Skilled Nursing Facility
Reference Guide

Updated: April 2014
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CHAPTER 1 - INTRODUCTION TO THE GUIDEBOOK

The information contained in this reference guide is intended to assist the reader in understanding the Skilled Nursing Facility (SNF) process implemented by Mercy Care Plan (MCP), Mercy Care Long Term Care (MCLTC) and Mercy Care Advantage (MCA).

The Mercy Care Provider manuals may be accessed by clicking the appropriate below links by plan:

Mercy Care Plan Provider Manual

Mercy Care Long Term Care Provider Manual

Mercy Care Advantage Provider Manual
## CHAPTER 2 – GENERAL CONTACT NUMBERS BY DEPARTMENT

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Care General Intake Number</td>
<td>602-263-3000 or 800-624-3879</td>
</tr>
<tr>
<td>Case Management</td>
<td>602-263-3000 or 800-624-3879</td>
</tr>
<tr>
<td>Case Management Referral</td>
<td>602-586-1870</td>
</tr>
<tr>
<td>Claims Inquiry/Claims Research (CICR)</td>
<td>602-263-3000, Express Service Code 626</td>
</tr>
<tr>
<td>Mercy Care’s Behavioral Health Crisis Line</td>
<td>800-876-5835</td>
</tr>
<tr>
<td>Pharmacy Prior Authorization</td>
<td>602-263-3000, Express Service Code 625</td>
</tr>
<tr>
<td>Medical Prior Authorization</td>
<td>602-263-3000, Express Service Code 622</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>602-263-3000, Express Service Code 631</td>
</tr>
<tr>
<td>Transportation Department</td>
<td>602-263-3000, Express Service Code 630</td>
</tr>
</tbody>
</table>
# CHAPTER 3 - FREQUENTLY USED ACRONYMS, DESCRIPTIONS AND DEFINITIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS</td>
<td>Arizona Health Care Cost Containment System</td>
<td>The Arizona Health Care Cost Containment System (pronounced ACCESS) is a program that is funded by state and federal dollars and acts as the health insurer for Members who qualify for Medicaid, KidsCare and ALTCS.</td>
</tr>
<tr>
<td>ALTCS</td>
<td>Arizona Long Term Care System</td>
<td>The Arizona Long Term Care System (pronounced ALLTEKS) is a state and federally funded program administered by AHCCCS to provide long term, acute, behavioral health and case management services to eligible members. Members are the elderly and/or physically disabled who meet financial eligibility and are at risk for institutionalization, and individuals with developmental disabilities.</td>
</tr>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
<td>Services to assess and treat mental health and substance abuse issues.</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Centers for Medicare &amp; Medicaid Services is a division within the Department of Health and Human Services and is the funding source and regulator of the AHCCCS program and all Medicaid, Medicare and State Children’s Health Insurance programs throughout the country.</td>
</tr>
<tr>
<td>CCR</td>
<td>Concurrent Review</td>
<td>Concurrent review is a utilization management function performed by Mercy Care Plan nurses on each inpatient admission to acute care hospitals or extended care facilities (with the exception of custodial stays for MCLTC members.)</td>
</tr>
<tr>
<td>CRN</td>
<td>Concurrent Review Nurse</td>
<td>A nurse who completes concurrent review</td>
</tr>
<tr>
<td>DD</td>
<td>Developmental Disability</td>
<td>DD is a designation that is used for a person with a developmental disability. Eligibility for DD services is determined by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Intake Unit.</td>
</tr>
<tr>
<td><strong>DME</strong></td>
<td><strong>Durable Medical Equipment</strong></td>
<td>Durable medical equipment is an item that can withstand repeated use such as a hospital bed, wheelchair, or crutches.</td>
</tr>
<tr>
<td><strong>EDI</strong></td>
<td><strong>Electronic Data Interchange</strong></td>
<td>Electronic Data Interchange allows the provider to submit their claims electronically for more accurate submission of information and faster processing.</td>
</tr>
<tr>
<td><strong>EFT</strong></td>
<td><strong>Electronic Funds Transfer</strong></td>
<td>Electronic Funds Transfer allows the transfer of claim payments to be electronically sent to a designated bank account.</td>
</tr>
<tr>
<td><strong>EOB</strong></td>
<td><strong>Explanation of Benefit</strong></td>
<td>Explanation of Benefits is a remittance that is sent out explaining payment of benefits.</td>
</tr>
<tr>
<td><strong>ERA</strong></td>
<td><strong>Electronic Remittance Advice</strong></td>
<td>Electronic Remittance Advice allows the provider to receive their remit electronically through an 835 file. This allows the provider to post to their practice management system quicker and more efficiently than by receiving paper remits.</td>
</tr>
<tr>
<td><strong>INSPIRIS</strong></td>
<td></td>
<td>INSPIRIS is the name of a contracted provider with Mercy Care that provides a nurse practitioner model of care within SNFs for specific health plan members.</td>
