects the most recent changes.

Mercy Care has updated our system to accommodate the new billing requirements. Providers should be billing with these codes for any services after January 1, 2013. Listed below are key updates.
Claims Coding
Effective for dates of service beginning on or after January 1, 2013, the provider must add the modifier SL (State Supplied Vaccine) to the following CPT Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administration</td>
</tr>
<tr>
<td>90461</td>
<td>Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>90471</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)</td>
</tr>
<tr>
<td>90472</td>
<td>Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>90473</td>
<td>Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)</td>
</tr>
<tr>
<td>90474</td>
<td>Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

This differs from previous instructions where the SL modifier was only added to the vaccine CPT code itself.

- **If the vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code.**
- **Do not add the SL modifier to vaccine and administration codes used to report services provided to members who are over 18 years of age or for vaccines that are not covered under the VFC program administered to children.**

If the provider individually administers more than one vaccine, the provider can bill for the administration of each vaccine, provided the additional vaccines are administered through a separate injection. The provider will not be paid for additional toxoids in the same syringe.

Providers cannot divide vaccines commonly administered in a single injection in order to report multiple administrations. When medically necessary and appropriate to administer a second injection, a second administration fee may be paid.
AHCCCS has opened the add-on code 90461 as of 1/1/13 and will pay a maximum of one unit for that code. No additional payment is made for additional toxoids in the same syringe for that code.

Under VFC, the CPT code identifying the vaccine or toxoid given should be identified with the appropriate CPT code to identify the vaccine, the SL modifier, and the charge listed as $0.00. The CPT code identifying the administration should be identified with the appropriate CPT code to identify the administration code, the SL modifier, and the charge appropriate for the administration.
CHAPTER 4 – INPATIENT CLAIMS

4.0 – Mercy Care Plan APR-DRG Pricing Information Summary

Mercy Care Plan determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems will be used to categorize each inpatient stay. Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. The DRG relative weight is a key factor in determining payment to the hospital. Exceptions to APR-DRG payments are described below and elsewhere in this document. Modifications to components of the APR-DRG pricing for certain in-state and most out-of-state hospitals are also defined later in this document.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:

- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term acute care facility
- Claims from a free-standing psychiatric facility
- Claims from an Indian Health Service facility or tribally operated 638 facility
- Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services
- Claims for administrative days only
- Claims for transplant services
- Claims in which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

Mercy Care Plan is not mandated to utilize AHCCCS’ methodology or rates except in the absence of a contract. Mercy Care Plan may enter into contracts with hospitals which specify alternative methodologies and/or rates.

Payment under DRG pricing will be comprised of a DRG base payment and a DRG outlier add-on payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price times the DRG relative weight. In addition, a few payment factors referred to as “policy adjustors” will be applied under specific scenarios to affect the DRG base payment. The DRG outlier add-on payment will be cost-based and calculated based on a fixed-loss threshold.

The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios,
• Provider specific policy adjustor
• Service specific policy adjustor – applied based on DRG assigned to the claim/encounter

All policies and numerical parameters identified in this document are applicable for initial implementation of DRG pricing on October 1, 2014. The payment policies and, in particular, the numerical pricing parameters are subject to change in future years.

4.1 - DRG Pricing Formulas
With DRG pricing, claim payment is made up of a DRG base payment and, when applicable, an outlier add-on payment. Final allowed amount is the sum of DRG base payment and the outlier add-on payment. In the pricing calculation, an unadjusted DRG base payment and an unadjusted outlier add-on payment are calculated. These values may then be adjusted based on covered days and a transitional adjustor which will be in place for the first three years of DRG pricing. A DRG pricing flow chart is listed below and details of the pricing calculation are shown in the following pages.

**DRG Pricing Flow Summary**

- Determine DRG code
- Calculate base payment = \([\text{hosp base price}] \times [\text{DRG rel wt}] \times [\text{policy adjuster(s)}]\)
- Adjust DRG base payment for acute-to-acute transfers
- Calculate outlier payment amount
- Adjust DRG base payment and outlier for covered days
- Adjust DRG base payment and outlier for DRG transition policy and DCI
- Calculate Medicaid allowed amt = [DRG base pymt] + [outlier amt]

**DRG Base Payment**
Initial DRG Base Payment will be calculated as:
Initial DRG Base Payment = \([\text{Wage Adjusted Provider DRG Base Rate}] \times [\text{Post-Health Care Acquired Condition DRG Relative Weight}] \times [\text{Provider Policy Adjustor}] \times [\text{DRG Service Policy Adjustor}]\)

The DRG Service Policy Adjustor will be determined based on the category of the DRG code found on the claim. Listed below are the DRG code categories along with the applicable DRG Service Policy Adjustor.

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65

The applicable DRG Service Policy Adjustor for claims for members under the age of 19 for which the assigned DRG codes fall outside of the categories listed above is 1.25.

If the patient discharge status code is in the following list of codes for which the DRG transfer policy applies,

02: Discharged/transferred to a short-term general hospital for inpatient care
05: Discharged/transferred to a designated cancer center or children’s hospital
66: Discharged/transferred to a critical access hospital

then the Transfer DRG Base Payment will be calculated as:

\[
\text{Transfer DRG Base Payment} = \frac{\text{Initial DRG Base Payment}}{\text{DRG National Average Length of Stay}} \times (\text{Length of Stay} + 1)
\]

**Note:** The “DRG National Average Length of Stay” means the national arithmetic mean length of stay published in version 31 of the All Patient Refined Diagnosis Related Group (APR - DRG) classification established by 3M Health Information Systems.

**Note:** The “Length of Stay” means the total number of days of an inpatient stay beginning with the date of admission through the date of transfer, but not including the date of transfer.

If the patient discharge status code is in the list of codes for which the DRG transfer policy applies, then:

\[
\text{Unadjusted DRG Base Payment} = \text{less of [Initial DRG Base Payment] and [Transfer DRG Base Payment]}
\]
Otherwise,

\[
\text{Unadjusted DRG Base Payment} = [\text{Initial DRG Base Payment}]
\]

**DRG Outlier Add-On Payment**

Not all claims will qualify for a DRG outlier add-on payment. For those that do, the DRG outlier add-on payment will be added to the DRG Base Payment to determine the final payment for the claim.

To determine if a claim will qualify for an outlier add-on payment, first the Claim Cost must be calculated. The Claim Cost will be calculated as:

\[
\text{Claim Cost} = ([\text{Claim Total Submitted Charges}] - [\text{Claim Non-Covered Charges}]) \times \text{Hospital Cost-to-Charge Ratio}
\]

The Claim Cost must then be compared to the Outlier Threshold. The Outlier Threshold is calculated as:

\[
\text{Outlier Threshold} = \text{Unadjusted DRG Base Payment} + \text{Fixed Loss Amount}
\]

The Cost-to-Charge (CCR) ratio necessary to determine the cost of the claim will vary depending on the hospital type as described below:

- For hospitals designated as type: hospital, subtype: children’s in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services (ADHS) Division of Licensing Services for March of each year, the outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1\textsuperscript{st} of that year.
- For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare IPPS by CMS.

The Fixed Loss Amount is $5,000 for Critical Access Hospitals (CAH) and $65,000 for all other providers.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG outlier add-on payment; else if the Claim Cost does not exceed the Outlier Threshold, the claim receives $0 DRG outlier add-on payment.
For claims that qualify for a DRG outlier add-on payment, the Unadjusted DRG Outlier Add-on Payment will be calculated as:

\[
\text{Unadjusted DRG Outlier Add-on Payment} = [\text{Claim Cost} - \text{Outlier Threshold}] \times \text{DRG Marginal Cost Percentage}
\]

The DRG Marginal Cost Percentage is 90% for burn DRGs and 80% for all other DRGs. The base DRG codes for burn DRGs are 841, 842, 843, and 844.

**Covered Day Adjustment**

There are scenarios for which payment may/will be adjusted because not all days of the inpatient stay are payable by Mercy Care Plan. Some examples are:

- Recipient is enrolled in the Federal Emergency Services Program (FES)
- Recipient gains Medicaid eligibility after admission into the hospital
- Recipient loses Medicaid eligibility after admission and before discharge

For each of these scenarios, a payment adjustment factor may/will be calculated in order to prorate the payment based on covered days. If the factor is greater than 1, it will be reduced to 1 so that the covered day adjustment never has the effect of increasing payment beyond the full DRG payment. The factor will be applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment.

