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Information highlighted in yellow represents a change made since the previous edition of the provider manual.
CHAPTER 1 - INTRODUCTION TO MERCY CARE

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

1.1 - About Mercy Care
Mercy Care, when referring to all lines of business, is a not-for-profit partnership created in 1985 and sponsored by Dignity Health and Carondelet Health Network. Mercy Care is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers Mercy Care.

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

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

Please refer to the AHCCCS website for further information on AHCCCS.

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

- **Acute Care**: Members select the managed care plan to administer their benefits. MCP is contracted in Maricopa and Pima Counties to provide covered services to enrolled members.
- **KidsCare**: Healthcare insurance made available by the State of Arizona to offer care at a low cost to Arizona children 18 years old or younger. The KidsCare Office is unable to approve any new applications. Enrollment in the KidsCare Program has been frozen since January 1, 2010 due to lack of funding for the program. Please review the KidsCare webpage on the AHCCCS website for additional information.
- **Division of Developmental Disabilities Long Term Care program**: Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCP is contracted with DDD to provide acute care services.
1.4 - MCP Policies and Procedures
MCP has robust and comprehensive policies and procedures in place throughout its departments that assure all compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates made as needed.

1.5 - Eligibility
DES, Social Security Administration or AHCCCS determines eligibility.

Member ID cards are generated by MCP.

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

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

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

For additional detail regarding Hospital Presumptive Eligibility, please review AHCCCS’ Hospital Presumptive Eligibility web page.
CHAPTER 2 - MERCY CARE PLAN CONTACT INFORMATION

2.0 - Health Plan Contacts Table

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Telephone Number</th>
<th>Health Plan Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Care Plan</td>
<td>602-263-3000 or 800-624-3879 toll-free</td>
<td><a href="http://www.MercyCarePlan.com">www.MercyCarePlan.com</a></td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Internal Contact</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Care</td>
<td>DD Liaison</td>
<td>602-453-6026</td>
</tr>
<tr>
<td></td>
<td>Claim Disputes/Appeals</td>
<td>602-453-6098</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Department</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Prior Authorization</td>
<td>Medical Fax: 800-217-9345 (Toll Free)</td>
</tr>
</tbody>
</table>

**Family Planning Prior Authorization**

(Family planning for DES/DDD Members should also submit their to the Family Planning Fax number. Final approval determination will be made by the DES/DDD medical director prior to providing sterilization and pregnancy termination procedures for members enrolled in DES/DDD.)

You may also call our main number and use the express service for prior authorization listed above.

**Dental**

Please contact DentaQuest at 844-234-9831 or [www.dentaquestgov.com](http://www.dentaquestgov.com).

**Inpatient Hospital and Hospice Services**

Fax: 800-217-9345

**Pharmacy Prior Authorization**

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

**Behavioral Health Department (For Acute and DD members)**

Mercy Care Behavioral Health Coordinator (BHC)  
Phone: 602-263-3000 or 1-800-624-3879  
Fax: 800-873-4570  
The BHC serves as liaison between members, the plan and RBHA.

**Medical Case Management**

Intake Referral – 602-453-8391
### 2.2 - Community Resources Contact Information Table

<table>
<thead>
<tr>
<th>Community Resource</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Early Intervention Program (AzEIP)</td>
<td><strong>Address:</strong> 3839 North Third Street, Suite 304&lt;br&gt;Phoenix, AZ 85012&lt;br&gt;<strong>Phone:</strong> 602-532-9960, toll free in AZ 888-439-5609&lt;br&gt;<strong>Fax:</strong> 602-200-9820&lt;br&gt;<strong>Email:</strong> <a href="mailto:allazeip2@azdes.gov">allazeip2@azdes.gov</a>&lt;br&gt;<strong>Website:</strong> <a href="https://www.azdes.gov/main.aspx?menu=98&amp;id=3026">https://www.azdes.gov/main.aspx?menu=98&amp;id=3026</a></td>
</tr>
<tr>
<td>Arizona’s Smokers Helpline (Ashline)</td>
<td><strong>Address:</strong> P.O. Box 210482&lt;br&gt;Tucson, AZ 85721&lt;br&gt;<strong>Phone:</strong> 800-556-6222&lt;br&gt;<strong>Fax:</strong> 520-318-7222&lt;br&gt;<strong>Website:</strong> <a href="http://www.ashline.org">www.ashline.org</a></td>
</tr>
<tr>
<td>Arizona Women, Infants &amp; Children (WIC)</td>
<td><strong>Address:</strong> 150 N. 18th Avenue, Suite 310&lt;br&gt;Phoenix, AZ 85007&lt;br&gt;<strong>Phone:</strong> 800-252-5942 or 800-2525-WIC&lt;br&gt;To report WIC Fraud &amp; Abuse, call our Fraud Hotline at 866-229-6561 or email <a href="http://www.azwic.gov/">http://www.azwic.gov/</a>&lt;br&gt;<strong>Website:</strong> <a href="http://www.azwic.gov/">http://www.azwic.gov/</a></td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td><strong>Address:</strong> 150 N. 18th Avenue, #200&lt;br&gt;Phoenix, AZ 85007&lt;br&gt;<strong>Phone:</strong> 602-364-4558&lt;br&gt;<strong>Fax:</strong> 602-364-4570&lt;br&gt;<strong>Website:</strong> <a href="http://www.azdhs.gov/bhs/index.htm">http://www.azdhs.gov/bhs/index.htm</a></td>
</tr>
<tr>
<td>Community Information and Referral</td>
<td><strong>Address:</strong> 2200 N. Central Avenue, Suite 601&lt;br&gt;Phoenix, AZ 85004&lt;br&gt;<strong>Phone:</strong> 602-263-8856 800-352-3792 (area codes 520 and 928)&lt;br&gt;<strong>Website:</strong> <a href="http://www.cir.org">http://www.cir.org</a></td>
</tr>
<tr>
<td>Arizona Department of Economic Security – Aging and Adult Service</td>
<td><strong>Phone:</strong> 602-542-4446&lt;br&gt;<strong>Website:</strong> <a href="https://www.azdes.gov">https://www.azdes.gov</a></td>
</tr>
</tbody>
</table>
CHAPTER 3 - PROVIDER RELATIONS

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

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

A Provider Relations representative is assigned to each provider’s office. You may reach your representative directly by calling 602-263-3000 or 800-624-3879, Express Service Code 631. Please click on the appropriate link below to find a listing of your assigned Provider Relations Representative along with their detailed contact information:

- Provider Relation Assignments - Maricopa County
- Provider Relation Assignments - Pima County
- Provider Relation Assignments - All Other Counties
- Provider Relations Management

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

Contact Provider Relations for:
- Recent practice or provider updates
- Forms
- To find a participating provider or specialist
- Termination from practice
- Notifying the plan of changes to your practice
- Tax ID change
- Obtaining a Secure Portal Login ID
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice
CHAPTER 4 - PROVIDER RESPONSIBILITIES

General Provider Responsibilities

4.0 - Provider Responsibilities Overview

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

Providing Member Care

4.1 - AHCCCS Registration

Each provider must first be registered with AHCCCS and obtain an AHCCCS provider ID number. This also includes non-participating providers. For additional information on registering to get an AHCCCS provider ID, please refer to the AHCCCS Provider Registration web page or our Claims Processing Manual, Chapter 8, Non-Par Provider Registration.

4.2 - Appointment Availability Standards

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

4.2a – Appointment Availability Standards Table

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Routine Services</th>
<th>Urgent Care</th>
<th>Emergent Care</th>
<th>High Risk</th>
<th>Wait Time in Office Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>Within 21 days</td>
<td>Within 2 days</td>
<td>Within 24 hours</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Specialty referrals</td>
<td>Within 45 days</td>
<td>Within 3 days of request</td>
<td>Within 24 hours</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>Within 45 days</td>
<td>Within 3 days of request</td>
<td>Within 24 hours</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
</tbody>
</table>
Behavioral Health Provider Appointments:

- Immediate Need appointments within 24 hours from identification of need.
- Routine care appointments:
  - Initial assessment within seven days of referral.
  - The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but no later than 23 days after the initial assessment.
  - All subsequent behavioral health services within the timeframe indicated by the behavioral health condition, but no later than 45 days from identification of need.

Referrals for Psychotropic Medications:

- Assess the urgency of the need immediately.
- If clinically indicated, provide an appointment with a Behavioral Health Medical Professional (BHMP) within the timeframe indicated by clinical need, but no later than 30 days from the identification of need.

4.3 - Telephone Accessibility Standards

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

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

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

### 4.4 - Covering Physicians

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

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

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

4.6 - Verifying Member Eligibility

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

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

Website*:  [www.MercyCarePlan.com](http://www.MercyCarePlan.com). Link available on homepage or you can login to the secure website portal. *You must have a confidential password to access. To register, either contact your Provider Relations representative or fill out the [MercyOneSource Provider Web Portal Registration Form](http://MercyOneSourceProviderWebPortalRegistrationForm) available by clicking the link or in the forms section of our website. More information is available in this Provider Manual under section 4.41 - MercyOneSource.

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

AHCCCS Interactive Voice Response (IVR): To use, dial 602-417-7200. For providers outside of Maricopa County only please dial 1-800-331-5090.

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

Monthly Roster: Monthly rosters are found on the secure website portal. Contact your Provider Relations representative for more information. Note that rosters are only updated once a month. More information is available in this Provider Manual under section 4.41 - MercyOneSource regarding provider rosters.
4.7 - Preventive or Routine Services

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

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

4.8 – Well-Woman Preventative Care Services Provider Requirements

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

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

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

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

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

- Screening and counseling is included as part of the well-woman preventative care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
  - Proper nutrition
  - Physical activity
  - Elevated BMI indicative of obesity
  - Tobacco/substance use, abuse, and/or dependency
  - Depression screening
  - Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
  - Sexually transmitted infections
  - Human Immunodeficiency Virus (HIV)
  - Family planning counseling
  - Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
- Reproductive history and sexual practices
- Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
- Physical activity or exercise
- Oral health care
- Chronic disease management
- Emotional wellness
- Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
- Recommended intervals between pregnancies
- NOTE: Preconception counseling does not include genetic testing.
- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

**WELL-WOMAN PREVENTATIVE CARE SERVICE STANDARDS**

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

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

**4.9 - Educating Members on their own Health Care**

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

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

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

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

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

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

4.11 - Emergency Services

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

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

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

4.12 - Primary Care Providers (PCPs)

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

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

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

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

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

4.13 - Specialist Providers

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

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

4.14 - Second Opinions

A member may request a second opinion from a provider within the contracted network. The provider should make a recommendation and refer the member to another provider.
4.15 - Provider Assistance Program for Non-Compliant Members

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

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

Documenting Member Care

4.16 - Member’s Medical Record

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

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

Each member is entitled to one copy of his or her medical record free of charge. Members have the right to amend or correct medical records. The record must be supplied to the member within fourteen (14) days of the receipt of the request.
When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. This information comes from the AHCCCS Policy 940 – Medical Records and Communication of Clinical Information contained in Chapter 900 – Quality Management and Performance Improvement Program:

- Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)
- Documentation of identifying demographics including the member’s name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member’s mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (required for children; recommended for adult members if available)
- Dental history if available, and current dental needs and/or services
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years)
- Documentation, initialed by the member’s PCP, to signify review of:
  - Diagnostic information including:
    - Laboratory tests and screenings
    - Radiology reports
    - Physical examination notes, and
    - Other pertinent data.
  - Reports from referrals, consultations and specialists
  - Emergency/urgent care reports
  - Hospital discharge summaries
  - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member’s health status changes or new medications are prescribed
  - Behavioral health history
  - Documentation as to whether or not an adult member has completed advance directives and location of the document
  - Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member’s health care.

b) **Medical Record Maintenance** – The provider must maintain member information and records for the longer of six (6) years after the last date provider services were provided to Member, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the member medical record shall survive the termination of a Provider’s contract with MCP, regardless of the cause of the termination.

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

4.17 - **Advance Directives**

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

- Providing written information to adult members regarding each individual’s rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member’s medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

4.18 - **Medical Record Audits**

MCP will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when MCP is responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS for quality review upon request. MCP shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.
4.19 - Documenting Member Appointments
When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at your office without an appointment), providers must verify eligibility and document the member’s information in the member’s medical record.