</tr>
<tr>
<td><strong>MCLTC</strong></td>
<td><strong>Mercy Care Long Term Care</strong></td>
<td>Mercy Care Long Term Care is a department within Mercy Care that is responsible for the oversight of the ALTCS members assigned to MCLTC.</td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>Title XIX</strong></td>
<td>Medicaid is a federal/state program authorized by Title XIX of the Social Security Act that provides federal matching funds for a medical assistance program for recipients of federally aided public assistance, SSI benefits and other specified groups.</td>
</tr>
<tr>
<td><strong>MEDICARE</strong></td>
<td><strong>Title XVIII</strong></td>
<td>Medicare is a federal program authorized by Title XVIII of the Social Security Act that provides for health services for Members 65 years of age and older and selected others.</td>
</tr>
<tr>
<td><strong>MEDICARE FFS</strong></td>
<td><strong>Medicare Fee for Service</strong></td>
<td>Medicare Fee for Service is what is known as traditional/original Medicare. Members may go to any doctor, specialist, hospital or health care provider that accepts Medicare. Members are charged a fee each time they receive a service from that provider. Members pay a deductible and/or a co-pay.</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
<td>Details</td>
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<td>--------------</td>
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<tr>
<td><strong>MCA</strong></td>
<td>Mercy Care Advantage</td>
<td>Mercy Care Advantage is contracted with the Centers for Medicare &amp; Medicaid (CMS) as a Medicare Advantage Prescription Drug Plan designed specifically for enrollees with Special Needs. Mercy Care Advantage enrolls only individuals who are dually eligible for both Medicare and Medicaid. MCA covers all traditional Medicare services and value added benefits.</td>
</tr>
<tr>
<td><strong>MCP</strong></td>
<td>Mercy Care Plan</td>
<td>Mercy Care Plan provides health care services for AHCCCS Acute, Mercy Care Long Term Care, and Developmentally Disabled (DD) Members. Mercy Care Plan also does business as Mercy Healthcare Group (MHG) which provides health care coverage for small business employer groups of fifty persons or less.</td>
</tr>
<tr>
<td><strong>NOMNC</strong></td>
<td>Notice of Medicare Non Covered Services</td>
<td>Notice of Medicare Non Covered Services is a requirement of the Centers for Medicare &amp; Medicaid Services for all Mercy Care Advantage and FFS Medicare Members.</td>
</tr>
<tr>
<td><strong>PCP</strong></td>
<td>Primary Care Provider</td>
<td>The term Primary Care Provider is used interchangeably with Primary Care Physician. The PCP is responsible for the overall management and coordination of a Member’s health care.</td>
</tr>
<tr>
<td><strong>PDL</strong></td>
<td>Preferred Drug List</td>
<td>A Preferred Drug List is a list of drugs chosen by Mercy Care Plan and a team of doctors. Mercy Care Plan will generally cover drugs listed in Mercy’s Preferred Drug List as long as they are medically necessary. Prescriptions must also be filled at a Mercy Care Plan network pharmacy in accordance with Plan rules.</td>
</tr>
<tr>
<td><strong>RBHA</strong></td>
<td>Regional Behavioral Health Authority</td>
<td>Regional Behavioral Health Authority (pronounced REEBAH) are entities that are designated by the Arizona Department of Health Services to provide covered behavioral health services to eligible AHCCCS and DD long term care Members.</td>
</tr>
<tr>
<td><strong>RUGS</strong></td>
<td>Resource Utilization Groups</td>
<td>Resource Utilization Groups are a payment term type utilized by CMS in response to the Balanced Budget Act of 1997 which mandated the implementation of a per diem Prospective Payment System (PPS) for SNFs covering all costs (routine, ancillary, and capital) related to the services furnished to beneficiaries under Part A of the Medicare program.</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td>Skilled Nursing Facility</td>
<td>Skilled Nursing Facilities are Mercy Care providers that must be Medicare certified facilities and are licensed by the Department of Health Services.</td>
</tr>
<tr>
<td><strong>SOC</strong></td>
<td>Share of Cost</td>
<td>Share of Cost is the amount paid by MCLTC members to contribute to the cost of their care based on their income and type of placement. Generally, only those members in institutions such as SNFs have a share of cost, which is an amount determined by AHCCCS.</td>
</tr>
<tr>
<td><strong>TRIAD</strong></td>
<td>Triad is the name of a contracted provider with Mercy Care Plan that provides a high touch model of care within SNFs for specific health plan members.</td>
<td></td>
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</tbody>
</table>
CHAPTER 4 – ROLES AND RESPONSIBILITIES