The formulas for calculating the Covered Day Adjustment Factor are:

If recipient is enrolled in the FES program:

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{[\text{Mercy Care Plan Covered Days} + 1]}{\text{DRG National Average Length of Stay}}
\]

Else if recipient gains Medicaid eligibility after admission then:

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{\text{Mercy Care Plan Covered Days}}{\text{DRG National Average Length of Stay}}
\]

Else if recipient loses Medicaid eligibility prior to discharge then:

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{[\text{Mercy Care Plan Covered Days} + 1]}{\text{DRG National Length of Stay}}
\]

The final covered day adjustment factor is calculated as:
If \([\text{Covered Day Adjustment Factor Unadjusted}] > 1.0\) Then \(\text{Covered Day Adjustment Factor Final} = 1.0\)

Else

\(\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}]\)

The Covered Day Adjustment Factor Final gets applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment using the following formulas:

\(\text{Covered Day Adjusted DRG Base Payment} = [\text{Unadjusted DRG Base Payment}] * [\text{Covered Day Adjustment Factor Final}]\)

\(\text{Covered Day Adjusted DRG Outlier Add-on Payment} = [\text{Unadjusted DRG Outlier Add-on Payment}] * [\text{Covered Day Adjustment Factor Final}]\)

**Note:** The adjustment factors are applied separately to the DRG base payment and the outlier payment so that the percentage of total payment coming from outliers can be monitored.

**Final Payment Adjustment**

DRG payment methodology will be transitioned over two years (FFY 2015 through FFY 2016). For FFY 2015 and 2016 of DRG pricing, there will be a provider-specific payment adjustment applied to every claim paid via the DRG pricing method. This payment adjustment will be made using a numeric multiplier that will be applied to both the DRG base payment and the DRG outlier payment. The multiplier will be loaded into a provider specific DRG pricing table.

The Provider DRG Transition Multiplier will be a combination of two payment adjustments—one for the DRG transition policy and the second for anticipated improvement in documentation and coding (DCI).

By applying this adjustment as the last step in the DRG pricing logic, final payment will be calculated as:

\(\text{Final DRG Base Payment} = [\text{Covered Day Adjusted DRG Base Payment}] * [\text{Provider DRG Transition Multiplier}]\)

\(\text{Final DRG Outlier Add-on Payment} = [\text{Covered Day Adjusted DRG Outlier Add-on Payment}] * [\text{Provider DRG Transition Multiplier}]\)

\(\text{Final Allowed Amount} = \text{Final DRG Base Payment} + \text{Final DRG Outlier Add-on Payment}\)

\(\text{Final Reimbursement Amount} = \text{Final Allowed Amount} – \text{Other Insurance Payment} +/- \text{Prompt Pay Adjustment}\)
**Note 1:** The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section 25 of this document for more information.

**Note 2:** A non-contracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the final payment, unless otherwise negotiated by both parties.

### 4.2 - Admit versus Discharge Date

DRG pricing and the DRG pricing logic will be based on date of discharge. All hospital stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. The Medicaid payer in effect on the date of discharge will always have responsibility for the full payment. The day of discharge is never paid unless the member expires on the date of discharge.

### 4.3 - Recipient Enrolled in Federal Emergency Services Program (FES)

Inpatient hospital services provided to recipients enrolled in the Federal Emergency Services Program (FES) are paid by the Administration under the fee-for-service program. Payment is limited to those services that meet the Federal definition of an emergency service, as determined through the Administration’s Medical Review process.

The emergency portion of an inpatient hospital service is determined on a claim-by-claim basis by determining the number of days of service for each inpatient hospital claim that meet the Federal definition of an emergency. Any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as a Mercy Care Plan covered day. It is possible that an entire stay will meet the definition of emergency and no covered day adjustment factor will be applied.

DRG payment is designed to be payment for a complete hospital stay. For claims paid via DRG pricing in which only emergency services are reimbursed, payment will be prorated based on the number of Mercy Care Plan covered days, if not all days of the stay meet the emergency definition. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as:

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{\text{AHCCCS Covered Days} + 1}{\text{DRG National Average Length of Stay}}
\]
If \([\text{Covered Day Adjustment Factor Unadjusted}] > 1.0\) Then 
\[\text{Covered Day Adjustment Factor Final} = 1.0\]

Else

\[\text{Covered Day Adjustment Factor Final} = [\text{Covered Day Adjustment Factor Unadjusted}]\]

4.4 - Enrollment Change during Hospital Stay
A recipient may change payers during a single hospital stay, while maintaining Medicaid eligibility throughout the entire stay. This may occur under a variety of scenarios including:
- A recipient changing enrollment from fee-for-service into a managed care plan
- A recipient changing enrollment from a managed care plan into fee-for-service
- A recipient changing enrollment between managed care plans within the same program
- A recipient changing enrollment between managed care plans in different programs, for example, moving from an Acute MCO to the Arizona Long Term Care System (ALTCS)

In these scenarios, services paid via the DRG method will be paid by the payer with which the recipient is enrolled on date of discharge. This payer will be responsible for reimbursement for the entire hospital stay, including any applicable outlier payment. If the member is eligible but not enrolled with Mercy Care Plan on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay.

Unique to these scenarios, providers are expected to submit a claim to the appropriate payer with the “From” date of service (form locator 6 on the UB-04 paper claim form) equal to the first day in which the recipient was enrolled with that payer. This will avoid denial based on eligibility/enrollment edits. Under these scenarios, the “From” date of service for the payer responsible on the Date of Discharge will be later than the Date of Admission. The “Through” date of service is the date of discharge. The claim may include all surgical procedures (form locator 74 on the UB-04 claim form) applicable for the hospital stay (admit through discharge), even if these procedures were performed prior to the recipient’s enrollment with the payer responsible for reimbursement. However, each payer’s claim(s) should only include revenue codes, service units, and charges applicable to services performed during the covered days included on the claim (e.g. days between the “From” and the discharge date).

Interim claims submitted to a payer other than the one with which the recipient is enrolled on date of discharge shall be handled in the same manner as all other interim claims. See Section 4.8 – Transfer Policy.

4.5 - Medicare Dual Eligibles
Throughout the duration of a single hospital stay, a recipient dually eligible for Medicare and Medicaid may exhaust the allowable Medicare Part A benefit.
In the event a recipient exhausts Medicare Part A benefits during a hospital stay, a separate 0111 or 0851 bill type claim should be filed for services performed after the date the maximum Medicare Part A benefit is exceeded. On the UB-04 paper claim form or the 837 institutional submission, providers shall report the “From” date of service as the first day Medicaid is the primary payer (i.e. the day after Medicare benefits have been exhausted). The “Through” date of service reported on the claim should be the date of the discharge. The provider will include on the claim only the charges associated with the Medicaid portion of the stay (i.e. the “From” date of service through the “Through” date of service reported on the claim). All diagnosis codes describing the patient’s medical condition may be included on the claim. However, the claim(s) should only include those revenue codes, surgical procedures, service units, and charges for services performed between the “From” and “Through” dates of service to ensure that Medicaid does not make a duplicate payment for services already covered for by Medicare. Since a separate claim is filed there is no proration of the claim; a full DRG payment will be paid for the Medicaid claim.

4.6 - Administrative Days
For hospitals reimbursed under the DRG method for acute care services, AHCCCS may also offer reimbursement for Medicaid recipients occupying a bed while not in need of acute care. For example, this may occur prior to an acute care episode when an expecting mother stays in a hospital awaiting birth of a baby. This may also occur at the end of an acute care episode in which a recipient is awaiting placement in a nursing home or other sub-acute or post-acute setting.

Those days in which a member does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the member cannot be safely discharged or transferred are referred to as administrative days. Administrative days also include discharges/transfers from one acute care facility to another when the receiving hospital provides sub-acute services to the member. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital’s administrative or operational delays. When prior authorized, administrative days will be reimbursed by Mercy Care Plan using a negotiated per diem rate. Reimbursement for administrative days will be separate from DRG reimbursement for acute care services.

To enable separate payment, administrative days must be billed on a different claim from acute care services. Administrative days are identified by the presence of a prior authorization for the member, the provider, and the dates of service that reflect an administrative rate. Further, administrative days for the provision of sub-acute services shall be billed with revenue code 016X (Room & Board).

When an acute care stay is followed by an administrative day stay, hospitals shall use patient discharge status 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) on the acute care claim. Likewise, when the opposite occurs
– an administrative day stay is followed by an acute care stay – hospitals shall use patient discharge status 70 on the administrative day claim.

4.7 - Interim Claims
A recipient may be in the hospital for an extended period of time. If a patient stay exceeds a 29 day period, hospitals may submit interim claims related to the patient stay in increments of 30 days. Interim claims will be reimbursed under a per diem rate of $500 per day.

Hospitals must submit a final claim associated with the patient stay upon the patient’s discharge. The final claim should reflect all procedures performed and all charges incurred during the entire patient stay – admit through discharge unless dates of service on the claim must be limited due to changes in Medicaid eligibility or changes in payer enrollment during the stay. The final claim will be paid under the DRG payment methodology.

Single Medicaid Payer for Entire Stay
Mercy Care Plan will accept the 117 bill type for the final replacement bill which will prompt full DRG payment and recoupment (void) of interim claims. This differs slightly from AHCCCS handling and is based on Mercy Care’s claims processing system.