4.20 - Missed or Cancelled Appointments
Providers must:
- Document and follow-up on missed or canceled appointments.
- Notify Member Services by completing a Provider Assistance Program form located on MCP’s website for a member who continually misses appointments.

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

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

4.22 - Respecting Member Rights
MCP is committed to treating members with respect and dignity at all times. Member rights and responsibilities are shared with staff, providers and members each year. Member rights are incorporated herein and may be reviewed in the Member Handbook located in the MCP website.

4.23 – Consent to Treat Minors or Disabled Members under Guardianship
Health care professionals and organizational providers who treat or provide services for MCP members must comply with federal and state laws requiring consent for the treatment of minors or disabled members under guardianship in order to be HIPAA compliant.

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

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

4.24 - Health Insurance Portability and Accountability Act of 1997 (HIPAA)
The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA
impacts what is referred to as covered entities; specifically, providers, health plans and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All Participating Health Providers (PHP) are required to adhere to HIPAA regulations. For more information about these standards, please visit the Health Information Privacy website. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

4.25 - Cultural Competency, Health Literacy and Linguistic Services

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. (Resource: National Standard for Culturally and Linguistically Appropriate Services in Health Care – Final Report)

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

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

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

Actions for providers and provider organizations to improve health outcomes:

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

Cultural and linguistic competence is defined as:

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

• “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (Ratzan and Parker, 2000)

Responding to cultural and linguistic needs of our members

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

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

- Delivering understandable and respectful care that is provided in a manner compatible with the member’s cultural health beliefs and practices and in their preferred language. Once the baseline understanding of cultural differences is understood, this serves as a context for future communication.

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

When members need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.
Encourage patients to use tools that would help them obtain information to manage their health care. Please refer to our Patient Checklist available under our Reference Material and Guides web page. Ask Me 3 is another one of the tools available. Ask Me 3 is a patient education program designed to improve communication between patients and health care providers, encourage patients to become active members of their health care team, and promote improved health outcomes. The program encourages patients to ask their health care providers three questions:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

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

Use Language Services for Mercy Care Plan members. Providers must deliver information in a manner that is understood by the member. MCP complies with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. MCP strongly recommends the use of professional interpreters, rather than family or friends.

- The TTY line is available for members who are hearing impaired.
- Voiance is the service provider contracted with Mercy Care Plan. They provide telephonic interpretation services in over 200 languages. This service is available at no cost to you or the member. To access telephone interpretation services to assist members who speak a language other than English or who use sign language, please call Voiance directly at either of the following phone numbers:
  - Clinical Services (CL): 1-877-756-4839, pin 1028;
  - or Non-Clinical Services (NC): 1-877-756-4839, pin 1030

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

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

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

- They would be able to read and comprehend prescription bottles, appointment slips, and other essential health-related materials required to successfully function as a patient;
- Have fewer ER visits;
- Have fewer illnesses related to mistakes in taking medication;
- Show up for appointments; and
- Follow up on their treatment plan as prescribed by their provider.
It is important not only to the member, but also the responsibility of all providers and health care service delivery organizations to create a health literacy environment and ensure the patient/provider relationship supports all components of health literacy. Components of Health Literacy include:

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

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

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

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

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

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

1. Keep language simple - no jargon; define terms.
2. Be aware of the member considerations or “roadblocks” to learning.
3. Create an open environment based on respect for the member and allowing them to communicate their cultural beliefs regarding what you are saying.
4. Use the “teach back” method – teach to goal.
5. Encourage members to use Ask Me 3.
6. Get rid of phrase, “Do you have any questions?” and replace with “What questions do you have?”
The teach-back method and communication tips are included in the Provider and Patient Communication Guide available on Mercy Care’s website. There are specific tools and techniques that providers can reference to help create awareness and learn new skills in the health literacy field.

Additional Provider Resources available for your use include:

- [http://www.nih.gov/clearcommunication/culturalcompetency.htm](http://www.nih.gov/clearcommunication/culturalcompetency.htm)
- [http://www.npsf.org/?page=askme3](http://www.npsf.org/?page=askme3)
- [www.healthliteracy.com](http://www.healthliteracy.com)
- [www.healthliteracymissouri.org](http://www.healthliteracymissouri.org)
- [http://nccc.georgetown.edu/information/providers.html](http://nccc.georgetown.edu/information/providers.html)
- [https://community.lincs.ed.gov/group/health-literacy](https://community.lincs.ed.gov/group/health-literacy) (Health Literacy Discussion Group)
- [http://www.ama-assn.org/ama](http://www.ama-assn.org/ama) (Foundation/Health Literacy)
- [http://www.acponline.org/about_acp](http://www.acponline.org/about_acp)
- [http://www.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx](http://www.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx)

### 4.26 - Individuals with Disabilities

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

### 4.27 - Primary Care Provider (PCP) Assignments

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

### 4.28 - Plan Changes

MCP members generally are not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe:

- A member was entitled to freedom of choice, but was not sent an auto-assignment/freedom of choice notice.
- A member was entitled to participate in an Annual Enrollment Choice but:
  - Was not sent an Annual Enrollment Choice notice or
  - Was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member’s control.
Family members were inadvertently enrolled with different Contractors. A member who is enrolled in a Contractor through the auto-assignment process may inadvertently be enrolled with a different Contractor than other family members. Upon receipt of notification by AHCCCS, the member who was inadvertently enrolled will be disenrolled from the Contractor of assignment and enrolled in the Contractor where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the Contractor to which the new member was auto-assigned. This process shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

A member who was enrolled with a Contractor, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled with a different Contractor within 90 days from the date of disenrollment. In this case the member shall be reenrolled with the Contractor that the member was enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct Contractor.

Newborns will automatically be assigned to the mother’s Contractor. If the mother is Title XIX or Title XXI eligible she will be given 30 days from notification to select another Contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 30 days from notification to select another Contractor.

Adoption subsidy children will be auto-assigned and the guardian will be given 30 days from notification to select another Contractor.

A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be given an opportunity to request a Contractor change following auto-assignment. The member will be given 30 days from the date of the choice letter to request a Contractor change. A member who does not make a selection within 30 days will remain with the auto-assigned Contractor.

A member whose eligibility category changed from Sixth Omnibus Budget Reconciliation Act (SOBRA) to the SOBRA Family Planning Extension Program may change to another available Contractor if their current primary care provider (PCP) will not be providing Family Planning Extension Program services.

Plan change requests may be granted based on continuity of medical care. Medical continuity of care situations are as follows:

**Medical Continuity of Prenatal Care**
A pregnant member who is enrolled with a Contractor through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another Contractor, may be granted a medical continuity Contractor change if the medical directors of both Contractors concur.

If there are other individuals in the pregnant member’s family who are also AHCCCS eligible and enrolled, they have the option to remain with the current Contractor or transition to the new Contractor if the medical continuity plan change is granted. The member may not return to the original Contractor or change to another Contractor after the medical continuity Contractor change has been granted except during the AEC period.
Medical Continuity of Care
In unique situations, Contractor changes may be approved on a case-by-case basis if necessary to ensure the member access to medical/health care.

A plan change for medical continuity is not an automatic process. The member’s PCP, or other medical provider, must provide documentation to both the receiving and relinquishing Contractors that supports the need for a Contractor change. The Contractors must be reasonable in the request for documentation. However, the burden of proof that a Contractor change is necessary rests with the member’s medical provider. The Contractor change must be approved by both Contractor Medical Directors.

When the Medical Directors of both the receiving and relinquishing Contractors have discussed the request and have not been able to come to an agreement, the relinquishing Contractor shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/Medical Management Manager within 14 business days from the date of the original request. The results of the review will be shared with both Medical Directors. The relinquishing Contractor will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing Contractor will send the member a Notice of Action.

The plan change determination will be made by the MCP medical director or designee based on information provided by the PCP.

Contractor Responsibilities When a Contractor Change is Not Warranted
The current Contractor has the responsibility to promptly address the member’s concerns regarding availability and accessibility of service and quality of medical care or delivery issues that may have caused a Contractor change request to be initiated. These issues include, but are not limited to:

- Quality of care delivery
- Case management responsiveness
- Transportation convenience and service availability
- Institutional care issues
- Physician or provider preference
- Physician or provider recommendation
- Physician or provider office hours
- Timing of appointments and services
- Office waiting time
- Network limitations and restrictions

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:

- The current Contractor’s Quality Management Department and/or
- The AHCCCS Medical Director
Additionally, the current Contractor must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

Quality of care and delivery of medical services issues raised by the member must be referred to the current Contractor’s quality management staff and/or the Contractor’s Medical Director for review within one day of the Contractor’s receipt/notification of the problem.

The delivery of covered services remains the responsibility of the current Contractor if a Contractor change for medical continuity of prenatal or other medical care is not approved.

The current Contractor must notify the member, in writing, that a Contractor change is not warranted. If the Contractor change request was the result of a member concern, the notice must include the Contractor’s resolution of this concern. The notice must also advise the member of the AHCCCS and Contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members’ period of illness and/or pregnancy in order to provide continuity of care.

Relinquishing Contractor Responsibilities

If a member contacts the current Contractor, verbally or in writing, and states that the reason for the plan change request is due to situations outlined above, the relinquishing Contractor shall advise the member to telephone the AHCCCS Verification Unit at 602-417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

If the member contacts the relinquishing Contractor, verbally or in writing, to request a plan change for medical continuity of care, the following steps must be taken:

- The relinquishing Contractor will contact the receiving Contractor to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both Contractors. When the AHCCCS Contractor Change Request Form is signed it is to be submitted to the AHCCCS Chief Medical Officer.

- To facilitate continuity of prenatal care for the member, Contractors shall sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS Chief Medical Officer within two business days of the member’s Contractor change request. The timeframe for other continuity of care issues is 10 business days.

- The AHCCCS Chief Medical Officer will review the Contractor change documentation and forward to the Communications Center for processing.
Receiving Contractor Responsibilities
The member must be transitioned within the requirements and protocols outlined in AHCCCS’ ACOM Policy 402 and in AMPM Chapter 500.

Member Responsibilities
The member shall request a change of Contractor directly from AHCCCS only for situations defined in above. The member shall direct all other Contractor change requests to the member’s current Contractor.

AHCCCS Administration Responsibilities
The AHCCCS Administration shall process change of Contractor requests listed above and shall send notification of the change via the daily recipient roster to the relinquishing and receiving Contractors. It is the Contractor’s responsibility to identify members from the daily recipient roster who are leaving the Contractor.

If the AHCCCS Administration denies a change of Contractor request, the AHCCCS Administration will send the member a denial letter. The member will be given 60 days to file a grievance.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current Contractor.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change for reasons above, the information will be forwarded to the current Contractor.

Provider Guidelines and Plan Details

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

Mercy Care Plan is the payor of last resort, unless specifically prohibited by State or Federal law. This means that Mercy Care Plan shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. Mercy Care will take reasonable measures to identify potentially legally liable third party sources and reports these to AHCCCS.

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

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

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

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

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

**Post Payment Recoveries**

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

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

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

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

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

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

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

- Motor Vehicle Cases
- Other Casualty Cases
- Tortfeasors
- Restitution Recoveries
- Worker’s Compensation Cases

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

**4.30 - Copayments**

**TMA Copayments**

Effective October 1, 2010, Transitional Medical Assistance (TMA) members over the age of 19 will have mandatory copays for some services. Copays are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$4.00</td>
</tr>
<tr>
<td>All Pharmacy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Surgeries (In-Office, Outpatient, Non-Emergent, Ambulatory Surgery Centers)</td>
<td>$3.00</td>
</tr>
<tr>
<td>Outpatient Professional Therapies</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

Copays may never be collected for the following services:

- Emergency services
- Children under the age of 19
• Services related to pregnancy or any other medical condition which might complicate pregnancy
• Family planning services and supplies

A provider can enforce collection of these copays and a member can be refused service if the member is not able to pay the copay.

**Nominal Copayments**

There are also copayment requirements that apply to all other AHCCCS eligible members. These copayments are called “nominal” copayments and are for the following services in the following amounts:

<table>
<thead>
<tr>
<th>Nominal Copays</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs</td>
<td>$2.30</td>
</tr>
<tr>
<td>Certain Evaluation &amp; Management Services</td>
<td>$3.40</td>
</tr>
<tr>
<td>Certain Physical, Occupational, or Speech Therapy</td>
<td>$2.30</td>
</tr>
</tbody>
</table>

Health care providers may not refuse to provide service if a patient states that they are unable to make these copayments. “Nominal” means that these are non-mandatory copays.