SNFs and Mercy Care have defined roles and responsibilities necessary to provide quality services. The roles and responsibilities outlined below are intended to assist facilities in the delivery of quality care to MCP, MCLTC and MCA members and to clarify processes that will facilitate prompt and accurate reimbursement for delivered covered services.

The intent of this information is to provide assistance to SNFs and does not replace or supersede the contract or the Provider Manual.

SNF Roles and Responsibilities

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

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

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

• **Notify Mercy Care regarding Patient Trust Accounts**
SNFs are required to send patient Trust Account summaries to the Mercy Care Plan (MCP) Finance Department on a quarterly basis within 10 days of the end of the previous quarter (January, April, July, and November).

• **Communicate with Provider Relations**
SNFs have a designated Provider Relations representative to assist with issues regarding claims payment or any other identified service issues.

• **Use Contracted Providers**
SNFs must use providers that are contracted with Mercy Care., i.e., durable medical equipment (DME), hospitals (for non-emergencies), labs, therapy, and non-emergency transportation.

**MCP Roles and Responsibilities**

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

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

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

• **Provider Relations**
  - Provider Relations representatives are available to assist in getting your research service issues resolved.
  - Provider Relations representatives serve as a point of contact for service issues and will collaborate with other Mercy Care staff on behalf of the SNF.
CHAPTER 5 - MEDICAL PROVIDERS

INSPIRIS – Nurse Practitioners

INSPIRIS is a contracted provider with Mercy Care that provides health plans with a system of clinical care using a nurse practitioner model that can reduce cost and acute-care hospitalization of Medicare members who live in nursing homes. INSPIRIS nurse practitioners focus on communication between the provider, the member, the family member and the health plan with the goal of alleviating inappropriate medical intervention and unnecessary emergency care and hospitalization.

INSPIRIS partners with individual health plans and customizes the services which they offer based on the needs of the individual health plan. The nurse practitioner in a SNF may be providing different services to residents based on the contract specifications between INSPIRIS and the individual’s health plan. Mercy Care’s contract with INSPIRIS provides nurse practitioner service for residents in SNFs who are:

- Mercy Care Plan members with MCA
- Mercy Care Plan members who do not have Medicare
- Mercy Care Plan members who have Medicare Part B, but not Medicare Part A

INSPIRIS nurse practitioners must obtain authorization from Mercy Care for all services requiring authorizations through the traditional prior authorization process. INSPIRIS nurse practitioners must use Mercy Care formularies and must obtain authorizations for pharmacy and any treatments outside the typical services covered by Mercy Care.
CHAPTER 6 - GENERAL AUTHORIZATION GUIDE

Mercy Care Plan requires prior authorization for selected acute outpatient services and planned hospital admissions.

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

MCLTC case managers authorize custodial stays for all MCLTC Members.