Multiple Medicaid Payers for Entire Stay
The initial Medicaid payer will recoup all interim payments at the time Medicaid enrollment changes to another Medicaid payer. To the extent that interim bills are submitted to and paid by the Medicaid payer in effect on the date of discharge, hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in section 4.4 – Enrollment Change during Hospital Stay, and paid by the Medicaid payer in effect on the date of discharge.

Medicaid Eligibility Changes During the Stay
A member may lose or gain Medicaid eligibility during an inpatient stay. To the extent there are interim bills submitted to and paid by the Medicaid payer, hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in section 4.9 – Recipient Gains Medicaid Eligibility after Admission and section 4.10 – Recipient Loses Medicaid Eligibility Prior to Discharge, and paid by the Medicaid payer in effect on the date of discharge or the date that eligibility changes.

See section 4.26 – Reinsurance for information on reinsurance related to interim claims.

4.8 - Transfer Policy
In the event a recipient is transferred from one acute care facility to another, payment to the “transferring” hospital will be subject to reduction (see clarification below regarding sub-acute
services). The “transferring” and “receiving” hospitals will file separate claims and may result in different DRG assignments. Payment to the receiving acute care facility will follow standard DRG pricing rules and is not subject to transfer payment reduction unless the recipient is transferred again out of the receiving hospital.

The transfer payment methodology is applicable when a patient is transferred from one acute care facility to another, as identified by the following discharge status codes:

- 02: Discharged/transferred to a short-term general hospital for inpatient care
- 05: Discharged/transferred to a designated cancer center or children’s hospital
- 66: Discharged/transferred to a critical access hospital

Under this transfer payment policy, DRG base payment for the transferring hospital will be calculated as follows:

\[
\text{Transfer DRG Base Payment} = \left( \frac{\text{Initial DRG Base Payment}}{\text{DRG National Average Length of Stay}} \right) \times (\text{Length of Stay} + 1 \text{ Day})
\]

Or:

\[
\text{Initial DRG Base Payment}
\]

The base DRG payment reimbursed to the “transferring” hospital will be the lesser of the Transfer DRG Base Payment, as calculated above, or the calculated Initial DRG Base Payment for the full hospital stay. The base payment is a prorated per diem amount for each day the recipient is in the hospital prior to the transfer. One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient prior to the transfer since the costs of stabilization are generally higher than the remaining days of the patient stay. In calculating the length of stay, the date of the discharge will not be included. The date of discharge is only payable by Mercy Care Plan when the recipient expires in the hospital, which is not a scenario in which the transfer payment policy applies.

AHCCCS will allow outlier payments for the “transferring” hospital if the claim meets the outlier criteria. The outlier payment will be added to the base payment (i.e. the Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

**Clarification Regarding Transfers for Sub-Acute Services:** A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharged/transferred to another type of health care institution not defined elsewhere in
code list) for the provision of sub-acute services. Dates of service for sub-acute services shall be considered administrative days. See section **4.6 – Administrative Days** for information on payment of administrative days.

**4.9 - Recipient Gains Medicaid Eligibility after Admission**

A recipient may be ineligible for Medicaid upon admission, however, may become eligible for Medicaid during his/her stay in the hospital. Under this circumstance, the DRG payment which is designed to cover the full hospital stay will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment is calculated as,

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{\text{AHCCCS Covered Days}}{\text{DRG National Average Length of Stay}}
\]

If \( \text{Covered Day Adjustment Factor Unadjusted} > 1.0 \) Then \( \text{Covered Day Adjustment Factor Final} = 1.0 \)

Else

\[
\text{Covered Day Adjustment Factor Final} = \text{Covered Day Reduction Factor Unadjusted}
\]

The covered day adjustment factor does not include one additional day to account for the first part of the stay when a disproportionate amount of costs are incurred since the recipient is not Medicaid eligible upon the admission of the stay. Rather the recipient gains eligibility at some point after admission.

When submitting a claim under this scenario, providers are expected to report the “From” date of service as the first date the recipient is eligible for reimbursement. Assuming the recipient is enrolled with Medicaid through discharge, the “Through” date of service will be set to the date of discharge. The number of AHCCCS covered days will be calculated as the “Through” date of service on claim less the “From” date of service. If the recipient expires in the hospital, the day of discharge is reimbursable and one day will be added to the number of AHCCCS covered days to account for date of discharge.

Only claims with dates of service where the recipient is enrolled with that payer will be accepted.

**4.10 - Recipient Loses Medicaid Eligibility Prior to Discharge**

A recipient may be an eligible member upon admission, however, may lose eligibility during the duration of a single hospital stay. In this scenario, the DRG payment attributable to the entire stay will be prorated based on the number of Mercy Care Plan covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that
the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

\[
\text{Covered Day Adjustment Factor Unadjusted} = \frac{\text{Mercy Care Plan Covered Days} + 1}{\text{DRG National Average Length of Stay}}
\]

If \([\text{Covered Day Adjustment Factor Unadjusted}] > 1.0\) Then \(\text{Covered Day Adjustment Factor Final} = 1.0\)

Else

\[
\text{Covered Day Adjustment Factor Final} = \text{Covered Day Adjustment Factor Unadjusted}
\]

One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient since the costs of stabilization are generally higher than the remaining days of the patient stay.

When submitting a claim in this scenario, the date of admission and the first date of service should be the same. The “Through” date of service on the claim should be reported as the last date the recipient is enrolled with the Medicaid payer. The number of AHCCCS covered days will be calculated as the “Through” date of service less the date of admission.

Only claims with dates of service where the recipient is an enrolled member will be accepted.

4.11 - Same Day Admit and Discharge
Mercy Care requires that the inpatient stay meet medical necessity criteria for the admission for payment. There is one exception to this methodology. Claims with a same date of admission and date of death will be reimbursed a full DRG payment. Providers may bill a same day admit/discharge as they would an inpatient bill. Since these services are required to be paid at an outpatient rate per AHCCCS guidelines, MCP will accept the inpatient bill and pay as an outpatient bill by denying the Room and Board line and paying all other lines using the hospital’s Cost-to-Charge ratio in place for the dates of service on the claim.

4.12 - Specialty Hospitals
Hospitals designated as type: hospital, subtype: short-term that have a license number beginning “SH” in the Provider & Facility Database for Arizona Medical Facilities posted by ADHS will be reimbursed under the DRG methodology, under a separate DRG base rate. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare will also be reimbursed under a separate DRG base rate that will also be reimbursed under the DRG methodology. The DRG base rate for these providers will be reflected in the rate tables as with all other DRG providers.
4.13 - Rehabilitation and LTAC Hospitals
Hospitals designated as rehabilitation and long term acute care (LTAC) hospitals will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate, including provisions for outlier payments, with provider designation of condition code 61 for consideration, where rates and outlier thresholds will be included in the capped fee schedule published by the Administration. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim.

A new provider type (C4) is established to identify these providers and includes freestanding rehabilitation and LTAC providers.

4.14 - Psychiatric Hospitals
Hospitals designated as freestanding psychiatric facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate consistent with ADHS reimbursement policy for this provider type (71). There is no outlier provision.

4.15 - Inpatient Claims for Recipients with Medicare Part B Only
The treatment of Medicare Part B payments on inpatient claims is not changing with the implementation of DRG pricing. On inpatient claims in which the Medicaid recipient has Medicare Part B coverage, no Medicare Part A coverage, or Medicare Part A coverage has been exhausted, final Medicaid reimbursement is calculated by subtracting the Medicare Part B payment amount from the Final Allowed Amount.

4.16 - Carved-out Services Within Claims Paid Under DRG Methodology
DRG payment when applied to an inpatient hospital claim will cover all inpatient services related to that stay. Effective 10/1/2016, the only service separately reimbursed from the DRG is for Long-Acting Reversible Contraception (LARC) devices. Payment for an LARC device will be eliminated in the future, if and when an ICD-10 PCS code is established and the DRG Grouper is updated.

Hospitals need to bill the LARC device separately on a CMS-1500 Form. The inpatient hospital claim will be billed normally with the appropriate DRG. The LARC device codes include:
- J7297 - Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg, 3 Year Duration
- J7298 - Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg, 5 Year Duration
- J7300 - Intrauterine Copper Contraceptive
- J7301 - Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg
4.17 - Non-Covered Charges
The current billing policy regarding the recording of non-covered charges remains unchanged. Hospitals shall report non-covered charges and AHCCCS shall consider them where appropriate.

4.18 - Transplants
Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates. The current methodology for identifying claims as transplants will remain the same. The evaluation component, when performed during an inpatient stay, will be paid under the DRG methodology (see section 4.30 – Inpatient Services Preceding Transplant for more information). Days in the hospital beyond day 60 will be reimbursed via a per diem when primary payment for the hospital stay is covered under the transplant contract.