**4.31 - Clinical Guidelines**

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

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

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

MCP has adopted the evidence based guidelines published by the National Guideline Clearinghouse.

**4.32 - Office Administration Changes and Training Requirements**

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

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

- Medical records standards
- Fraud and abuse training
• Behavioral health step therapy for members with depression, post-partum depression, anxiety and attention deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals (appendices E and F)

• PCP training regarding behavioral health referral and consultation services

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

4.33 - Consent Forms

The following consent forms are available on the AHCCCS website:

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

4.34 - Contract Additions or Terminations

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

4.35 - Continuity of Care

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

The Bureau of Health Systems Development has recently posted a new interactive website to help people easily locate a clinic that provides free or low cost primary, mental and dental health services to people without health insurance. These Sliding Fee Schedule clinics determine, based on gross family income, the portion of billed charges that the uninsured client will be responsible for. Sliding Fee Schedules are based on current Federal Poverty Guidelines. The Interactive SFS Clinics map will help you find a clinic in your community, simply by moving the cursor over your neighborhood, or by typing in your zip code or city.

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

You can also download a Mobile App to find federally-funded health centers on the go.

You may also contact MCP’s Case Management Department for assistance.
4.36 - Contract Changes or Updates

Providers must report any changes to demographic information to MCP at least 90 days prior to the change in order to be in compliance with contractual obligations and state and federal regulations. Providers are required to continue providing services to members throughout the termination period. For information on where to send change information, refer to the Table 8, Provider Record Updates (below).

4.36 – Provider Record Updates Table

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

4.37 - Credentialing/Re-Credentialing

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

Temporary/Provisional Credentialing Process

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

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

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

4.38 - Licensure and Accreditation

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

4.39 - Marketing

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

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

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

4.41 - MercyOneSource

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

- **Member Eligibility Search** – Verify current eligibility on one or more members. Please note that eligibility may also be verified through the AHCCCS website.
- **Panel Roster** – View the list of members currently assigned to the provider as the primary care provider (PCP).
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- **Claims Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user’s account provider ID will be displayed.
- **Remittance Advice Search** – Search for provider claim payment information by member name, member ID, provider name, provider ID, date of service, or date range or specific claim number. Only remits associated with the user’s account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user’s account provider ID will be displayed.
- **HEDIS** – Check the status of the member’s compliance with any of the HEDIS measures. “Yes” means the member has measures that they are not compliant with; “No” means that member has met the requirements.

Important provider documents are also available for your use once you sign into Mercy OneSource, including:
- MercyOneSource Provider Web Portal Instructions
- MercyOneSource Add User Process
- MercyOneSource Provider Web Portal Registration Form
- Current and Historical Mercy Care Fee Schedules
- Pro-Report Log On

For registration information regarding MercyOneSource, please access the MercyOneSource Provider Web Portal Registration Form available on the website under the Forms section. Once you have your log in you may access MercyOneSource by clicking on the link.
CHAPTER 5 - COVERED AND NON COVERED SERVICES

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

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

5.1 - Covered Services
Covered Services for all members include:
- Hospital care;
- Doctor office visits, including specialist visits;
- Health risk assessments and screenings for members age 21 years of age and over;
- Laboratory, radiology and medical imaging;
- Durable medical equipment and supplies;
- Medications on Mercy Care Plan’s list of covered medicines. Members with Medicare will receive their medications through Medicare Part D;
- Emergency care;
- Care to stabilize you after an emergency;
- Home health services (such as nursing and home health aide);
- Nursing home, when used instead of hospitalization, up to 90 days a year;
- Inpatient rehabilitation services, including occupational, speech and physical therapy;
- Respiratory therapy;
- Routine immunizations;
- AHCCCS-approved organ and tissue transplants and related prescriptions (limitations apply);
- Dialysis;
- Foot and ankle services;
- Maternity care (prenatal, labor and delivery, postpartum);
- Family planning services;
- Behavioral health services;
- Medically necessary and emergency transportation. 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; Medical foods;
- Emergency eye exam and lens post cataract surgery;
- Urgent care;
- Hospice;
- Wellness exams and preventative screenings; and
- Incontinence briefs to avoid or prevent skin breakdown, with limitations.
**Additional covered services for children (under age 21):**
- Identification, evaluation and rehabilitation of hearing loss;
- Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons;
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, X-rays, fillings, extractions and other therapeutic and medically necessary procedures;
- Vision services, including exams and prescriptive lenses (a limited selection of lenses and frames are covered);
- Outpatient speech, occupational and physical therapy;
- Chiropractic services;
- Conscious sedation;
- Adaptive aids (DD members only);
- Medically necessary practitioner visits to member’s home (DD members only);
- Incontinence briefs, with limitations; and
- Acute services for DDD Members enrolled in CR.

**Additional services for Qualified Medicare Beneficiaries (QMB):**
- Chiropractic services;
- Outpatient occupational therapy; and
- Any services covered by Medicare but not by AHCCCS.

**Limited and Excluded Services:**
The following services are not covered for adults 21 years and older. (If a member is a Qualified Medicare Beneficiary, we will continue to pay their Medicare deductible and coinsurance for these services.)

<table>
<thead>
<tr>
<th>BENEFIT/SERVICE</th>
<th>SERVICE DESCRIPTION</th>
<th>SERVICE EXCLUSIONS OR LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percussive vests</td>
<td>This vest is placed on a person’s chest and shakes to loosen mucus.</td>
<td>AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.</td>
</tr>
<tr>
<td>Bone-anchored hearing aid</td>
<td>A hearing aid that is put on a person’s bone near the ear by surgery. This is to carry sound.</td>
<td>AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.</td>
</tr>
<tr>
<td>Cochlear implant</td>
<td>A small device that is put in a person’s ear by surgery to help you hear better.</td>
<td>AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.</td>
</tr>
<tr>
<td><strong>Lower limb microprocessor controlled joint/prosthetic</strong></td>
<td>A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.</td>
<td>AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Emergency dental service</strong></td>
<td>Emergency treatment for pain, infection, swelling and/or injury</td>
<td>Emergency dental services are covered for members under the age of 21. Covered emergency dental services for members 21 years of age and older are limited to problem focused exam, required X-rays, jaw fractures, biopsies and medically necessary anesthesia.</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>A transplant is when an organ or blood cells are moved from one person to another.</td>
<td>Approval is based on the medical need and if the transplant is on the “covered” list. Only transplants listed by AHCCCS as covered will be paid for.</td>
</tr>
<tr>
<td><strong>Physical therapy</strong></td>
<td>Exercises taught or provided by a physical therapist to make you stronger or help improve movement</td>
<td>Outpatient physical therapy visits are limited to 15 habilitate / 15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 9/30). For dual eligible members, the health plan is responsible for paying the Medicare cost of share limited to 15 habilitate/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1-09/30).</td>
</tr>
</tbody>
</table>

**Orthotic Devices:**
Orthotic devices for members under the age of 21 are provided when prescribed by the member’s primary care provider, attending physician or practitioner.

**Orthotics devices for members who are 21 years of age and older:**
Mercy Care Plan covers orthotic devices for members who are 21 years of age and older when the orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, along with the following criteria:
- The orthotic costs less than all other treatments and surgical procedures to treat the same condition; and
- The orthotic is ordered by a physician or primary care practitioner (nurse practitioner or physician assistant).

**Repairs or Adjustments of Purchased Equipment:**
Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than
renting or purchasing another unit. The component will be replaced if at the time authorization is sought and documentation is provided to establish that the component is not operating effectively.

5.2 - Non Covered Services

- Services from a provider who is NOT contracted with MCP (unless prior approved by the Health Plan)
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;
- Any service that needs prior authorization that was not prior authorized;
- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;
- Services that are determined to be experimental by the health plan medical director;
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by MCP;
- Prescriptions not on our list of covered medications, unless approved by MCP;
- Physical exams for the purpose of qualifying for employment or sports activities;
Other Services that are Not Covered for Adults (age 21 and over);

- Hearing aids, including bone-anchored hearing aids.
- Cochlear implants;
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- Routine dental services and emergency dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members);
- Outpatient speech and occupational therapy (except for Medicare QMB members).
CHAPTER 6 - EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

6.0 - EPSDT Program Overview

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

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

Please refer to the Claims Processing Manual, Chapter 3 – Early Periodic Screen and Developmental Testing (EPSDT) on MCP’s website for specific claim codes.

6.1 - Requirements for EPSDT Providers

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

- Documenting immunizations within 30 days of administration into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children Program.
- Providing all screening services according to the AHCCCS Periodicity Schedule and community standards of practice. The Periodicity Schedule can be viewed by accessing the AHCCCS’ website.
- Ensuring all infants receive both the first and second newborn screening tests. Specimens for the second test may be drawn at the PCP’s office and mailed directly to the Arizona State Laboratory, or the member may be referred to MCP’s contracted laboratory for the draw.
- Using current AHCCCS standardized EPSDT tracking forms to document services provided and compliance with AHCCCS standards. The EPSDT Tracking Forms are available on Mercy Care’s website under Forms. They are also available on the AHCCCS website.
- Sending copies of EPSDT Tracking Forms to MCP on a monthly basis. Please send forms by mail to: 4350 E. Cotton Center Blvd., Bldg. D, Phoenix, AZ 85040 - Attn: Quality Management or fax the forms to 602-431-7157.
- Using all clinical encounters to assess the need for EPSDT screening and/or services.
- Documenting in the medical record the member’s decision not to participate in the EPSDT program, if appropriate.
- Making referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Scheduling the next appointment at the time of the current office visit for children 24 months of age and younger.
- Reporting all EPSDT encounters on required claim forms, using the Preventive Medicine Codes.
Referring MCP members (Acute and DD) to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.

Referring members to WIC, AzEIP and Head Start as appropriate.

Initiating and coordinating referrals to behavioral health providers as necessary.

An EPSDT screening includes the following basic elements:

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

**6.2 - Health Education**

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

**Screenings**

**6.3 - Periodic Screenings**

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of the child's development. The AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1) can be viewed on the AHCCCS website. This schedule follows the Center for Disease Control (CDC) recommendation. Children may receive additional inter-periodic screening at the discretion of the provider. MCP does not limit the number of well-child visits that members under age 21 receive. Claims should be billed with the following CPT/ICD-9-CM Diagnosis (prior to 10/1/15) or ICD-10-CM Diagnosis (effective 10/1/15 and after) Codes based on age appropriateness:
Codes to Identify Well-Child Visits – Ages 0 – 15 Months

**CPT**

**ICD-9-CM Diagnosis Codes for Dates of Service**
**Prior to 10/1/15**

99381, 99382, 99391, 99392, 99461

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

**ICD-10-CM Diagnosis Codes for Dates of Service**
**After 10/1/15**

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

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

**CPT**

**ICD-9-CM Diagnosis Codes for Dates of Service**
**Prior to 10/1/15**

99382, 99383, 99392, 99393

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

**ICD-10-CM Diagnosis Codes for Dates of Service**
**After 10/1/15**

Z00.121, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

Codes to Identify Well-Care Visits – Adolescents

**CPT**

**ICD-9-CM Diagnosis Codes for Dates of Service**
**Prior to 10/1/15**

99383-99385, 99393-99395

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

**ICD-10-CM Diagnosis Codes for Dates of Service**
**After 10/1/15**

Z00.121, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

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

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

The following requirements apply:

- Must be assessed at each visit.
- Members in need of nutritional assessment or nutritional therapy should be identified and referred to a registered dietician in MCP’s network.
- Members in need of nutritional supplements may be referred to Option 1 Nutrition Solutions, LLC, Mercy Care’s contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by Mercy Care. In order to determine prior authorization, MCP requires the AHCCCS Exhibit 320-2, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT Aged Members – Initial or Ongoing Requests) form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity be sent to Option 1 Nutrition Solutions, LLC. Their fax number is 480-883-1193. Option 1 will contact Mercy Care to request prior authorization.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the AHCCCS Medical Policy Manual (AMPM), Chapter 400 – Medical Policy for Maternal and Child Health.