When requesting an authorization for a skilled stay for inpatient SNF admission, sufficient information must be provided or Mercy Care will not be able to generate the prior authorization. In order to expedite the prior authorization process, please be prepared to provide the following information when calling:

- Facility Face Sheet
- Admit Date
- Admit Diagnosis
- Which services will be rendered

When making a request for a continued authorization, please complete the request on the Skilled Stay Continued Authorization Request Form. It is available on the Mercy Care website at www.MercyCarePlan.com or www.MercyCareAdvantage.com or call your Provider Relations representative if you do not have web access. Missing or inaccurate information may delay important processing of the review and ultimately, the payment of the claim. This request will be reviewed for clinical information to certify the continuation of the stay (intensity of need vs. intensity of services being rendered).

The Continued Authorization Request Form must contain the following:

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

**MCP – Acute**

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

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

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

• **Sub-Acute (Skilled) Stay**
  - The SNF calls the MCP SNF Authorization Line at 602-263-3000, Express Code 622 for initial authorization for SNF placement.
  - The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.
  - The SNF nurse or designee will issue an authorization number to the SNF with an approved length of stay and level of care.
  - NOTE: INSPIRIS does not manage these members.
  - For continued stay requests, the SNF must fax to the SNF review line or call the SNF Authorization Line with clinical information to support continued stay.
  - The SNF can use their form or MCP’s [Skilled Stay Continued Authorization Request Form](#) to submit requests. This must be done at least 3 days prior to end date of authorization.
  - MCP CRN or designee will render a decision within 24 hours of receipt of clinical information.
  - The purpose of concurrent review is to reach an agreement between MCP and the SNF at the time the member is in the SNF.
  - If the SNF disagrees with the level of care or length of stay after the member has been discharged, the SNF must appeal.
  - If MCP Acute secondary applies to Medicare Fee for Service (FFS) or another Medicare Advantage Plan or other primary insurance the following applies:
    - No authorization is required for co-pay, co-insurance or deductible
    - Claims need to be billed separately

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

• MCLTC/Non-Medicare
  - Sub-Acute (Skilled) Stay
    - For new admissions from the hospital, Medical Management will notify SNF of sub-acute (skilled) stay and give level of care and authorization number.
    - For members currently in the nursing home who have had a change of treatment and now qualify for sub-acute level, the nursing home will call the assigned MCP CRN and provide substantiating information.
    - Mercy Care Plan’s SNF CRN will communicate with the MCLTC Case Manager when the member is no longer in a sub-acute (skilled) stay.
  - Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)
    - MCLTC Case Manager determines level of care based on supporting documentation.
    - MCLTC Case Manger creates an authorization and notifies SNF.
    - There is no secondary payer for custodial care.
    - Other commercial carriers will not cover a custodial stay.
    - Mercy Care pays 100% of contracted rate minus member’s Share of Cost (SOC).