4.19 - Negotiated Settlements
Mercy Care Plan will continue to support the current claim dispute and settlement process. The grievance settlement process will be conducted after initial adjudication of the claim and providers will be expected to follow the current claim dispute process independent of whether claim payment is calculated using a per diem, DRG, or other payment methodology.

4.20 - Detox / Behavioral Health versus Physical Health Diagnosis
A recipient admitted to a hospital may require both physical health treatment as well as psychiatric/behavioral health treatment. Only one claim will be submitted and reimbursed for a single hospital stay in which both physical and behavioral health treatment are necessary.

The principle diagnosis for the recipient for the hospital stay will determine if the claim will be submitted to the MCO under which the member is eligible or to the Tribal/Regional Behavioral Health Authority (T/RBHA) assigned to the member. An exception to this rule applies to members who are enrolled with integrated payers. Integrated payers are described more fully below. If the principle diagnosis on the claim is a physical health diagnosis, the claim should be submitted to the associated MCO and will be reimbursed under DRG methodology, if DRG pricing applies. If the principle diagnosis on the claim is a behavioral diagnosis, the claim should be submitted to the appropriate T/RBHA and will be reimbursed under a per diem rate consistent with ADHS reimbursement policy.

When a member is enrolled with the following integrated payers, DRG pricing will apply regardless of principle diagnosis (if DRG pricing applies to the hospital):
- ALTCS Elderly & Physically Disabled (EPD) MCO
- CRS Fully Integrated
- CRS Partially Integrated – Behavioral Health (if the physical health diagnosis is NOT related to the CRS condition the CMDP or DDD plan of enrollment is the payer)
When the member with Serious Mental Illness is enrolled with the integrated RBHA, pricing will apply as follows:

- If the principle diagnosis is a physical health diagnosis, DRG pricing will apply (if DRG pricing applies to the hospital)
- If the principle diagnosis is a behavioral health diagnosis, ADHS per diem pricing will apply

4.21 - HCAC and POA

Health care acquired conditions (HCACs) are identified using the standard rules put forth by the Centers for Medicare and Medicaid Services (CMS). These rules include a finite list of diagnosis codes and surgical procedure codes. In some cases, the surgical procedure codes are considered to be a HCAC only if billed in conjunction with a specific diagnosis code, and only in the absence of a present on admission (POA) indicator.

For claims paid via the DRG methodology, AHCCCS will utilize DRG assignment to determine payment reductions in cases of health care acquired conditions. If a Medicaid recipient acquires a medical condition while in the hospital, that condition will be ignored when assigning a DRG code and calculating DRG payment.

To implement this policy, POA indicators will continue to be required on all inpatient claims. This is because the HCAC payment reduction policy only applies if the HCAC condition(s) were acquired in the hospital (after admission). POA indicators associated with each diagnosis code on the claim (except the admit diagnosis code) will be edited to ensure they are valid. Claims with invalid POA indicators will be denied. Diagnosis codes defined as exempt from POA reporting will not require a POA code. CMS publishes a list of diagnoses exempt from POA reporting annually.

The following values are valid for the POA indicator:

- **Y** Diagnosis was present at time of inpatient admission
- **N** Diagnosis was not present at time of inpatient admission
- **U** Documentation insufficient to determine if condition was present at the time of inpatient admission
- **W** Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
- **Blank** Diagnosis is exempt from POA reporting

Under the DRG pricing methodology, values of “N,” “U,” and “W” will all be interpreted as indicating the diagnosis was not present at the time of admission. This is consistent with current Mercy Care Plan policy applied to claims paid via per diem. Blank is a valid value only for diagnoses included on CMS’ list of codes exempt from POA reporting.
Under the DRG payment methodology, two DRGs will be assigned to every claim, one referred to as a “pre-HCAC” DRG and a second referred to as a “post-HCAC” DRG. The “pre-HCAC” DRG is assigned using all diagnosis codes on the claim whether or not they were present on admission. The “post-HCAC” DRG is assigned after removing any diagnosis and/or procedure codes identified as HCACs.

In the rare cases where the pre-HCAC and post-HCAC DRGs are different, the DRG with the lower relative weight will be used to price the claim. This will almost always be the post-HCAC DRG, but logic will be implemented to compare both relative weights and select the DRG with the lower relative weight to price the claim.

4.22 - Same Day Admit and Date of Death
Claims with a same date of admission and date of death will be reimbursed a full DRG payment. Providers must report the discharge status code of 20 on the claim indicating death.

4.23 - Out-of-State Hospitals
Acute care services provided by out-of-state providers will be reimbursed under the DRG methodology.

For out-of-state hospitals determined by the Administration to be high volume out-of-state hospitals, which are located in counties bordering the State of Arizona and have 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2010, payments for services will be determined using the same methods used for payment of services to in-state hospitals, except that out-of-state hospitals will not be eligible for the Provider Policy Adjustor. Wage Adjusted Provider DRG Rates and Hospital Cost-to-Charge Ratios will be determined using the same methods as those used to determine such values for in-state hospitals.

All other out-of-state hospitals will be assigned Wage Adjusted Provider DRG Rates that will be equal to the simple average of the Wage Adjusted Provider DRG Rates for in-state hospitals. They will also be assigned Cost-to-Charge ratios equal to the sum of the Arizona statewide urban default operating cost-to-charge ratio and the Arizona statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. As with designated border hospitals described above, these hospitals will not be eligible for the Provider Policy Adjustor. Further, for purposes of determining the Provider DRG Transition Multiplier for these providers, the DRG transition policy component will not be applied.

4.24 - Slow Pay Penalties and Quick Pay Discounts
The Administration will continue to support the current slow pay penalty and quick pay discount policies. The Administration will calculate the quick pay discounts and slow pay penalties on the Final Allowed Amount for providers classified as types 02 and C4, excluding IHS and 638 providers, billed on the UB-04 claim form.
A quick pay discount of 1 percent will continue to be applied to claims paid within 30 days. The slow pay penalty will continue to be based on a 30 calendar day month, as illustrated below:

- Claim paid within 31-60 days of clean claim date: 0% discount/penalty
- Claim paid within 61-90 days of clean claim date: 1% penalty
- Claim paid within 91-120 days of clean claim date: 2% penalty

The slow pay penalty will continue to accrue at a rate of 1 percent per month or partial month until the claim is paid by AHCCCS.

4.25 - Readmission Policy

A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, the Administration will identify certain readmission cases and conduct a medical review prior to finalizing payment associated with the readmission claim.

The following criteria will prompt a medical review:
- Recipient must be readmitted to the same hospital within 72 hours, and
- The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digits of the DRG code), and
- In the event that the claim has been prior authorized, the readmission claim may be considered to have already gone through medical review.

If the claim associated with the readmission meets the criteria above, the claim will be pended for medical review. The payment associated with the readmission claim will be held until the completion of the medical review process. Upon the medical review, if the readmission is determined to have been preventable by the hospital, the payment associated with the readmission claim will be disallowed. Alternatively, if upon the medical review it is determined the hospital would not have been able to prevent the readmission, the claim will be paid under DRG methodology.

Specific criteria for identifying preventable readmissions by a hospital during the medical review process will be developed. The criteria will be the same for FFS as well as MCO claims.

The Administration may consider monitoring readmission rates across providers and may consider future rate adjustments for providers with potentially preventable rates in excess of their peers or some established standard.

4.26 - Reinsurance

Any final claims which cross over contract years will not be eligible for reinsurance.
The Administration will not pay reinsurance on interim claims. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the hospital stay do not cross contract years.

AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

4.27 - Non-covered Services
Charges associated with use of robotic technology will be disallowed when claims are reviewed for outlier consideration.

4.28 - Newborn Birth Weight Reporting
For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims in which the age of the newborn is fourteen (14) days or less. Birth weight should be communicated in a value amount field with associated value code equal to 54. Birth weight should be billed as a number of grams.

4.29 - Hemophilia HCPCS / NDC Reporting
For claims which include Hemophilia drugs, providers should include the appropriate HCPCS, NDC code and units, on the corresponding Pharmacy revenue code.

4.30 - Inpatient Services Preceding Transplant
During a hospitalization in which transplant services are performed (where those services are governed under specialty transplant contracts between AHCCCS and the hospital, and paid under component pricing) a recipient may first receive inpatient hospital services that are not related to the transplant, or related to the evaluation component of the transplant, all of which are paid under the APR-DRG methodology.

In the event a recipient receives services during an inpatient stay prior to “Prep and Transplant” (or any other transplant component priced in the specialty contract), a separate 0111 or 0851 bill type admit through discharge claim utilizing a Discharge Status code of 70, should be filed for services performed before the specialty-contract transplant components and paid at APR-DRG. On the UB-04 paper claim form or the 837 institutional submission, the “From” date of service should correspond to the initial admission date of the member. The “Through” date of service reported on the claim should be the date immediately preceding the specialty-contract transplant components. All diagnosis codes describing the patient’s medical condition may be included on the claim. However, the claim should only include those revenue codes, surgical procedures, service units, and charges for services performed between the “From” and “Through” dates of service, which reflect the services that are not related to the transplant, or related to the evaluation component of the transplant. Since a separate claim is filed there is no proration of the claim; a full DRG payment will be paid for the portion of the stay associated
with the services that are not related to the transplant, or related to the evaluation component of the transplant.