6.5 – Developmental Screening Tools

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

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

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

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

6.6 – PCP Application of Fluoride Varnish

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

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

PCPs and attending physicians must refer EPSDT recipients to a dentist for appropriate services based on the needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 431-1). Evidence of the referral must be documented on the ESPDT Tracking Form and in the recipient’s medical record.

Recipients must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT recipients for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to physician referrals, EPSDT recipients are allowed self-referral to an AHCCCS registered dentist.

AHCCCS recommended training for fluoride varnish application is located at the Smiles For Life website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should 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.

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

Please refer to our Claims Processing Manual, Chapter 3 – Early and Periodic Screen and Developmental Testing (EPSDT), Section 3.3 – PCP Application of Fluoride Varnish for additional claims processing information.
6.8 - Pediatric Immunizations/Vaccines for Children Program

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

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

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

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

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

6.8 - Body Mass Index (BMI)

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>BMI Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>BMI for age &lt;5th percentile</td>
</tr>
<tr>
<td>At risk of Overweight</td>
<td>BMI for age 85th percentile to &lt;95th percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>BMI for age &gt; 95th percentile</td>
</tr>
</tbody>
</table>

6.7 – Body Mass Index (BMI)
If a child is determined to be below the 5th percentile, or above the 85th percentile, the PCP should provide guidance to the member’s parent or guardian regarding diet and exercise for the child. Additional services may be provided or referrals made if medically necessary.

Additional resources available for your review regarding the prevention of childhood obesity include:

AAP Institute for Healthy Childhood Weight
https://ihcw.aap.org/Pages/default.aspx

AAP Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity
http://pediatrics.aappublications.org/content/pediatrics/early/2015/06/23/peds.2015-1558.full.pdf

ADHS

AzAAP Childhood Obesity Committee Toolkit
http://www.getfitazkids.org/

CDC BMI Assessment
http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

6.9 - Blood Lead Screening
All children 6 months to 6 years old are required to have a verbal lead screening completed at each EPSDT visit. Those screening results should identify members who are at risk for blood lead poisoning, and in need of blood lead testing. •

Low-risk: All verbal lead screen questions are answered “No” – blood lead testing is only required if the member resides in a targeted high-risk zip code (see below). •

High-risk: One or more lead screen questions are answered “Yes”. In this case, a blood lead test is required at that visit and each subsequent EPSDT visit.

In addition, in accordance with the AHCCCS Medical Policy Manual (AMPM), all children who are living in targeted high-risk zip codes as indicated in the Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning, published by the Arizona Department of Health Services, and who are 12 months old, 24 months old, or who are 24-72 months old and have not had a previous blood lead test, must have a blood lead test.
6.10 - Eye Examinations and Prescriptive Lenses
EPSDT includes eye exams and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams and refer members to the contracted vision provider for further assessment.

6.11 - Hearing/Speech Screening
Hearing evaluation consists of appropriate hearing screens given according to the EPSDT schedule. Evaluation consists of history, risk factors, parental questions and impedance testing.
- Pure-tone testing should be performed when medically necessary.
- Speech screening shall be performed to assess the language development of the member at each EPSDT visit.

6.12 - Behavioral Health Screening
Screenings for mental health and substance abuse problems are to be conducted at each EPSDT visit. Treatment services are a covered benefit for members under age 21. The PCP is expected to:
- Initiate and coordinate necessary referrals for behavioral health services.
- Monitor whether a member has received services.
- Keep any information received from a behavioral health provider regarding the member in the member’s medical record.
- Initial and date copies of referrals or information sent to a behavioral health provider before placing in the member’s medical record.
- If the member has not yet been seen by the PCP, this information may be kept in an appropriately labeled file in lieu of actually establishing a medical record, but must be associated with the member’s medical record as soon as one is established.

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

In addition to the screening, members three years of age and older must be referred to a dentist at least annually. American Association of Pediatric dentistry recommends that the dental visits begin by age one but the referral isn’t mandatory until age 3. Documented dental findings and treatment must be included in the member’s medical record in the PCP’s office. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:
- **Urgent** - (Within 24 hours) Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer
- **Early** - (Within three weeks) Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas
- **Routine** - (Next regular checkup) none of the above problems identified.

The member’s parent or guardian may also self-refer and schedule dental appointments for the member with any MCP contracted general dentist. They may go directly to the dentist without seeing...
the PCP first and no authorization is required. For more information regarding PCP Fluoride Application, please refer to section 6.6 – PCP Application of Fluoride Varnish.

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

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

6.15 – Metabolic Medical Foods
Children who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. MCP covers medical foods, within the limitations specified in the AHCCCS Medical Policy Manual, (AMPM), Chapter 300 – 320-H Metabolic Medical Foods, for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- Methylcrotonyl CoA Carboxylase Deficiency
- Isovaleric Acidemia
- Methylmalonic Acidemia

State Programs

6.16 - Arizona Early Intervention Program
The Arizona Early Intervention Program (AzEIP) is an early intervention program that offers a statewide system of support and services for children birth through three years of age and their families who have disabilities or developmental delays. This program was jointly developed and implemented by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services, such as physical therapy, occupational therapy, speech/language therapy and care coordination under Sec. 1905 [42 U.S.C 1396d]. Concerns about a child’s development may be initially identified by the child’s Primary Care Provider or by AzEIP.
MCP coordinates with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner to promote optimum child health and development. For additional information, please contact the MCP AzEIP Coordinator.

6.17 - Children’s Rehabilitative Services (CRS)

Effective October 1, 2013 AHCCCS enrolled children with CRS-qualifying conditions under the Acute line of business were transitioned to United Health Care Community Plan for not only CRS related conditions but for all medical care.
CHAPTER 7 - BEHAVIORAL HEALTH

INTRODUCTION
Effective October 1, 2015, in accordance with AHCCCS directives, 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 current Regional Behavioral Health Authority (RBHA) to Mercy Care Plan. Prior to October 1, 2015, this coverage is facilitated by the RBHA (Mercy Maricopa Integrated Care in Maricopa county and CPSA in Pima county).

Please note that we have divided CHAPTER 7 – BEHAVIORAL HEALTH into two sections – one for MEMBERS WITH ACUTE CARE OR DDD PROGRAMS and the other for MEMBERS WITH MEDICARE PRIME PLANS OR MERCY CARE ADVANTAGE for your convenience.

MEMBERS WITH ACUTE CARE – NON-MEDICARE PRIMARY PLANS OR DDD PROGRAMS

7.0 – Behavioral Health Overview
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.

On October, 1, 2010, AHCCCS automatically assigned all Acute Care enrolled members into the RBHA. Members were assigned based on the zip code in which they reside and the RBHA they were assigned to was identified on the Member’s ID Card.

As a result of automatic RBHA enrollment, the RBHA assumes financial responsibility for all behavioral health services upon enrollment with AHCCCS. 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.

7.1 - Behavioral Health Screening
Medically necessary health and behavioral assessment procedures are covered services when used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment and management of physical health problems.

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening is required as a part of the EPSDT screening services for members under age 21.
7.2 – Behavioral Health Emergency Services

When members 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.

7.2a – AHCCCS Acute and DDD Patient Psychiatric and Detoxification Services Crosswalk

<table>
<thead>
<tr>
<th>Patient</th>
<th>Entity Responsible for Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary condition is medical with the need for detoxification secondary.</td>
<td>MCP is responsible.</td>
</tr>
<tr>
<td>Patient requires detoxification and primary condition is <strong>not</strong> medical.</td>
<td>RBHA is responsible for detoxification stay.</td>
</tr>
<tr>
<td>Patient requires inpatient psychiatric care.</td>
<td>RBHA is responsible for inpatient psychiatric care.</td>
</tr>
</tbody>
</table>

Please refer to the AHCCCS Behavioral Health Services Guide for additional information.

7.3 – Behavioral Health versus Medical - Determining Plan Responsibility

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’s.
• If the primary diagnosis listed is a behavioral health diagnosis and the Acute member has a Medicare Prime plan or Mercy Care Advantage, the financial responsibility to process the claim would be Mercy Care’s.
• 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).

7.4 - Behavioral Health Medication Monitoring and Pharmacy Benefits
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 mild depression. PCPs may also make a referral to a RBHA for services to treat these and other behavioral health conditions.
  ▪ 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.

Requirements for PCPs Providing Care to Acute and DDD Members

7.5 – Behavioral Health Clinical Guidelines
PCPs that provide treatment and medication management for ADHD, anxiety and depression 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.

7.6 - Behavioral Health Records
A medical record must be established by the PCP for assigned members when behavioral health information is received from the RBHA or a RBHA provider, even if the member has not yet been seen by the PCP. The behavioral health information must be included as a part of that record. If a medical record has not been established for the member, behavioral health information may be maintained in an appropriately labeled file and incorporated in the medical record when it is established.

Providers should:
  ▪ Initial and date incoming documents from the RBHA or RBHA provider related to behavioral health treatment to demonstrate that the records have been reviewed.
  ▪ Document coordination of care efforts and further treatment recommendations in the member’s medical record.
- Respond within 10 business days to the RBHA or RBHA provider requests for a member’s medical information such as current diagnosis, medication, pertinent laboratory results, last PCP visit and last hospitalization.
- Treat all member behavioral health records and transfer of information with confidentiality, in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines.

### 7.7 – Behavioral Health Required PCP Protocols and Procedures for RBHA Referrals and Transition of Care

Providers must establish and implement protocols and procedures to use when:
- Referring a member to the RHBA.
- Transitioning a member’s care for a behavioral health need to the RBHA.
- Coordinating care for MCP members in their patient panel who are receiving behavioral health services from the RBHA.

The protocols must address:
- Criteria for a referral or transition of care.
- Notification to the RBHA of the referral/transition.
- Transitioning of prescriptions for current medications.
- Timeframes for dispensing and refilling medications during the transition period.

### 7.8 – Behavioral Health Referral of a Member to the RBHA

Acute Care or DD members without a Medicare Prime plan or Mercy Care Advantage as their primary payor may be referred to the RBHA. Referrals to the RBHA for screening, evaluation and treatment may be initiated by:
- A PCP;
- Mercy Care Plan;
- The member or their parent/guardian; or
- Schools, state agencies or other service providers.

The RBHA Referral Form for Acute and DD members without a Medicare Prime plan or Mercy Care Advantage may be mailed or faxed directly to the RBHA and is available on MCP’s website. There are two forms available along with instructions on how to fill out:
- [RBHA Referral Form – Maricopa County Only](#)
- [RBHA Referral Form – Non-Maricopa Counties Only](#)

MCP will provide transportation to a member’s first RBHA evaluation appointment if a member is unable to provide his/her own transportation.

### 7.9 – Behavioral Health Guidelines for Referring a Member to the RBHA

- Use the above mentioned forms to refer a member.
- Provide copies of all applicable records to the RBHA provider per HIPAA guidelines, including but not limited to, the reason for referral, diagnostic information, medical history, medication history and all current prescriptions that have been provided for the member.
• Develop a plan for transition of care if medication management is being transferred.
• Coordinate the transfer of care and ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with a RBHA prescriber. An appointment for a member to be seen by a RBHA prescriber may take up to 30 days or longer. Therefore the PCP’s oversight of member continuity of care during the transition of care is of utmost importance.
• Members may also be referred to the RBHA for concurrent therapy and counseling services while receiving medication management through their PCP. In these circumstances, coordination of care is again of the utmost importance.
• PCPs are required to refer and transition a member’s behavioral health care to the RBHA for members who:
  o Have been admitted to an inpatient hospital for a behavioral health diagnosis.
  o Do not respond to treatment and therefore need additional behavioral health services such as counseling and/or more intense medication monitoring.
  o Present with a behavioral health diagnosis other than ADHD, anxiety, depression, or postpartum depression.
  o Have experienced a sentinel event (e.g. attempted suicide).
  o Require services outside the PCP’s scope of expertise.
• The transition period to the RBHA provider should take place within 30 days, and no later than 90 days. PCPs will receive a return fax with a “Notification of Assessment” after a referral form has been faxed to the RBHA.
• PCPs should maintain documentation in the member’s medical record related to:
  o Ongoing treatment during the transition period;
  o The date that the member was referred;
  o The reason the member was referred;
  o Receiving contact name and pertinent information;
  o The date that the medical record was forwarded to the RBHA; and
  o Any other pertinent information.
• If the PCP does not receive feedback from the RBHA, the medical record must reflect that follow-up was initiated by the PCP with the RBHA and/or the member to inquire about the status of the referral.
• If there is a problem in communicating with the local RBHA regarding a particular referral, contact the MCP behavioral health coordinator for assistance.