• MCLTC/Medicare
  - Sub-Acute (Skilled) Stay
    - No authorization is required for co-pay, co-insurance or deductible.
    - Claims need to be billed separately.
  - Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)
    - MCLTC Case Manager determines level of care based on supporting documentation.
    - MCLTC Case Manager creates an authorization and notifies SNF.
    - There is no secondary for payer for custodial care. Other commercial carriers will not cover a custodial stay. Mercy Care pays 100% of the contracted rate less member’s Share of Cost (SOC).
• MCA
  o Sub-Acute (Skilled) Care
    ▪ The SNF calls the MCP SNF Prior Authorization Line at 602-263-3000, Express Code 622 for initial authorization for SNF placement.
    ▪ The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.
    ▪ The Concurrent Review Nurse or designee will issue an authorization number to the SNF at that time, with an approved length of stay.
    ▪ SNF must give MCA the RUGS code after the MDS assessment is reviewed.
      • RUGS code must be given within 14 days of admission to skilled stay or at the point of discharge if the stay is less than 14 days.
      • Claims payment cannot be made if there is no RUGS code reported.
      • If the RUGS code changes within the stay of the member, the SNF must fax the SNF review line, 602-414-7252, with the updated RUGS code.
      • If a claim is billed with RUGS code(s) different than initially provided, the claim will deny.
    ▪ For continued stay requests, the SNF must fax to the SNF review line or call the SNF prior authorization line with clinical information to support continued stay.
      • The SNF may use their internal form or the MCA Cru to submit request. This must be submitted at least 3 days prior to end date of authorization. MCA CRN or designee will render a decision within 24 hours of receipt of clinical information.
      • After a determination has been made by MCA that the enrollee no longer meets the criteria and must be discharged, the SNF is responsible for serving the Notice of Medicare Non Coverage (NOMNC) to the enrollee at least 2 days in advance of the services ending and retain the NOMNC in their records.
      • If an enrollee decides to appeal the discharge, the Quality Improvement Organization (QIO) will contact the plan asking for medical records supporting the discharge decision and MCA is required to provide those records by the end of the day of request.
      • If the QIO overturns the appeal, the QIO will notify MCA of the discharge date for the enrollee and MCA is responsible for payment through that date. If QIO concurs with MCA, the enrollee is financially responsible if he/she chooses to remain in the facility beyond the discharge date.
  ▪ MCP is responsible for co-insurance, co-pay or deductible.
    • No authorization is required
    • SNF must bill with appropriate Medicaid revenue code(s)
• **Hospice Authorizations**
MCP members who have Medicare Part A through Original Medicare or through MCA do not require authorization for hospice services because the hospice provider bills Medicare directly. For additional information regarding hospice payments under MCA, please refer to our Provider Notification titled, [Hospice Election Coverage While Covered Under Mercy Care Advantage (HMO SNP)].

Hospice is a covered service for MCLTC members who do not have Medicare; however, authorization is required by Mercy Care. SNFs should advise hospice providers to request authorization from Mercy Care if they are caring for a MCLTC member who doesn’t have Medicare. Only hospice providers that are contracted with Mercy Care can receive authorization from Mercy Care for services to members who don’t have Medicare.

• **Bed Hold Authorizations**
Payment for bed-hold authorization will require approval by a MCLTC Case Manager. It is important to note that bed holds must be billed on a separate claim form from their SNF stay, using a UB-04. An example of this would be a member is in a SNF from 1/1/12 – 1/31/12, however, on 1/15/12 – 1/20/12, they were hospitalized. We would need three claims submitted as follows:

1/1/12 – 1/14/12 – Normal SNF Billing on a UB-04
1/15/12 – 1/20/12 – Bed Hold Days Billing on a UB-04
1/21/12 – 1/31/12 – Normal SNF Billing on a UB-04

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

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

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

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

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

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

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

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

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

**DME in a Nursing Facility**

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

*For MCA – If a facility is licensed for skilled care then the services for DME are not covered even if the member is in a custodial stay.
CHAPTER 7 - BEHAVIORAL HEALTH SERVICES

Routine behavioral health services are administered according to routine plan benefits.

**MCP Acute**

**Emergency Behavioral Health Services**
If an MCP (Acute) member is in a behavioral health crisis, and you know that the member is enrolled with a Regional Behavioral Health Authority (RBHA), contact the RBHA for your respective County.

- Community Partnership of Southern Arizona (CPSA) (Pima) – (520) 622–6000
- Northern Arizona Regional Behavioral Health Authority (Coconino and Yavapai) - (877) 756–4090
- Cenpatico Behavioral Health (Gila, Pinal, La Paz, Cochise, Graham, Santa Cruz, Greenlee and Yuma) - (866) 495-6735

**Non-Emergent Behavioral Health Services**
Comprehensive behavioral health and substance abuse services are available to MCP members and are provided through the RBHA for AHCCCS Acute members. AHCCCS Acute members are automatically enrolled in RBHA as soon as they become eligible.