**4.31 - Mercy Care Advantage MS-DRG Payment System**

Mercy Care Advantage processes inpatient hospital claims using the same methodology as CMS – the Medicare Severity Diagnosis Related Group (MS-DRG). One MS-DRG is assigned to each inpatient stay. The MS-DRGs are assigned using the principal diagnosis and additional diagnoses, the principal procedure and additional procedures, sex and discharge status. Diagnoses and procedures assigned determine the MS-DRG assignment. For additional information regarding the CMS Prospective Payment System (PPS) for inpatient claims, please refer to the CMS Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing.

**CHAPTER 5 – FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) PROSPECTIVE PAYMENT SYSTEM (PPS) PROCESSING**

**5.0 – FQHC PPS Overview**

Effective 4/1/2015, AHCCCS, along with Mercy Care Plan, began paying FQHCs an all-inclusive per visit PPS rate on a per claim basis, which replaces the current methodology of reimbursing claims through a fee for service methodology. This will affect Mercy Care Advantage as well.

FQHCs and FQHC Look-Alikes will need to re-register under the provider type of C2 and obtain a unique NPI number not already associated with another active AHCCCS provider ID for each clinic covered by the CMS FQHC, FQHC-LA or RHC designation. The new NPIs will be used for claim submissions beginning with dates of service on or after 4/1/15. A new NPI can be obtained at: [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do).

Per AHCCCS, an FQHC/RHC Visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

**5.1 – FQHC PPS – Mercy Care Plan Billing**

Beginning 4/1/2015, all FQHC, FQHC-LA, and RHC visits must be billed using the Form 1500 (02-12) or the 2012 ADA Form. For purposes of reimbursing visits beginning 4/1/2015, Mercy Care has adopted HCPCS code **T1015** – Clinic visit/encounter, all-inclusive for reporting physical health, behavioral health, and dental visits. A claim for a FQHC, FQHC-LA or RHC visit must
include all appropriate procedure codes describing the services rendered in addition to HCPCS visit code T1015.

A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at $0.00. T1015 is reimbursable at the established AHCCCS PPS rate for each FQHC and should be billed using that rate. We follow all regulatory requirements for FQHC billing.

5.2 – FQHC PPS - Mercy Care Advantage Billing

Beginning 4/1/2015, all FQHC and RHC visits must be billed using the UB-04 Form. A visit will be identified by, and reimbursement for the visit will be associated with the following HCPCS codes; all other services reported on the claim will be bundled into the visit and valued at $0.00. Current reimbursement rates for the following codes are as follows:

- Established patients - $89.00 per visit
- New patients - $105.00 per visit

For purposes of reimbursing visits beginning 4/1/2015, Mercy Care Advantage will be using Medicare specific codes as follows:

- **G0466** – Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit
- **G0467** - Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit
- **G0468** – Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV
- **G0469** – Federally qualified health center (FQHC) visit, mental health, new patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit
- **G0470** – Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
Certain services are not considered FQHC services either because they are 1) not included in the FQHC/RHC benefit; or 2) are not a Medicare benefit. These services include:

- **Medicare Excluded Services** – This includes physical checkups, dental care, hearing tests, eye exams, etc. A full listing of Medicare excluded services can be found in the Medicare Benefit Policy Manual – Chapter 16 – General Exclusions from Coverage under Section 10 – General Exclusions from Coverage.

  **Please Note:** Mercy Care Advantage offers additional benefits that are not normally covered by traditional Medicare. Please refer to our Additional Benefits web page for detail regarding these services. While these are not part of the FQHC/RHC services, they should be billed and will be processed separately from FQHC.

- **Technical Component of an FQHC/RHC** – This includes diagnostic tests such as the technical component of x-rays, EKGs and other tests.

- **Laboratory Services** – This does not include venipunctures.

- **Durable Medical Equipment** – This include crutches, hospital beds and wheelchairs used in the patient’s place of residence, whether rented or purchased.

- **Ambulance Services**
- **Prosthetic Devices**
- **Body Braces**
- **Practitioner Services at Certain Other Medicare Facility**
- **Tele-Health Distant Site Services**
- **Hospice Services**

The above services are not part of the FQHC/RHC services, and as such they should be billed and will be processed separately from the FQHC payment.

5.3 – FQHC PPS - Dual Eligible Claims Billing

Since CMS billing requirements are different from AHCCCS billing requirements, we will require the initial claim sent to Mercy Care Advantage be billed according to the instructions above in the Mercy Care Advantage Billing section. Once you have received the remit, please rebill the service following billing instructions in the Mercy Care Plan Billing Section and submit with the Mercy Care Advantage remit you previously received. Claims must be billed in this fashion in order for us to properly encounter claims to our regulators.

5.4 – FQHC PPS - Billing Resources

Additional information regarding FQHC PPS billing is available at the AHCCCS website as follows:

**Fee For Service Provider Manual – Chapter 10 Addendum FQHC/RHC**

Additional information regarding FQHC PPS billing is available at the CMS website as follows:
CHAPTER 6 – SKILLED NURSING FACILITY CLAIMS

6.0 – Skilled Nursing Facilities General Information
In this section we are providing an overview of Skilled Nursing Facilities related to Mercy Care’s authorization requirements and claims payment rules. For additional information regarding Skilled Nursing Facilities, please refer to Mercy Care’s Skilled Nursing Facilities (SNF) Reference Guide posted to our website. Chapter 3 in our Mercy Care Plan Long Term Care Provider Manual also contains valuable information.

6.1 – Roles and Responsibilities
Skilled Nursing Facilities (SNF) and Mercy Care have defined roles and responsibilities necessary to provide quality services. The roles and responsibilities outlined below are intended to assist facilities in the delivery of quality care to Mercy Care Plan (MCP), Mercy Care Plan Long Term Care (MCPLTC) and Mercy Care Advantage (MCA) members and to clarify processes that will facilitate prompt and accurate reimbursement for delivered covered services.

SNF Roles and Responsibilities
• Obtain Authorization from Mercy Care for the following services:
  o Sub-Acute Services (Skilled) - Mercy Care Concurrent Review Nurse (CRN)
  o Custodial Services (MCPLTC) - MCPLTC Case Manager
  o Specialty Levels of Care (wandering dementia, ventilator, high respiratory, behavioral health units) MCPLTC Case Manager
  o Bed Holds (MCPLTC) – MCPLTC Case Manager

• Communicate with MCPLTC Case Manager
  All MCPLTC members are assigned to a MCPLTC Case Manager. The SNF must communicate all changes in medical condition, level of care, hospitalizations, deaths, discharges, and presentation of 30 day notices to the Case Manager.

• Submit Claims
  o Submit claims meeting timeliness standards
  o Submit claims on correct billing forms
  o Manage accounts receivables by regularly checking MercyOneSource, the secured Mercy Care web portal. SNFs must register and receive a password to access this secured site. Additional information regarding MercyOneSource is contained in the Provider Manuals.
  o Do not submit spreadsheets to Claims or Provider Relations, unless requested to do so by Mercy Care.
  o All resubmissions of claims must meet timeliness standards and be clearly marked as a resubmission, with blue or black ink, as indicated in the Provider Manual.
  o Follow appropriate appeal/resubmission steps as outlined in each plan’s Provider Manual with regard to any claim that cannot be resolved in order to maintain timely filing rights.
• Coordinate Discharge
  o Sub-Acute Stays (Skilled) – Coordinate with the Mercy Care Medical Management SNF CRN and the MCPLTC Case Manager if the member is a MCPLTC member.
  o Custodial Stays (MCLTC) – Coordinate with MCPLTC Case Manager.

MCP Roles and Responsibilities

• Respond to Authorization Requests in a Timely Manner
  The Prior Authorization Department will respond to authorization requests within 24 hours of the request.

• MCPLTC Case Manager
  o Each MCPLTC member has an assigned case manager.
  o Case managers serve as a point of contact for member issues.

• Claims Payment
  o Claims will be paid timely.
  o Interest will be paid on MCPLTC claims that are not paid within the timelines set forth by contract.
  o Adhere to state and federal guidelines when responding to claims disputes and follow appeals process.

6.2 – Skilled Nursing Facility Authorizations Requirements
Mercy Care Plan requires prior authorization for selected acute outpatient services and planned hospital admissions.

Concurrent Review Nurses must authorize all skilled stays for MCP Acute, MCPLTC, and MCA skilled stays. The Concurrent Review Nurses also authorize custodial stays for all MCP Acute Members.