7.10 - Behavioral Health Consultations
Consultation regarding treatment options, medications, referrals, and transition of care is available from the RBHA. This may include a telephone consult, a face-to-face evaluation of a member by a psychiatrist, or a comprehensive assessment of the member by the RBHA evaluation specialist. PCPs should specify what information they are seeking, e.g. diagnostic consultation, medication recommendations, or other treatment recommendations. To obtain a behavioral health consultation from the RBHA, PCPs should:
• Contact the RBHA directly and request a consultation; and/or
• Fax the RBHA referral form directly to the RBHA (see instructions above regarding this form).
For questions regarding member referrals to the RBHA for general behavioral health services (nonemergency), transition of care or coordination of care issues, please contact the MCP behavioral health coordinator.

7.11 - Behavioral Health RBHA Services for Mercy Care Plan Acute and DD Members

The RBHA is responsible for screening and evaluation of members to determine their eligibility to receive behavioral health services from RBHA providers. In addition to screening and evaluation, the RBHA provides comprehensive behavioral health services including:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health nursing services
- Behavioral Health case management services
- Emergency behavioral health care
- Emergency/non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level 1 residential treatment centers and sub-acute facilities)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screenings
- Home Care Training to Home Care Client

7.12 – Behavioral Health Members with Diabetes and the Arizona State Hospital

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

7.13 – Behavioral Health Provider Coordination of Care
It is very important that PCPs develop a strong communication link with a member’s behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, diagnosis and treatment within 10 business days of receiving the request from the behavioral health provider.

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

The PCP should also document and initial signing review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate care on behalf of the member should be documented in the member’s medical record.

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

7.15 – Behavioral Health Court Ordered Treatment and Petition Process
At times a MCP member may need to be petitioned through the Mental Health Court.

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

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

**ACUTE MEMBERS WITH MEDICARE PRIME PLANS OR MERCY CARE ADVANTAGE**

**7.16 - Behavioral Health Overview for Members with Medicare Prime Plans or Mercy Care Advantage**

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

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

7.17 - Behavioral Health Provider Types
Several main provider types typically provide behavioral health services for members with Acute Medicare Prime Plans or Mercy Care Advantage. These may include, but are not limited to, the following licensed agencies or individuals:
- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Licensed substance abuse counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse programs

7.18 – Behavioral Health Alternative Living Arrangements
MCP also includes the following alternative living arrangements for Acute Medicare Prime plans or Mercy Care Advantage:
- Behavioral Health Level II and III – these settings provide behavioral health treatment with 24-hour supervision. Services may include on site medical services and intensive behavioral health treatment programs.
- Traumatic Brain Injury Treatment Facility – this setting provides treatment and services for people with traumatic brain injuries.

7.19 – Behavioral Health Emergency Services
MCP covers behavioral health emergency services for Acute 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.

7.20 - Behavioral Health Consults
Behavioral Health consultations are required by AHCCCS on all Acute members with Medicare Prime plans or Mercy Care Advantage who receive behavioral health services. Behavioral Health Consults are completed between an MCP case manager and a behavioral health case manager reviewing the behavioral health provider’s progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultation Process:

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

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

7.21 - Behavioral Health Screening

- Acute members with Medicare Prime Plans or Mercy Care Advantage should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each EPSDT visit for members under age 21.

7.22 - Behavioral Health Appointment Standards
MCP routinely monitors providers for compliance with appointment standards. The minimum standard requirements for Acute members with Medicare Prime Plans or Mercy Care Advantage are:

- **Emergency** – the same day or within 24 hours of the referral request.
- **Initial Assessment** – within 7 days of referral.
- **Ongoing Services** - within 23 days of the initial assessment.
- **Wait Times** – Should be no longer than 45 minutes unless the provider is unavailable due to an emergency.

7.23 - Behavioral Health Provider Coordination of Care Responsibilities

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

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

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

**7.24 – Behavioral Health PCP Coordination of Care**

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

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

The PCP should also document and initial signifying review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate on care on behalf of the member should be documented in the member’s medical record.

**7.25 – Behavioral Health Prior Authorization Requirements and Process**

MCP requires prior authorization for outpatient behavioral health services and hospital admissions to assure medical necessity for Acute 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.

Behavioral health forms available on our website include:
7.26 – Behavioral Health Family Involvement

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

7.27 – Behavioral Health Members with Diabetes and the Arizona State Hospital

Acute members with Medicare Prime plans or Mercy Care Advantage with diabetes who are admitted to the Arizona State Hospital (AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.

- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MCP’s behavioral health coordinator will notify the PCP of the member’s discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MCP behavioral health coordinator will work with AzSH to ensure the member has sufficient testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member’s mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MCP behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.
- For re-authorization for continued behavioral health services, contact the member’s case manager and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

7.28 – Behavioral Health Court Ordered Treatment and Petition Process

At times an MCP Acute member with Medicare Prime Plans or Mercy Care Advantage may need to be petitioned through the Mental Health Court.

Maricopa County

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

**Urgent Psychiatric Care Center/ConnectionsAZ**  
602-416-7600  
903 N. 2nd Street  
Phoenix, AZ  85004

**Psychiatric Recovery Center West/Recovery Innovations**  
602-416-7600  
11361 N. 99th Avenue, Suite 402  
Peoria, AZ  85345

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

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

**Pima County**

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

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

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

**NurseWise**
1-866-495-6735

The evaluating hospitals are:

**Sonora Behavioral Health**
6050 N. Corona Rd. Bldg. 3
Tucson, AZ  85704
520-469-8700

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

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

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

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

**Court Order Definitions**
A Mental Disorder is deemed by ARS Title 36 as follows: A substantial disorder of the person’s emotional processes, thought, cognition or memory. **Exclusions:** the person is primarily disabled due to drug abuse, alcoholism, or mental retardation; declining mental abilities that accompany impending death; or character and personality disorders characterized by life-long and deeply ingrained anti-social behaviors that can be reasonably expected, on the basis of competent medical opinion, to result in serious physical harm.
**Danger to Others (DTO)** [ARS § 36-501-4]: Judgment of a person having a mental disorder is so impaired that he/she is unable to understand his need for treatment and as a result of his/her mental disorder, his/her continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.

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

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

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

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.

**7.29 - Behavioral Health Treatment Plans and Daily Documentation**

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

**Daily Documentation**
Daily documentation is required to reflect the Acute member’s behaviors and issues that occur. This should include frequency of behaviors, frequency and type of staff interventions required throughout the day, and the member’s level of responsiveness to interventions/redirections.
CHAPTER 8 - FAMILY PLANNING

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

Please refer to our Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.14 – Family Planning for the submission of family planning claims.

8.1 - Provider Responsibilities for Family Planning Services
All providers are responsible for:

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

8.2 - Covered and Non Covered Services
Full health care coverage and voluntary family planning services are covered.

The following services are not covered for the purposes of family planning:
- Treatment of infertility;
- Pregnancy termination counseling;
- Pregnancy terminations;
- Hysterectomies;
- Hysteroscopic tubal sterilization;
- Services to reduce voluntary, surgically induced fertilized embryos.

8.3 - Prior Authorization Requirements
Prior authorization is required for family planning services, sterilization or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement.

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

Aetna Medicaid Administrators LLC
800-573-4165

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

Aetna Medicaid Administrators LLC
800-573-4165

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from Mercy Care Plan by faxing your
Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.
CHAPTER 9 - MATERNITY

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

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

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

Maternity Care for Members with Developmental Disabilities
Women with developmental disabilities may have higher rates of adverse pregnancy outcomes. Mercy Care Plan recognizes the needs of DDD enrolled pregnant women and our intent is to keep our providers updated.

ALL pregnant Mercy Care Plan members with a Developmental Disability (DD) designation are considered high risk and require engagement by the high risk perinatal case management team.

Identified DDD enrolled pregnant members enrolled in the case management process receive comprehensive interventions during the perinatal and post-partum periods by skilled professional case managers.

Providers caring for DDD enrolled pregnant women should:
- REFER ALL DDD enrolled pregnant Mercy Care Plan members to the High Risk Perinatal Care Management program. The perinatal case management team will assist with coordination of care by providing member specific education and support, along with referrals to community resources as needed.
- Referrals can be made by faxing both the completed ACOG and OB Referral Forms electronically to Obfaxes@aetna.com or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.
When submitting the ACOG form, please clearly document all high risk issues. Submitted forms are reviewed by our perinatal triage RN. All High Risk pregnant members are case managed by a skilled social worker or registered nurses throughout the perinatal and post-partum period.

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

Members who present with high risk perinatal conditions should be referred to perinatal case management. These conditions include:
- a history of preterm labor before 37 weeks of gestation;
- bleeding and blood clotting disorders;
- chronic medical conditions;
- polyhydramnios or oligohydramnios;
- placenta previa, abruption or accreta;
- cervical changes;
- multiple gestation;
- teenage mothers;
- hyperemesis;
- poor weight gain;
- advanced maternal age;
- substance abuse;
- mental illness;
- domestic violence;
- non-compliance with OB appointments.

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

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

9.4 - Obstetrical Care Appointment Standards
MCP has specific standards for the timing of initial and return prenatal appointments. These standards are as follows:
**Initial Visit**

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

### 9.4 – Pre-Natal Care Appointment Availability Table

<table>
<thead>
<tr>
<th>Category</th>
<th>Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>Within 14 days of the request for an appointment</td>
</tr>
<tr>
<td>Second Trimester</td>
<td>Within seven days of the request for an appointment</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>Within three days of the request for an appointment</td>
</tr>
<tr>
<td>Return Visits</td>
<td>Return visits should be scheduled routinely after the initial visit. Members must be able to obtain return prenatal visits: First 28 weeks - every four weeks From 28 to 36 weeks - every two to three weeks From 37 weeks until delivery – weekly</td>
</tr>
<tr>
<td>High Risk Pregnancy Care</td>
<td>Within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists. Return visits scheduled as appropriate to their individual needs; however, no less frequently than listed above.</td>
</tr>
<tr>
<td>Postpartum Visits</td>
<td>Postpartum visits should be scheduled routinely after delivery. Routine postpartum visits should be scheduled within 21 and 60 days after delivery.</td>
</tr>
</tbody>
</table>

### 9.5 - General Obstetrical Care Requirements

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

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

9.6 - Additional Obstetrical Physician and Practitioner Requirements

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

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

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

9.7 - Provider Requirements for Medically Necessary Termination of Pregnancy

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

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

If the pregnancy termination is requested as a result of incest or rape, the following information must be included:
- identification of the proper authority to which the incident was reported, including the name of the agency
- the report number
- the date that the report was filed

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

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from Mercy Care Plan by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

**9.8 - Reporting High Risk and Non-Compliant Behaviors**

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

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

**9.9 - Outreach, Education and Community Resources**

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

MCP is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including:
- The **WIC Nutritional Program** - Please encourage members to enroll in this program.

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

Questions regarding the availability of community resources may also be directed to the Arizona Department of Health Services (ADHS) Hot Line at 800-833-4642.

**9.10 - Providing EPSDT Services to Pregnant Members Under Age 21**

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

**Additional Claims Information**

While these services are already performed in the initial prenatal visit, additional information is necessary for claims submission. The provider (PCP or OB) providing EPSDT services for members 12-20 years of age, must submit the medical claims for these members. When submitting claims, please include one of the following codes that reflect the appropriate EPSDT visit:

- **Ages 12 through 17 years**
  - New patient - 99384
  - Established patient - 99394

- **Ages 18 through 20 years**
  - New patient - 99385
  - Established patient - 99395

**9.11 - Loss of AHCCCS Coverage During Pregnancy**

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

**9.12 - Pre-Selection of Newborn’s PCP**

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

**9.13 – Newborn Notification Process**

Providers must fax a newborn notification to Mercy Care Plan’s dedicated Profax number—
1-844-525-2221. Mercy Care Plan will report newborn information to AHCCCS and in turn will fax back the newborn AHCCCS ID number to the provider.

**Authorization Information**

**Well Newborn:**
- No authorization is required for vaginal delivery (2 days).
- No authorization is required for cesarean section delivery (4 days).