MCPLTC case managers authorize custodial stays for all MCPLTC members.

When requesting an authorization for a skilled stay for inpatient SNF admission, sufficient information must be provided or Mercy Care will not be able to generate the prior authorization. In order to expedite the prior authorization process, please be prepared to provide the following information when calling:
• Facility face sheet
• Admit date
• Admit diagnosis
• Which services will be rendered

When making a request for a continued authorization, please complete the request on the Skilled Stay Continued Authorization Request Form. It is available on the Mercy Care website at www.MercyCarePlan.com or www.MercyCareAdvantage.com. Missing or inaccurate information may delay important processing of the review and ultimately, the payment of the...
The request will be reviewed for clinical information to certify the continuation of the stay (intensity of need versus intensity of services being rendered).

The Continued Authorization Request Form must contain the following:

- Date of admission
- Diagnosis
- Reason for the admission
- Services the member receiving
- Plan of care
- Member baseline functional level (usually available by the second week PT/OT has completed the initial evaluation)
- Functional progress that has been made since last request in the space provided
- Estimated length of stay
- Discharge plan
- Status of MCPLTC application
- Status change

**Mercy Care Plan – Acute**

Medical management issues an authorization for the Mercy Care Acute Care members’ stay and the level of care for all skilled and all custodial stays.

AHCCCS policy states that AHCCCS members who have not been determined eligible for ALTCS are covered for up to 90 days of nursing facility coverage per contract year (October 1 – September 30). The 90 days of AHCCCS acute care coverage for SNF services begins on the day of admission, even if the member is insured by a third party insurance carrier, including Medicare.

SNFs should work with the member and their family to begin the ALTCS application procedure as quickly as possible.

- **Sub-Acute (Skilled) Stay**
  - The SNF calls the MCP SNF Authorization Line at 602-263-3000, Express Code 622 for initial authorization for SNF placement.
  - The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.
  - The SNF nurse or designee will issue an authorization number to the SNF with an approved length of stay and level of care.
  - NOTE: INSPIRIS does not manage these members.
  - For continued stay requests, the SNF must fax to the SNF review line or call the SNF Authorization Line with clinical information to support continued stay.
The SNF can use their form or MCP’s Skilled Stay Continued Authorization Request Form to submit requests. This must be done at least 3 days prior to end date of authorization.

- MCP CRN or designee will render a decision within 24 hours of receipt of clinical information.
- The purpose of concurrent review is to reach an agreement between MCP and the SNF at the time the member is in the SNF.
- If the SNF disagrees with the level of care or length of stay after the member has been discharged, the SNF must appeal.
- If MCP Acute secondary applies to Medicare Fee for Service (FFS) or another Medicare Advantage Plan or other primary insurance the following applies:
  - No authorization is required for co-pay, co-insurance or deductible
  - Claims need to be billed separately

- **Custodial Stay**
  - Medical Management issues the authorization and notifies the SNF.
  - INSPIRIS does not manage:
    - If SNF disagrees, SNF receives a denial notice.
    - If SNF disagrees, they can request a peer to peer review or submit an appeal.
  - MCP Acute secondary to Medicare
    - Authorization is entered if we are notified.
    - Medical Management follows members for possible MCPLTC transition (for tracking purposes only).

**Mercy Care Plan Long Term Care/Non-Medicare**

- **Sub-Acute (Skilled) Stay**
  - For new admissions from the hospital, Medical Management will notify SNF of sub-acute (skilled) stay and give level of care and authorization number.
  - For members currently in the nursing home who have had a change of treatment and now qualify for sub-acute level, the nursing home will call the assigned MCP CRN and provide substantiating information.
  - Mercy Care Plan’s SNF CRN will communicate with the MCPLTC Case Manager when the member is no longer in a sub-acute (skilled) stay.

- **Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)**
  - MCPLTC Case Manager determines level of care based on supporting documentation.
  - MCPLTC Case Manager creates an authorization and notifies SNF.
  - There is no secondary payer for custodial care. Other commercial carriers will not cover a custodial stay. Mercy Care pays 100% of contracted rate minus member’s Share of Cost (SOC).

**Mercy Care Plan Long Term Care/Medicare**

- **Sub-Acute (Skilled) Stay**
  - No authorization is required for co-pay, co-insurance or deductible.
• Claims need to be billed separately.

- **Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)**
  - MCPLTC Case Manager determines level of care based on supporting documentation.
  - MCPLTC Case Manager creates an authorization and notifies SNF.
  - There is no secondary for payer for custodial care. Other commercial carriers will not cover a custodial stay. Mercy Care pays 100% of the contracted rate less member’s Share of Cost (SOC).

**Mercy Care Advantage**

- **Sub-Acute (Skilled) Care**
  - The SNF calls the MCP SNF Prior Authorization Line at 602-263-3000, Express Code 622 for initial authorization for SNF placement.
  - The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.
  - The Concurrent Review Nurse or designee will issue an authorization number to the SNF at that time, with an approved length of stay.
  - SNF must give MCA the RUGS code after the MDS assessment is reviewed.
    - RUGS code must be given within 14 days of admission to skilled stay or at the point of discharge if the stay is less than 14 days.
    - Claims payment cannot be made if there is no RUGS code reported.
    - If the RUGS code changes within the stay of the member, the SNF must fax the SNF review line, 602-414-7252, with the updated RUGS code.
    - If a claim is billed with RUGS code(s) different than initially provided, the claim will deny.
  - For continued stay requests, the SNF must fax to the SNF review line or call the SNF prior authorization line with clinical information to support continued stay.
    - The SNF may use their internal form or the MCA **Skilled Stay Continued Authorization Request** form to submit their request. This must be submitted at least 3 days prior to end date of authorization. MCA CRN or designee will render a decision within 24 hours of receipt of clinical information.
    - After a determination has been made by MCA that the enrollee no longer meets the criteria and must be discharged, the SNF is responsible for serving the Notice of Medicare Non Coverage (NOMNC) to the enrollee at least 2 days in advance of the services ending and retain the NOMNC in their records.
    - If an enrollee decides to appeal the discharge, the Quality Improvement Organization (QIO) will contact the plan asking for medical records supporting the discharge decision and MCA is required to provide those records by the end of the day of request.
    - If the QIO overturns the appeal, the QIO will notify MCA of the discharge date for the enrollee and MCA is responsible for payment through that date. If QIO concurs with MCA, the enrollee is financially responsible if he/she chooses to remain in the facility beyond the discharge date.
MCP is responsible for co-insurance, co-pay or deductible.

- No authorization is required
- SNF must bill with appropriate Medicaid revenue code(s)

6.3 – Skilled Nursing Facility Bed Hold Authorizations and Claims Billing

Payment for bed-hold authorization will require approval by a MCPLTC Case Manager. It is important to note that bed holds must be billed on a separate claim form from their SNF stay, using a UB-04. An example of this would be a member is in a SNF from 1/1/15 – 1/31/15, however, on 1/15/15 – 1/20/15, they were hospitalized. We would need three claims submitted as follows:

1/1/15 – 1/14/15 – Normal SNF Billing on a UB-04
1/15/15 – 1/20/15 – Bed Hold Days Billing on a UB-04
1/21/15 – 1/31/15 – Normal SNF Billing on a UB-04

Since these are covered under separate authorizations, they require separate claims.

The facility must provide the reason for the bed hold and the anticipated length of leave. There are two types of leave that can be authorized for a bed hold for MCPLTC members; short term hospitalization leave and therapeutic leave. Members under the age of 21 may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per contract year (October 1 – September 30).

- **Short Term Hospitalization Leave**
  A bed hold may be authorized when short-term hospitalization is medically necessary. The total number of days available for each member over the age of 21 is limited to 12 days per contract year (October 1 – September 30).

- **Therapeutic Leave**
  This service may be authorized due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as part of discharge planning. The total number of therapeutic leave days available for each member over the age of 21 is limited to 9 days per contract year (October 1 – September 30).

6.4 - Durable Medical Equipment

All durable medical equipment (DME) is included in the SNF per diem rate, with the exception of customized equipment and specialty beds.

- **Customized Equipment** - Customized DME may be provided to members by a contracted Mercy Care DME provider if the items are ordered by the member’s primary care provider and authorized by Mercy Care.

- **Specialty Mattresses** - A specialty mattress such as a low air loss or high air loss mattress must be medically necessary and requires prior authorization. SNFs must obtain prior authorization through the Mercy Care Prior Authorization Department.

- **Specialty Beds** – A specialty bed such as a Clinitron bed must be medically necessary and requires prior authorization. SNFs must obtain prior authorization through the Mercy Care Prior Authorization Department. Effective 8/1/14, Clinitron beds are no longer billed directly to
Mercy Care Plan by the DME vendor who supplies them, but now must be submitted on the claim from a SNF. Effective 10/1/16, in order to allow additional payment for the Clinitron bed (included in the per diem), SNFs must bill a revenue code of 0271 along with HCPCS E0194 – Air Fluidized Bed and modifier RR. The Clinitron rental rate is a daily rate, so units must match the number of days billed. Billing in this manner will trigger the higher payment.

- Routine equipment is included in the per diem paid to the SNF and should be provided by the SNF. This includes bariatric durable medical equipment.

Some of the more common DME items used are listed below. This list is not all-inclusive and serves as general reference only. Any DME items not listed require Prior Authorization.

### DME in a Nursing Facility

<table>
<thead>
<tr>
<th>Equipment</th>
<th>MCA Non-Custodial</th>
<th>MCA Custodial</th>
<th>Acute/ALTCS/DDD Non-Custodial</th>
<th>Acute/ALTCS/DDD Custodial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Fluidized Bed (i.e. Clinitron) and Powered Air Flotation Bed</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>See above instructions regarding Clinitron beds. Authorization required.</td>
<td>See above instructions regarding Clinitron beds. Authorization required.</td>
</tr>
<tr>
<td>Bariatric Bed, Wheelchair, etc.</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in Bariatric per diem rate. Other per diem rates: Separately payable to DME company with authorization</td>
<td>Included in Bariatric per diem rate. Other per diem rates: Separately payable to DME company with authorization</td>
</tr>
<tr>
<td>Bedside Commode</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Cane/Crutches</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Equipment</td>
<td>MCA Non-Custodial</td>
<td>MCA Custodial</td>
<td>Acute/ALTCS/DDD Non-Custodial</td>
<td>Acute/ALTCS/DDD Custodial</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>Cushions</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Feeding Pumps</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Foot Cradles</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Geri-Chairs (Non-Customized)</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Glucose Monitors (i.e. Accu-Chek)</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Heating/Cooling Pads</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Hospital Beds (Electric &amp; Manual)</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>IV Pole</td>
<td>Included in per diem or RUG rate</td>
<td>Covered under Part B when used in conjunction with Enterals</td>
<td>Included in per diem rate.</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Lifts</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate.</td>
<td>Included in per diem rate.</td>
</tr>
<tr>
<td>Equipment</td>
<td>MCA Non-Custodial</td>
<td>MCA Custodial</td>
<td>Acute/ALTCS/DDD Non-Custodial</td>
<td>Acute/ALTCS/DDD Custodial</td>
</tr>
<tr>
<td>-----------</td>
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<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Misc. Supplies – emesis basins, bed pans, catheters, surgical dressings, etc.</td>
<td>Included in per diem or RUG rate</td>
<td>Part B: Enterals, gravity kits, syringe kids, pump kits, tubes, pumps, dressings, parenteral nutrition, trach supplies, ostomy supplies, catheters</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Nebulizer</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Powered Pressure-Reducing Air Mattress (Alternating), Other mattresses, mattress overlays and/or pads</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Suction Machine</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Walker</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Wheelchairs (All Non-Customized)</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Included in per diem rate</td>
<td>Included in per diem rate</td>
</tr>
<tr>
<td>Wheelchairs (Customized)</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Separately payable to DME company with authorization</td>
<td>Separately payable to DME company with authorization</td>
</tr>
<tr>
<td>Equipment</td>
<td>MCA Non-Custodial</td>
<td>MCA Custodial</td>
<td>Acute/ALTCS/DDD Non-Custodial</td>
<td>Acute/ALTCS/DDD Custodial</td>
</tr>
<tr>
<td>--------------------</td>
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<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Wound Vac.</td>
<td>Included in per diem or RUG rate</td>
<td>Not covered in SNF</td>
<td>Separately payable to DME company with authorization</td>
<td>Separately payable to DME company with authorization</td>
</tr>
</tbody>
</table>

*For MCA – If a facility is licensed for skilled care then the services for DME are not covered even if the member is in a custodial stay.

### 6.5 – Therapy Authorizations and Claims Payment

When MCP, MCLTC or MCA is the primary payer, the SNF must use contracted therapy providers and therapies must be prior authorized. For a listing of contracted therapy providers, please visit the Mercy Care Provider Directory located on our website under [Find A Provider](#).

Mercy Care members in SNFs may receive covered therapy services more than one time per day when each therapy service visit is prior authorized.

**MCP Acute**
All covered therapy services are included in the per diem rate. The SNF must arrange or provide covered therapy services for MCP Acute members residing in its facility.

**MCPLTC**
Covered therapy services are **not** included in the per diem rate. The SNF should arrange or provide covered therapy services for MCPLTC members residing in its facility.

MCPLTC members may receive covered therapy services more than once per day and each therapy service visit must be prior authorized in order to be reimbursed. The SNF must obtain authorization for therapy services from the Mercy Care Prior Authorization Department.

**MCA**
- When a SNF is paid under RUGS, therapies are included in the RUGS reimbursement
- For SNFs outside of Maricopa County on per diem contracts, therapy is included as part of the per diem rate.

Recent changes made to our system now allow Skilled Nursing Facilities to bill therapy codes along with Custodial Services in a Skilled Nursing Facility on a UB-04 Form. Prior to this change, providers were required to bill therapies separately on a CMS-1500 (02-12) Form. Our provider manual has been updated to reflect this.

We encourage our providers to immediately start to bill these services together on one form (UB-04 Form). Effective 6/1/15, we will no longer allow therapy services to be billed separately.
Allowing this grace period will provide enough time so that providers can incorporate this change into their billing system.

**Medicare Exception:** The only exception to this is when traditional Medicare is the primary payer but there is no Medicare Part A Coverage. Those claims will need to be split on two claims between inpatient services and the ancillary therapy services. This is due to the fact that Medicare pays for Part B ancillary services when there is no Part A coverage. You should bill Medicare for the Medicare Part B covered services. Once you receive Medicare’s Explanation of Benefits, submit the claim with the Medicare EOB separate from the Medicare non-covered inpatient stay.

**6.6 – Insertion of PICC Lines**
Mercy Care pays for PICC line insertion. The physician/nurse practitioner who administers the PICC line must be AHCCCS registered. The Skilled Nursing Facility should not bill directly for this service.

**6.7 - Share of Cost**
Share of Cost (SOC) is the dollar amount a member must contribute toward the cost of their care and typically applies to MCP-LTC members residing in SNFs. The amount of the SOC is determined by AHCCCS. The member is notified of this amount and the SOC is paid to the facility by either the member or their representative, regardless of payment received from other payers or insurance. Additional information regarding SOC includes:
- Share of Cost begins on the first day of the month following placement of the member but may start at a later date depending on AHCCCS processes. SOC is the first money used towards the per diem. SOC is not prorated for partial months.
- One hundred percent (100%) of the SOC for the month of discharge is refunded by the SNF to the member upon discharge if the member is discharged to the community.
- If the member is discharged to another SNF, the SOC amount will be applied to the per diem rate for the days the member was in the first facility. If any SOC money remains, this money should be applied to the second SNF.
- If the member or the member’s designated payee fails to pay the member’s SOC within the facility’s established time requirements, the facility should proceed with its usual collection methods (i.e., reminder telephone call), and notify the case manager.
- If payment is 30 days overdue, the facility shall contact the MCP-LTC case manager and will also contact the member and/or representative and send a collection letter.

**6.8 – Prior Period Coverage**
Prior Period Coverage refers to the period of time from the effective date of AHCCCS eligibility to the day before the member is enrolled with the program contractor. MCP is retroactively liable for payment of covered services received by the member during Prior Period Coverage. In addition:
- AHCCCS is solely responsible for determining if a member is eligible for Prior Period Coverage and also in assigning the Prior Period Coverage eligibility dates.
- MCP is not responsible for payment of non-covered services during the Prior Period Coverage period.
• SNFs should refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310 of the Medical Policy for AHCCCS Covered Services.