**Sick Newborn:**
- Authorization will be created and faxed back to provider with newborn AHCCCS ID and authorization number.
CHAPTER 10 - DENTAL AND VISION SERVICES

Dental Services

10.0 – DentaQuest

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

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

MCP will administer the following for our members:

- Grievances
- Customer Service Calls from Members

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

**By Mail**
Mercury Care Plan
Dental Claims Department
P.O. Box 61235
Phoenix, AZ 85082-1235

**Electronic Submissions**
Through Electronic Clearinghouse

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

DentaQuest of Arizona, LLC – Attention: Claims
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 claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest’s 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.

**Vision Services**

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

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

10.2 - Coverage for Children (Under Age 21)

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

10.3 - Nationwide Referral Instructions

Nationwide is MCP’s contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by the PCP’s office to a Nationwide provider listed on MCP’s website. The member may call Nationwide directly to schedule an appointment.
10.4 - Coverage for Adults (21 years and older)

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

10.5 - Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MCP’s Member Services at 602-263-3000 or 800-624-3879 (toll-free), Express Service Code 629.
CHAPTER 11 - CASE MANAGEMENT AND DISEASE MANAGEMENT

11.0 - Case Management and Disease Management Overview

MCP has a comprehensive case management program. The Medical Case Management team considers the medical, social and cultural needs of members by targeting, assessing, monitoring and implementing services for members identified as "at risk." Case Management services are available for all eligible members, excluding MCP (acute and DD) members who are identified as "at risk," such as transplant and hemophilia, or those who are high-service utilizers, and are assigned a case manager.

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

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

Please refer to the Clinical Guidelines available on MCP’s website for treatment protocol related to:

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

11.1 - Referrals

The MCP central intake coordinator accepts referrals from any source. Please call the central intake coordinator at 602-453-8391 to make a referral. For the most part, the central intake coordinator can respond to questions and resolve the issue during the initial call. However, a case management referral is initiated for members that require more than a single intervention. Case managers will contact the member either by telephone or by letter. The Case Management staff communicates with members, family and the PCP on an ongoing basis while the member’s case is open.

11.2 - Case Management MCP Acute and DD

MCP provides case management services to medically complex members. The members are assigned to an RN, LPN or social work case manager who works closely with the PCP and member to coordinate care and services. The case manager also collaborates with community resources, home health services and PCPs to coordinate medical care and assure appropriate access to medical and social services.

Members who meet any of the following criteria and do not fall under other identified categories of case management also will be considered for case management services:
- High utilizers of services
- Frequent inpatient readmissions
- Substance abusers
- Poor compliance with prescribed medical treatment
- Experiencing social problems that are impacting medical care
- Overuse of emergency department
- Complex care needs

A health assessment will be conducted of each member accepted into case management. A care plan will be developed and the member’s compliance with the plan will be monitored. The case manager interacts routinely with the PCP, the member and the member’s care giver/family.

11.3 - HIV/AIDS

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

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

11.4 - High Risk OB

Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB case manager to try to ensure a good newborn/mother outcome. Please refer to Chapter 9 – Maternity of this Provider Manual for additional information. The case manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy case management, shelters and counseling to address substance abuse issues. A case manager monitors the pregnant woman throughout the pregnancy, and provides support and assistance to help reduce risks to the mother and baby.

Case managers also work very closely with the PCP to make sure that the member is following through with all prenatal appointments and the prescribed medical regimen. Members with complex medical needs are also assigned a medical case manager so that all of the member’s medical and perinatal care issues are addressed appropriately.
11.5 - Behavioral Health

The Case Management department is available to assist with referrals to RBHA and to help members who are experiencing problems related to behavioral health services. Please refer to Chapter 7 - Behavioral Health of this Provider Manual for additional information.

11.6 - Disease Management

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

The objectives of disease management programs are to:

- Identify members who would benefit from the specific disease management program.
- Educate members on their disease, symptoms and effective tools for self-management.
- Monitor members to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care.
- Provide evidence-based, nationally recognized expert resources for both the member and the provider.
- Monitor effectiveness of interventions.

The following conditions are specifically included in MCP’s Disease Management programs and have associated Clinical Guidelines that are reviewed annually.

11.7 - Asthma

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

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

- Preventing chronic symptoms.
- Maintaining “normal” pulmonary function.
- Maintaining normal activity levels.
- Maintaining appropriate medication ratios.
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations.
- Providing optimal pharmacotherapy without adverse effects.
- Providing education to help members and their families better understand the disease and its prevention/treatment.
11.8 - Chronic Obstructive Pulmonary Disease (COPD)

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

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

11.9 - Congestive Heart Failure (CHF)

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

11.10 - Diabetes

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

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

11.11 - Active Health

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

Active Health will expand MCP’s opportunities to identify members at risk for poor health outcomes and to communicate directly with the providers who are responsible for their care, in a time-critical mode. It also enables the member to work closely with their physician to choose treatments and tests
that are right for them. Active Health utilizes data received through claim, lab and pharmacy submissions to identify potential opportunities to meet evidence based guidelines, such as through the addition of new therapies, avoidance of contraindications or prevention of drug interactions. When an opportunity is identified for our member, a formal patient-specific communication will be sent to the provider to assist in offering health care to the patient based upon the physician’s independent medical judgment. A “Care Consideration” letter will be sent to the member as well, encouraging them to discuss the “Care Consideration” with their physician.

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

Examples of “Care Consideration” are:

- If the member is a diabetic and there are no records that the patient has had their eyes checked or an HgA1c lab has been done.
- If the patient has a heart condition and there are no records to show that the member is on any type of drug to lower cholesterol.
CHAPTER 12 - CONCURRENT REVIEW

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

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

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

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

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

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted MCP providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers). The CRN
is key in assisting with discharge planning and may authorize services required for a safe discharge such as pharmacy, home health and DME. MCP CRN staff work to make sure there is a safe discharge even when the primary payor is not MCP so it is important that the facilities notify MCP of all members.

- Informing hospital staff and attending physician of covered benefits as indicated.

12.3 - Physician Medical Review

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

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

For inpatient denials, hospital staff is verbally notified when MCP is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal claim dispute may be filed according to the established MCP claim dispute process.
CHAPTER 13 - PHARMACY MANAGEMENT

13.0 - Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized provider, such as a PCP, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The Preferred Drug List (PDL), also referred to as a Formulary, identifies the medications selected by the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of our members in a cost effective manner.

13.1 - Updating the Preferred Drug Lists (PDLs)

MCP’s PDLs are developed, monitored and updated by the P&T Committee. The P&T Committee continuously reviews the PDLs and medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

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

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

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

13.2 - Notification of PDL Updates

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

13.3 - Prior Authorization Required

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

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

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs. Please see section 13.12 - Request for Non-PDL Drugs for additional information.

13.4 - Over The Counter (OTC) Medications

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

13.5 - Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with A-rated products is mandatory unless the brand has been specifically authorized or as otherwise noted. Medications on the PDL noted with an asterisk (*) will be filled with the brand name only, even when a generic form is available. In all other cases, brand names are listed for reference only.
13.6 - Diabetic Supplies
Diabetic supplies are limited to a one-month supply (to the nearest package size) with a prescription.

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

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

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

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

13.9 - Family Planning Medications and Supplies
Aetna Medicaid Administrators LLC administers the family planning benefit for MCP that includes:

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

13.10 - Behavioral Health Treatment of ADHD, Anxiety and Mild Depression
For Acute and DD members, behavioral health benefits, including antipsychotics, are covered by the RBHA and provided by RBHA contracted pharmacies. Please refer to Chapter 7 - Behavioral Health in this Provider Manual for additional information. PCPs must use the AHCCCS Behavioral Health Services Guide for the treatment and prescribing of medications for ADHD, Anxiety and Depression.
PCPs may prescribe behavioral health medications to treat selected behavioral health disorders for MCP Acute and DD members. These include ADHD, mild depression or anxiety disorder. Behavioral health must be:

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

For more information regarding ADHD, please reference the CDC webpage [ADHD in Young Children](https://www.cdc.gov/mentalhealth/adhd/preschool.html).

### 13.11 - RBHA Covered Services Medication Management Program

Close communication between PCP’s and RBHA prescribers must occur to prevent duplicate filling of prescriptions by both the RBHA and MCP. PCPs may treat members for ADHD, anxiety and depression. If the PCP believes the member’s condition is beyond his/her area of expertise or the member fails to respond to treatment, the member must be referred to the RBHA for ongoing treatment, medication management and prescriptions. Members who are enrolled with the RBHA must be referred to a RBHA contracted pharmacy to have their prescriptions filled. For a list of RBHA contracted pharmacies refer to the website of the RBHA in your county.

### 13.12 - Request for Non-PDL Drugs

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

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

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

Requests should be sent to:

Aetna Medicaid Administrators, LLC  
Corporate Pharmacy Director  
4645 E. Cotton Center Blvd.  
Building 1, Suite 200  
Phoenix, AZ 85040
CHAPTER 14 - QUALITY MANAGEMENT

14.0 - Quality Management Overview
MCP works in partnership with providers to continuously improve the care given to our members. The MCP Quality Management (QM) Department is comprised of the following areas:
- The Quality of Care Review unit monitors the quality of care provided by the PHP network, as well as the review and resolution of issues related to the quality of health care services provided to members.
- The Prevention and Wellness unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters. Findings are reported to AHCCCS and to providers about their performance on specific quality indicators.
- The Credentialing unit is responsible for provider credentialing/recredentialing activities.

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

14.2 - Quality of Care, Peer Review and Fair Hearing Process
The QM department reviews potential quality of care (QOC) issues referred by internal and external sources. Applicable medical records are requested from providers as needed for review. The QOC, peer review and fair hearing processes are all confidential. Each QOC issue is assigned a severity level based on potential adverse effect(s) for the member. In addition, cases are trended and reported to the QM/UM Committee. QOC Severity Levels are as follows:
- **Level 0** - No quality of care or utilization issue exists and no action is needed.
- **Level 1** - Potential for significant adverse effect(s) on the member was not found, no harm or negative outcome occurred, and the risk of further problems is low.
- **Level 2** - Potential for significant adverse effect(s) was evident. Because of the care received or services provided, or because of the omission of care or services, the member required a change in the plan of care or suffered a complication, which caused no major life impact.
- **Level 3** - Medical management resulted in significant adverse effect(s). Because of the care received or services provided, or omission of care or services, the member suffered a major complication or poor outcome.

14.3 - Escalation Process
All potential QOC issues involving health professionals are forwarded to the CMO or one of the MCP medical directors for review. After review, it may be determined that a case should be referred to a specialist for further review. The case is sent to the medical care ombudsman. Program is sent for review by a provider in the same specialty as the subject provider.
If indicated by the evaluation conducted by the MCP medical director or specialist review, the QOC case is forwarded to the Executive Session of the QM/Utilization Review (UM) Committee for peer review discussion, final determination and recommendation for action. Health professionals have the right to appeal adverse actions such as termination from MCP.

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

**14.4 - Ambulatory Medical Record Review**

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

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

**14.5 - Quality Management Studies**

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

- Reducing hospital readmissions
- Increasing utilization of E-Prescribing

**14.6 - Data Collection and Reporting**

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

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

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

14.7 - Reports
The QM department has developed reports for health professionals on the following topics:
• Well woman: A quarterly report of members who are in need of a mammogram, cervical cancer screening or chlamydia screening.
• Diabetes: A quarterly report of members diagnosed with diabetes and diabetes-related services rendered during the past 12 months.
• Immunizations: A monthly report listing members due for one or more immunizations.
• Well Child: A monthly report listing members due for a Well Child visit.
• HEDIS Star: A quarterly report listing MCA members in need of one or more of the following services:
  o Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
  o Breast Cancer Screening
  o Controlling High Blood Pressure
  o Comprehensive Diabetes Care
  o Colorectal Cancer Screening
  o Osteoporosis Management in Women Who Had a Fracture
14.8 - Credentialing/Re-Credentialing

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

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

14.9 - Streamlining Process

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

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

- AZ Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS)
- ADHS Division of Children’s Rehabilitation Services (CRS) and
- AZ Department of Economic Security, Division of Developmental Disabilities.