6.9 – General Claim Submission Guidelines

MCLTC/MCP Acute
• Mercy Care shall compensate the SNF according to their contract for the provision of Covered Services to eligible members. Reimbursement and service descriptions are also found in the contract with Mercy Care.
• Claims for skilled or custodial stays should be billed on a UB-04 claim form.
• Levels of Care are determined as follows:
  • The appropriate level of care will be determined by the Mercy Care Concurrent Review Nurse utilizing Mercy Care criteria.
  • All Covered Therapy Services are included in the per diem rate. The SNF shall arrange or provide Covered Therapy Services for members while residing in its facility.
  • Pharmacy is not included in the per diem rate. The SNF shall use a contracted pharmacy to obtain medications.
  • Daily documentation in the medical chart of continued need for sub-acute level of care is required.
  • The SNF must notify Mercy Care Staff within 24 hours when a member no longer requires sub-acute level of care services.
• Levels of Care are defined as follows:
  • Level I – Custodial - Member must be pending ALTCS eligibility. Additionally, the member must be awaiting surgery, on tube feeding or oxygen dependent (or identified as new occurrence of need). Level I may include up to one hour per day of therapy (PT/OT/ST).
  • Level II - Sub-Acute - This includes all components of Level I plus any combination of the following must be provided; simple wound care, administration of IV fluids or antibiotics, small volume nebulizer (at 5 or greater) or any therapy up to 2 hours per day (PT/OT/ST). Please note that Level II or greater may go to a Level III.
  • Level III - Intensive Sub-Acute - This includes all components of Level I and II, plus any combination of the following must be provided: 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 the Level III members are located 24 hours a day.
  • Level IV - Vent Care/Dialysis - This includes all components of Level I, II and III, plus ventilator with tracheotomy care or dialysis on site.
**MCA**

- MCA submission of claims is based on the terms of the MCA contract for RUGS reimbursement.
- The secondary claims for MCP Acute services will automatically cross over. You only need to bill the services once.
- Claims for RUGS reimbursement should be billed on a UB-04 claim form.
CHAPTER 7 – TRANSPLANT CLAIMS

MCP/MCPLTC Transplant Claims
This section offers general guidance to providers regarding the billing of transplant claims for Mercy Care Plan and Mercy Care Plan Long Term Care. For additional detail, please refer to the following:

AHCCCS Fee-For-Service Provider Manual – Chapter 24

AHCCCS Medical Policy Manual – Chapter 300 – 310DD – Covered Transplants and Related Immunosuppressant Medications

Mercy Care Plan covers medically necessary transplants for members. In order to be covered, a transplant must be medically necessary, not experimental, and not for the purposes of research. Transplant services must be reimbursable on both a federal and state level.

Although transplant coverage is limited for individuals age 21 and older (adults), Mercy Care covers all medically necessary, non-experimental transplants for individuals under the age of 21 under the EPSDT Program.

Transplant services are excluded for individuals who are only eligible for emergency services under the Federal Emergency Services Program.

Transplant services are covered only when performed in specific settings:

- Solid organ transplantation services must be provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers delineated in 42 CFR Part 482.
- Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation. The facility must also satisfy the Medicare conditions of participation and any additional federal requirements for transplant facilities.

The negotiated specialty contract is held between the provider and AHCCCS and specifies the inpatient, outpatient, and ancillary services that are included and the payment amount to be received for the services provided.

PCPs or Specialists will refer a member to the Transplant Center. The Transplant Center will contact Mercy Care to request prior authorization via the following fax number:

Mercy Care Plan- 855-671-5914

Mercy Care’s Transplant Coordinator will review all prior authorization requests for all transplant service billing components for members enrolled with Mercy Care Plan.
Mercy Care Plan will issue a written decision approving or denying the authorization request within fourteen (14) days from receipt of a complete request for non-emergent services. In the case of emergent requests, the written decision will be provided within three (3) days of the request. Authorizations are input into QNXT by component.

The provider (facility that meets above specified settings) will submit a packet of all individual claims for all transplant related services as a transplant service billing component, along with the Transplant Invoice Coversheet directly to Mercy Care Plan at the following address:

Mercy Care Plan  
Attention: Claims Transplant Coordinator  
Cost Containment Unit  
4500 E. Cotton Center Blvd.  
Phoenix, AZ 85040

The payment amount is based on the specialty contract held by AHCCCS and will be made directly to the facility. The facility is then responsible for paying individual providers for their services. Other claims attached to the component will be entered into QNXT, but will $0.00 pay.

The provider is responsible for billing Mercy Care Plan within six (6) months of the end date of each of the transplant service billing components. Timeliness of the claim submission for each billing component of the transplant will be based on the submission date for the complete set of claims related to the component. Claims initially received beyond the six (6) month time frame will be denied. If a claim is originally received within the six (6) month time frame, Mercy Care Plan has up to twelve (12) months from the end date of the billing component to resubmit the claim and achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjudicated correctly within twelve (12) months of the end date of the billing component, Mercy Care Plan is not liable for payment.

All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis codes, CPT codes, HCPCS procedure codes, and revenue codes to meet clean claim status.

**MCA Transplant Claims**
This section offers general guidance to providers regarding the billing of transplant claims for Mercy Care Advantage. For additional detail, please refer to:

*Medicare’s Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing, Section 90 – Billing Transplant Services*
PCPs or Specialists will refer a member to the Transplant Center. The Transplant Center will contact MCA to request prior authorization via the following fax number:

Mercy Care Advantage - 855-671-5914

Mercy Care Advantage's Transplant Coordinator will review all prior authorization requests for members enrolled with Mercy Care Advantage.

Mercy Care Plan will issue a written decision approving or denying the authorization request within fourteen (14) days from receipt of a complete request for non-emergent services. In the case of emergent requests, the written decision will be provided within three (3) days of the request. Authorizations are input into QNXT.

If a Transplant Network contract, such as LifeTrac or Optum Health is utilized, those transplant networks will send the Transplant Center the contract, including all claims instructions. The Transplant Center then sends Optum or LifeTrac the claims for pricing. Once pricing is completed by LifeTrac or Optum Health, the claims will be sent to Mercy Care Advantage, along with a cover sheet indicating how the claim should be paid. The claims should be sent to:

Mercy Care Advantage  
Attention: Claims Transplant Coordinator  
Cost Containment Unit  
4500 E. Cotton Center Blvd.  
Phoenix, AZ 85040

All Transplant Centers are contracted with LifeTrac, Optum Health, or other transplant networks. For all other billing other than LifeTrac or Optum Health, Mercy Care Advantage should be billed directly and the claims will be paid at either the CMS rates or per their Letter of Agreement.

All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis codes, CPT codes, HCPCS procedure codes, and revenue codes to meet clean claim status.
CHAPTER 8 – NON-PARTICIPATING PROVIDER REGISTRATION

Per The AHCCCS website, any person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation.

All providers of AHCCCS-covered services (either Fee-For-Service or managed care) must meet the following requirements:

- Register with the AHCCCS Administration which requires signing the Provider Agreement that includes Federal requirements under 42 CFR Part 431.107.
- Meet AHCCCS requirements for professional licensure, certification or registration.
- Complete all applicable registration forms.
  - IMPORTANT NOTICE: Planned Parenthood of Arizona has filed a lawsuit seeking to permanently enjoin the State from requiring, as a condition of participation in the AHCCCS program, an attestation regarding abortion services as required by A.R.S. § 35-196.05. The United States District Court for Arizona is scheduled to hold a hearing on that case on October 5, 2012. Until the Court rules following that date, the State has agreed not to terminate any current provider agreements based on the attestation or lack of an attestation. Neither will the State deny any applications to register as an AHCCCS provider based solely on the attestation or the lack of an attestation.
- Institutions (companies/facilities) are required to pay an enrollment fee, effective January 1, 2012
- Specific provider types will require an OIG site visit prior to enrollment, and are subject to unannounced post enrollment site visits ([PDF] | [RTF])

In accordance with the Deficit Reduction Act of 2005, Section 6085, contractors, including Mercy Care Plan, is required to reimburse non-contracted emergency services providers at no more than the AHCCCS Fee-For-Service rate. This applies to in state as well as out of state providers. In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, Mercy Care is required to reimburse non-contracted non-emergent in state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at ninety-five percent of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

Non-participating providers have the option of registering their group with AHCCCS, versus an individual physician. If the non-participating provider wants individual checks to go to each provider within a group, they don’t have to register a group payment provider. However, if they choose to have one check made to the group entity, then they will need to register the group NPI in addition to the individual physician NPI.
If the group or individual we pay is a “Doing Business As”, they must be registered with AHCCCS and their W-9 record provided must match the Tax Identification Number (TIN) registration with the IRS, as the owner of the TIN.

Please feel free to visit the AHCCCS Provider Registration web page which includes the following information:

- **Provider Reenrollment**
- **AHCCCS Provider Registration Enrollment Fee**
- **AHCCCS Provider Registration Packets**
- **AHCCCS Enrollment Application Fee**

Mercy Care cannot process a claim if a provider is not registered through AHCCCS for Mercy Care Plan and Mercy Care Plan Long Term Care. Providers do not need an AHCCCS ID for Mercy Care Advantage. Below are other important guidelines to keep in mind.

- Urgent/emergent services are payable as long as the provider is AHCCCS registered. Please follow the Out of State/One-Time Waiver of Registration Requirements.
- Non-emergent/non-urgent services are only payable if the provider is AHCCCS registered and the provider has attained prior authorization from Mercy Care.
- Any and all services provided by a non-par provider are not payable without a valid prior authorization from Mercy Care.
- A non-participating provider who is part of a contracted group must be credentialed and contracted in order to see Mercy Care members.
- Out of state providers, while subject to interest payment rules, are not subject to prompt payment discounts.
- Medicare certification is required in order to make Mercy Care Advantage payments, along with a valid active NPI. Prior authorization rules apply.