MCP performs the following activities:

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

14.10 - CRS Eligible Members

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

MCP activities include overseeing referrals to the RBHA for behavioral health screenings, evaluations and treatment; coordination of benefits with the statewide RBHA system; consultation with MCP departments regarding MCP Acute members with behavioral disorders; and serving as the contact for selected members with a behavioral health disorder.

For members with a developmental disability, activities include coordination of benefits with DES/DDD and private insurance carriers; consultation with other MCP departments to ensure that they receive medically necessary services; monitoring the timeliness of service delivery; providing information to members and their parents/guardians and providers; and coordinating with DES/DDD support managers regarding long term care and other services that members are also entitled to receive.
CHAPTER 15 - REFERRALS AND AUTHORIZATIONS

15.0 - Referral Overview

It may be necessary for a MCP member to be referred to another provider for medically necessary services that are beyond the scope of the member’s PCP. For those services, providers only need to complete their own Referral Form and refer the member to the appropriate MCP PHP. MCP’s website includes a provider search function for your convenience. More information is available in this Provider Manual under section 4.41 - MercyOneSource concerning prior authorizations.

There are two types of referrals:

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

Referrals must meet the following conditions:

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

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

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

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

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

15.1 - Referring Provider’s Responsibilities

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

**15.2 - Receiving Provider’s Responsibilities**

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

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

**15.3 - Period of Referral**

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

**15.4 - Maternity Referrals**

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

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

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

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MCP referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
  - Through twenty-eight weeks of gestation – every four weeks
  - Between twenty-nine and thirty six weeks gestation every two weeks
  - After the thirty sixth week – once a week
  - Schedule first-time appointments within the required time frames
  - Members in first trimester – within seven calendar days
  - Members in third trimester – within three calendar days
High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

15.5 - Ancillary Referrals
All practitioners and providers must use and/or refer to MCP contracted ancillary providers.

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

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

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

15.7 - Prior Authorization
MCP requires prior authorization for select acute outpatient services and planned hospital admissions.

Prior authorization is not required for the following:

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

Prior authorization guidelines are reviewed and updated regularly. To request an authorization, to find out what requires authorization, or check on the status of an authorization, please visit MercyOneSource. More information is available in this Provider Manual under section 4.41 - MercyOneSource concerning authorizations. You may also call our Prior Authorization department at 602-263-3000 or 800-624-3879 (toll-free) and dial Express Service Code 622.

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

- **Routine Request**: Request will be responded to within a maximum of fourteen (14) calendar days upon receipt of request.

**15.9 - Medical Prior Authorizations**
The Medical Prior Authorization team is responsible for processing prior authorization request for nonemergency, elective procedures and services.

**15.10 – Complex Radiology Service Authorizations**
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

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.
15.11 – Bariatric Surgery Approval Process

Bariatric surgery is covered by Mercy Care as long as there is evidence based criteria to support the need for the surgery. Bariatric surgery requires prior authorization and the following information must be documented and met:

- Certificate of Seminar Attendance and class attendance.
- 2 years of medical records (must include documented weight history) and if possible a monthly summary.
- BMI of 35 or greater with one co-morbidity.
- Six month physician supervised diet. It must be consecutive and within the last two years. Each monthly visit must be documented and signed by the physician. For your convenience, MCP has a Bariatric Surgery Monthly Summary Form that must be filled out. This form is available under the Forms section of our website or by clicking on the link. Documentation includes:
  - The date the patient was seen
  - The patient’s weight
  - Detailed documentation of the weight loss program the patient is following, including progress or non-progress
  - The patient’s BMI
  - Exercise activity (increase/decrease). If there is an inability to exercise this must be documented as to why.
  - A Food/Exercise journal must be reviewed on monthly visits with the PCP.
- Letter of recommendation from the Primary Care Physician documenting medical necessity.
- One consultation of a Nutritionist or Dietician, as soon as possible.
- Psychological Evaluations (including MMPI) are only necessary for a patient who has an established behavioral health diagnosis. It is recommended this be completed by the fourth month into the program. A behavioral health condition may be exacerbated or may interfere with the long-term management of the patient after the procedure.
- Cardiac clearance and pulmonary clearance are recommended for patients. MCP requires the actual test results and a letter stating that the patient is cleared for surgery by the Cardiologist and the Pulmonologist, respectively.

Mercy Care maintains a list of approved Bariatric Surgeons to conduct the surgery, Nutritionist/Dieticians to provide nutritional counseling, as well as contracted psychologists to provide evaluations for bariatric surgery (only if the patient has an existing behavioral health diagnosis). Please contact our prior authorization department to get a list.

Member steps for approval requirements for bariatric surgery are as follows:

- Attend Bariatric seminar of surgeon of choice
- Obtain a referral to a Bariatric surgeon.
- Start requirements with monthly documentation of diet/exercise with primary care doctor (six consecutive months).
- Obtain a referral to dietician/nutritionist (as soon as possible after seminar and consult with surgeon).
• Start food/exercise journal as soon as possible, documenting everything (and how much) the patient eats and drinks on a daily basis. The amount of exercise and type must be tracked as well. Members should discuss with their PCP at their monthly visit and results should be documented in the PCP’s notes. The PCP’s notes are the notes reviewed by MCP.
• Fourth month into program, obtain referrals for clearances to the Psychologist (if needed based on an existing behavioral health diagnosis), Cardiology and Pulmonary physicians.
• Support groups are recommended (all surgeons have their own groups). Members will need to find their own transportation. Mercy Care will transport to first meeting only,
• The PCP writes all referrals.
• When all requirements are completed, the member will have documenting PCP send the six months of documentation, including clearances and past medical history to the bariatric surgeon.
• The process of getting the paperwork reviewed and signed by the surgeon to send to health plan may take several weeks.

15.12 - Pharmacy Prior Authorization
The Pharmacy Prior Authorization team is responsible for processing prior authorization requests for the following:
• Medications not included in the MCP’s PDL, also referred to as a formulary.
• Medications that require prior authorization.
• Step Therapy medications.
• Medications with Quantity Limits.

A team of registered pharmacists and certified pharmacy technicians authorize based on a set of pre-established clinical guidelines. Refer to Chapter 13 – Pharmacy Management in this Provider Manual for additional information.

15.13 - Nutritional Assessment and Nutritional Therapy
MCP covers nutritional assessment and nutritional therapy for members over 21 on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake.
The following requirements apply:
- Must be assessed at each visit.
- Members in need of nutritional assessment or nutritional therapy should be identified and referred to a registered dietician in MCP’s network.
- Members in need of nutritional supplements may be referred to Option 1 Nutrition Solutions, LLC, Mercy Care’s contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by Mercy Care. In order to determine prior authorization, MCP requires the AHCCCS Attachment C – Certificate of Medical Necessity for Commercial Oral Nutritional Supplements for Members 21 Years of Age or Greater – Initial or Ongoing Request form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity be sent to
Option 1 Nutrition Solutions, LLC. Their fax number is 480-883-1193. Option 1 will contact Mercy Care to request prior authorization.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the AHCCCS Medical Policy Manual (AMPM), Chapter 300 - 310-GG Nutritional Assessments and Nutritional Therapy.

15.14 – Metabolic Medical Foods
Members who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. MCP covers medical foods, within the limitations specified in the AHCCCS Medical Policy Manual, (AMPM), Chapter 300 – 320-H Metabolic Medical Foods, for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- Methylcrotonyl CoA Carboxylase Deficiency
- Isovaleric Acidemia
- Methylmalonic Acidemia

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

15.16 - Prior Authorization and Referrals for Services

- **Laboratory Services and Referrals:** Prior authorization is NOT required for approved in office lab procedures that are on Mercy Care’s in office labs code list. MCP is contracted with Sonora Quest to provide laboratory services. Please refer to our Claims Processing Manual under Chapter 2 – Professional Claim Types by Specialty, Section 2.0 – Laboratory for a listing of Mercy Care’s in office labs code list.

- **Radiology Services Referrals:** Prior authorization IS required before referring members for certain radiology services. To request an authorization, find out what requires authorization or check on the status of an authorization, please visit MercyOneSource.

- **Infusion or Enteral Therapy Referrals:** Prior authorization is NOT required to refer members to a contracted infusion or enteral provider. However, any medically necessary services rendered by an infusion, enteral provider or through a home health agency must be prior authorized. All
infusion medications must be processed through the MCP PBM (Pharmacy Benefit Manager) pharmacy benefit. Referrals may be processed through the PBM. All enteral needs are processed through the nutritional therapy contracted provider for MCP and comply with medical necessity criteria.

- **Durable Medical Equipment (DME) Referrals:** Prior authorization is **NOT** required to refer members to a contracted DME provider. However, certain services may require prior authorization, as indicated in the provider’s contract.

- **DES/DDD Prior Authorization:** Prior authorization **IS** required. For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from Mercy Care Plan by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

**15.17 - Prior Authorization and Coordination of Benefits**

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

**15.18 - Prior Authorization Contacts**

**Inpatient Hospital and Hospice Services**
Fax: 800-217-9345

**Pharmacy Prior Authorization**
Fax: 800-854-7614 (Toll Free)

**Behavioral Health Department**
(For Acute and DD members)
Mercy Care Behavioral Health Coordinator (BHC).
Fax: 602-414.7669

The BHC serves as liaison between members, the Plan and RBHA.
CHAPTER 16 - BILLING, ENCOUNTERS AND CLAIMS

16.0 - Billing Encounters and Claims Overview

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

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

BILLING

16.1 - When to Bill a Member

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

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

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

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

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

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

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

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

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

ENCOUNTERS

16.3 - Encounter Overview

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

16.4 - When to File an Encounter

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

16.5 - How to File an Encounter

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

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

**16.6 - When to File a Claim**

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

**16.7 - Timely Filing of Claim Submissions**

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

Mercy Care shall not pay:
- Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
- Claims that are submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later (A.R.S.§36-2904.G).

Regardless of any subcontract with Mercy Care Plan, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor); the provider may file a claim for payment with the responsible Contractor. The provider must submit a clean claim to the responsible Contractor no later than:
- 60 days from the date of the recoupment,
- 12 months from the date of service, or
- 12 months from date that eligibility is posted, whichever date is later.

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

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

**16.8 - MCP as Secondary Insurer**

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

- File an initial claim with MCP if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely in order to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to MCP, showing the other insurer payment amount or denial reason, if applicable, and enclosing a complete legible copy of the remittance advice or Explanation Of Benefits (EOB) from the other insurer.
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, MCP will coordinate payment of benefits.
In accordance with requirements of the Balanced Budget Act of 1997, MCP will pay co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lower of either MCP’s fee schedule or the Medicare/other insurance allowed amount.

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

Claims should be resubmitted within one year from the last date of service or 60 days from the date of the other insurance explanation of benefits, whichever is later, once the other insurance explanation of benefits is received.

16.9 - Dual Eligibility Mercy Care Advantage Cost Sharing and Coordination of Benefits
For MCA members enrolled in both MCP and MCA, any cost sharing responsibilities will be coordinated between the two payors. For the most part, providers only need to submit one claim to MCP and MCA and benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under the section titled Instruction for Specific Claim Types.

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

16.11 - How to File a Claim
1) Select the appropriate claim form (refer to table below).

### 16.11a – Claim Form Type

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

Instructions on how to fill out each claim form type can be found on Mercy Care’s website under the Claims Processing Manual, Chapter 1 – General Claims Processing Information, Section 1.2 – Form Types and Instructions.
2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit **original** copies of claims electronically or through the mail (do NOT fax or hand-deliver). To include supporting documentation, such as members’ medical records, clearly label and send to the Claims department at the correct address.
   a) Electronic Clearing House
      Providers who are contracted with MCP can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
      ▪ The EDI vendors that Mercy Care Plan uses are as follows:
        ○ Change Healthcare
        ○ SPSI
        ○ SSI
      ▪ Contact your software vendor directly for further questions about your electronic billing.
      ▪ Contact your Provider Relations representative for more information about electronic billing.

Additional information can be attained by reviewing Mercy Care’s **Claims Processing Manual**, Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and MercyOneSource.

All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and MCP policies and procedures.
b) Through the Mail

16.11b - Claim Address Table

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

*See individual sections for further information: 16.19 - Claim Resubmission or Reconsideration and 17.1 - Provider Claim Disputes.

16.12 - Correct Coding Initiative

MCP and AHCCCS follow the same standards as Medicare’s Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please review the CMS website under National Correct Coding Initiative Edits.

MCP utilizes ClaimCheck as our comprehensive code auditing solution that will assist payors with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with both AHCCCS and CMS, in addition to pertinent coding information received from other medical organizations or societies.

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

Providers will have access to Clear Claim Connection through MCP’s website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.
Further detail on how to use Clear Claim Connection can be found on the application itself by using the help link. Clear Claims Connection can be found after logging in to MercyOneSource.

16.13 - Correct Coding
Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:
- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

16.14 - Incorrect Coding
Examples of incorrect coding include:
- “Unbundling” - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

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

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

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with evaluation and management codes 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. MCP follows the same billing
process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one line reporting one unit with a 50 modifier.

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

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

**EP Modifier – Service provided as part of a Medicaid early periodic screening diagnosis and treatment [EPSDT] program** – must be appended to CPT code 96110 to receive additional developmental screening tool payment. For additional information please refer to our Claims Processing Manual, Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT), which is available on our website.

**SL Modifier – State Supplied Vaccine** – If a vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code. For additional information please refer to our Claims Processing Manual, Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT), Section 3.4 – Vaccines for Children Program, which is available on our website.


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

**16.17 - Checking Status of Claims**
Providers may check the status of a claim by accessing MCP’s secure website or by calling the Claims Inquiry Claims Research (CICR) department.

**Online Status through MCP’s Secure Website**
MCP encourages providers to take advantage of using online status, as it is quick, convenient, can be used off-hours, and used to determine status for multiple claims. To register, go to MercyOneSource and Log In or contact your Provider Relations representative to establish a Login. More information is available in this Provider Manual under section 4.41.
MercyOneSource. MercyOneSource is available 24 hours a day/7 days a week to providers. 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.

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

The Claims Inquiry department is also available to:
- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
  - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
  - Excludes rebilling a claim (the entire claim must be resubmitted with corrections, see section 16.19 - Claim Resubmission or Reconsideration.

Please be prepared to give the service representative the following information:
- Provider name and AHCCCS provider number with applicable suffix if appropriate.
- Member name and AHCCCS member identification number.
- Date of service.
- Claim number from the remittance advice on which you have received payment or denial of the claim.

16.18 - Payment of Claims
MCP processes and records the payment of claims through a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MCP encourages providers to take advantage of receiving Electronic Remittance Advices (ERA), as you will receive much sooner than receiving through the mail, enabling you to post payments sooner. Please contact your Provider Relations representative for further information on how to receive ERA. Remittance Advice samples are available under the Forms section of the Mercy Care website. Links to those remits are available under the section 16.29 - Provider Remittance Advice in this Provider Manual.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. MCP encourages you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. You may enroll in EFT by submitting an Electronic Funds Transfer (EFT) Form. Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT implementation. Your Provider Relations representative will assist you with this.
Additional information can be attained by accessing the Claim Processing Manual, Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and MercyOneSource on Mercy Care’s website.

16.19 - Claim Resubmission or Reconsideration

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

Providers may resubmit a claim that:

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

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

- Use the Resubmission Form located under the Forms section of Mercy Care’s website.
- An updated copy of the claim. All lines must be rebilled or a copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as “Resubmission” or “Reconsideration” at the top of the claim in black ink and mail to appropriate claims address as indicated in 16.11b - Claim Address Table.

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

If billing a resubmission electronically, you must submit with:

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

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

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

16.20 Overpayments

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

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

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

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

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

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

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

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

Supporting documentation must include:
- The overpayment claim number(s); and/or
- The remittance advice specific to the overpayment.

**INSTRUCTION FOR SPECIFIC CLAIMS TYPES**

**16.21 - MCP General Claims Payment Information**
MCP claims are always paid in accordance with the terms outlined in the PHP’s contract. Prior authorized services from Non PHPs will be paid in accordance with AHCCCS processing rules.

**16.22 – Inpatient Claims**
MCP processes inpatient claims at APR-DRG in accordance with AHCCCS requirements. Please refer to our [Claims Processing Manual, Chapter 4 – Inpatient Claims](#) for additional detail.

**16.23 – Federally Qualified Health Centers (FQHCs)**
Special billing rules apply to FQHCs. Please refer to our [Claims Processing Manual, Chapter 5 – Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) Processing](#) for additional detail on how these claims should be billed.

**16.24 - Skilled Nursing Facilities (SNFs)**
Providers submitting claims for SNFs should use the [CMS UB-04 Form](#). Please refer to our [Claims Processing Manual, Chapter 6 – Skilled Nursing Facility Claims](#) for additional detail on how these claims should be billed.

**16.25 - Dental Claims**
Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on [Form 1500 (02/12)](#). Please refer to our [Claims Processing Manual, Chapter 2 – Professional Claims by Specialty, Section 2.11 – Dental Claims](#), as well as [Section 2.12 – Oral Surgery Claims](#) on Mercy Care’s website for additional claims information.

**16.26 – Durable Medical Equipment (DME)**
Mercy Care Plan covers reasonable and medically necessary durable medical equipment (DME) when ordered by a primary care provider or a practitioner within certain limits based on member age and
eligibility. Durable Medical Equipment (DME) may be purchased or rented. Total expense of the rental must not exceed the purchase price of the item.

16.27 - Family Planning Claims
- Claims for medical services will only be accepted on Form 1500 (02/12).
- Inpatient hospitalizations, outpatient surgery and emergency department facility claims should be filed on CMS UB-04 Form.
- Please refer to our Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.14 – Family Planning Claims for additional billing information.
- Family Planning services may be billed with other services on the same claim. When billed on the same claim though, a provider will receive two remits, one for family planning services and one for non-family planning services, as these services are paid out of separate funds.
- Family Planning claims may be submitted electronically.

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

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

If you have authorization or claims questions related to family planning, please call:
- Aetna Medicaid Administrators LLC
  602-798-2745: Phoenix
  888-836-8147: Outside Phoenix

16.28 - Complete Obstetrical Care Package
Reimbursement for obstetrical care is dependent upon the provider’s contract with Mercy Care. Please refer to your contract for further detail. Providers are expected to bill for obstetrical care according to the terms of their contract and should file claims using a Form 1500 (02/12).
Fee for Service
For additional information regarding fee for service billing, please refer to our Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing. It is important to note that providers must bill all pre-natal and post-partum visits when submitting a finalized claim. This information is required per AHCCCS guidelines to increase the data available for calculating Performance Measures as well as to provide an opportunity to improve care, services and outcomes for members. Most providers are currently contracted on a fee for service basis and are paid in accordance with CPT Guidelines.

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

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

Services will not be separately reimbursed if billed separately.

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

Services Not Included in the Package
- Amniocentesis
- Obstetrical Ultrasonography
- Non-stress and contraction stress tests
- Coloscopy and/or biopsy for accepted indication
- Return to operating or delivery room for postpartum hemorrhage/curettage
- Non-obstetrical related medical care
- Cerclage.
Separate reimbursement will be provided, if medically necessary.

16.29 - Trimester of Entry into Prenatal Care

Claims for obstetrical services are submitted on Form 1500 (02-12). Health providers must bill in accordance with our Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing.

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

16.30 - Provider Remittance Advice

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

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

Information provided on the remit includes:

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

The Ending Balance represents any funds still owed to MCP after this payment cycle. This will result in a negative Amount Paid.

The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.

The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
- Member/Patient Name
- ID
- Birth Date
- Account Number,
- Authorization ID, if Obtained
- Provider Name,
- Claim Status,
- Claim Number
- Refund Amount, if Applicable

The Claim Totals are totals of the amounts listed for each line item of that claim.

The Code/Description area lists the processing messages for the claim.

The Remit Totals are the total amounts of all claims processed during this payment cycle.

The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

The following Remittance Advice samples are available under the Forms section on Mercy Care’s website:

- Mercy Care Plan Remit Format for Check
- Mercy Care Plan Remit Format for EFT
- SA FPS Remit Format for Check
- SA FPS Remit Format for EFT

More information is available in this Provider Manual under section 4.41 - MercyOneSource regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact your Provider Relations Representative to assist you with this process.
CHAPTER 17 – GRIEVANCES, APPEALS AND CLAIM DISPUTES

17.0 - Grievances
MCP’s Grievance System includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the State Fair Hearing system.

A Grievance is described as any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member’s behalf. A grievance may be submitted orally or in writing to any Mercy Care Plan staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity)
- Claims or billing
- Failure to respect a member’s rights

In order to file a grievance, members and/or providers filing on behalf of a member, should contact Member Services by phone at 602-263-3000, Toll-Free at 800-634-3879, or in writing at:

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

Mercy Care will respond and resolve member grievances at the time of the initial call, if possible, or within 90 days if further investigation is needed. In the event that resolution to the grievance is not favorable to the member or representative, Mercy Care will also provide written information to both members and providers, regarding the Grievance and Appeal System requirements. This includes:

- The right to a state fair hearing, the method for obtaining a state fair hearing
- The Rules that govern representation at the hearing
- The right to file grievances, appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claims disputes
- The availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or appeal by phone
- That benefits will continue when required by the member in an appeal or a state fair hearing request concerning certain actions which are timely filed
- That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the member, and
- That a provider may file an appeal on behalf of a member with the member’s written consent
If the grievance involves a quality of care concern, it will be forwarded to Mercy Care Plan’s Quality Management Department for further review. The concern will be investigated and the member and/or the member’s representative will be notified in writing within 90 days of the results of the investigation.

17.1 - Provider Claim Disputes

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

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

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

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

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

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

MCP will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MCP may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:
Mercy Care Plan  
Appeals Department  
4350 E. Cotton Center Boulevard, Building D  
Phoenix, AZ 85040

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

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

17.2 - Appeals

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

Standard Appeals - An appeal must be filed either orally or in writing with MCP within 60 days after the date of the Notice of Action. A provider may assist a member in filing an appeal. MCP does not restrict or prohibit a provider from advocating on behalf of a member.
Standard Appeal Resolution - MCP will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MCP receives the appeal.

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

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

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

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

A member may also file an Appeal orally by contacting:

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

An authorized representative, including a provider, acting on behalf of the member, with the member’s written consent, may request a State Fair Hearing on behalf of the member. The request for State Fair Hearing must be in writing, submitted to and received by MCP, no later than 30 days after the date the member receives the Notice of Appeal Resolution.
All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care Plan
Appeals Department
Attention: Hearing Coordinator
4350 E. Cotton Center Boulevard, Building D
Phoenix, AZ 85040
602-351-2300 (fax)
CHAPTER 18 – FRAUD AND ABUSE

18.0 - Fraud and Abuse Overview

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

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

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

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

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

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

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

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

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686.
AHCCCS has published to its website an e-learning seminar entitled "Fraud Awareness for Providers" that discusses provider and member fraud. This seminar is available at the following website under the tab marked Fraud Awareness for Providers:

https://azahcccs.gov/Fraud/Providers/

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

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

18.1 - Deficit Reduction Act and False Claims Act Compliance Requirements

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

Activities for which one may be liable under the FCA:

- Knowingly presenting to an officer or employee of the United States government a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting false or fraudulent claims allowed or paid.
- Having possession, custody, or control of property or money used, or to be used by the government and, intending to defraud the government by willfully concealing property, delivering, or causing to be delivered less property than the amount for which the person receives.
- Authorizing to make or deliver a document, certifying receipt of property used by the government and intending to defraud the government and making or delivering a receipt without completely knowing that the information on the receipt is true;
- Knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

The definition of “knowing” and “knowingly” as it relates to the FCA includes actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, and/or acting in reckless disregard of the truth or falsity of the information. Proof of specific intent to “defraud” is not required for reporting potential violations of the law.

18.2 - False Claims Training Requirements
As required by MCP’s contract with AHCCCS Administration, providers must train their staff on the following:
- The administrative remedies for false claims and statements.
- Any state laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower (or relater) protections under such laws.

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

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

Additional information on the Deficit Reduction Act and False Claims Act is available on the following websites:
- Deficit Reduction Act – Public Law 109-171
- Arizona Revised Statutes (ARS):
  - ARS 13-1802: Theft
  - ARS 13-2002: Forgery
  - ARS 13-2310: Fraudulent schemes and artifices
  - ARS 13-2311: Fraudulent schemes and practices; willful concealment
  - ARS 36-2918: Duty to report fraud
  - AAC R9-22-1101, et seq.: Civil Monetary Penalties and Assessments