**MCLTC**

- **Emergency Behavioral Health Services**
  - If a MCLTC member is in a behavioral health crisis, please call the MCLTC Behavioral Health Crisis Line at (800) 876-5835.
  - The Crisis Line is available 24 hours a day, seven days a week. The Crisis Line is not for Medication Evaluation. If the member needs a medication evaluation or any other behavioral health service, the MCLTC Case Manager will need to be contacted. The Crisis Line will be able to assess if the member is:
    - Danger to Self
    - Danger to Others
    - Needing Hospitalization
    - Experiencing Situational De-escalation

- **Non-Emergent Behavioral Health and Substance Abuse Services**
Behavioral Health Services and Substance Abuse are provided through behavioral health providers contracted directly with MCP. Requests for these services should be coordinated through the member’s MCLTC Case Manager, the member’s family, or through the PCP. MCLTC members may also self refer for behavioral health services.
For an MCLTC member who has any other insurance coverage, including Medicare or a Medicare Advantage plan, that plan is primary and behavioral health services must be provided by the member’s primary insurance. MCP is considered secondary when the member has Medicare.

MCLTC members should not be referred to the RBHA for behavioral health services.

A member should be referred for behavioral health services if:
- Physical and psychiatric co-morbidity
- Medically unexplained symptoms
- Deliberate self-harm
- Drug and alcohol misuse
- Acute organic disorders
- Behavioral problems (non-adherence to treatment; lack of capacity to consent; abnormal eating habits; denial or exaggeration of symptoms)

All members receiving behavioral health services have a 90 day consultation with the member’s Case Manager and a behavioral health professional.

MCA
- Emergency Behavioral Health Services
  If enrollee is in a behavioral health crisis, please call the MCA Behavioral Health Hotline at 800-876-5835.
- Non-Emergent Behavioral Health and Substance Abuse Services
  MCA enrollees are eligible for behavioral health services through MCA’s contracted behavioral health providers. When the Medicare behavioral health benefits have been exhausted or the enrollee is in need of services not covered by Medicare, MCA enrollees with MCLTC can receive behavioral health services through contracted MCP providers. MCA enrollees with MCP Acute can receive behavioral health services through the RBHA.
CHAPTER 8 - THERAPY AUTHORIZATIONS

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

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

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

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

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

**MCA**
- When a SNF is paid under RUGS, therapies are included in the RUGS reimbursement
- For SNFs outside of Maricopa County on per diem contracts, therapy is included as part of the per diem rate.
CHAPTER 9 - CASE MANAGEMENT

Every MCLTC member has a Case Manager. The majority of MCP Acute members do not have their own Case Manager. MCA members will have a Case Manager only when they are also covered under the MCLTC plan.

**MCP Acute**

MCP provides case management services to medically complex members. These members are assigned to an RN, LPN or Case Manager who works closely with the PCP and the member to coordinate care and services.

**MCLTC**

- The role of the MCLTC Case Manager is to work with the SNF by planning and authorizing custodial and specialty levels of care; coordinating with the SNF on difficult cases; and advocating, monitoring and reassessing the member. MCLTC will also coordinate admission planning and assist in discharge planning for the member.
- The SNF will need to notify MCLTC department of the following situations:
  - When there is a significant change in a member's level of care or a new condition arises
  - Behavioral Health Referral
  - Potential Discharges
  - Discharge Planning
  - Challenging Members
  - 30 Day Notices
  - Bed hold authorization is required
CHAPTER 10 - CLAIMS

MCLTC/MCP Acute
- Mercy Care shall compensate the SNF according to their contract for the provision of Covered Services to eligible members. Reimbursement and service descriptions are also found in the contract with Mercy Care.
- Claims for skilled or custodial stays should be billed on a UB-04 claim form.

MCA
- MCA submission of claims is based on the terms of the MCA contract for RUGS reimbursement. After MCA has processed the claim, the facility will receive a remittance.
- For secondary benefits payable for MCP Acute services, the facility will submit a second claim with the appropriate Medicaid coding and attach a copy of the MCA remittance (EOB). The coordination of benefits will not occur automatically, as AHCCCS billing requirements and CMS billing requirements follow different payment methodologies. Billing two separate claims will help facilitate accurate claims processing and will enable the claims to encounter correctly per AHCCCS guidelines.
- Claims for RUGS reimbursement should be billed on a UB-04 claim form.
CHAPTER 11 - CLAIMS PAYMENT AND SUBMISSION

Electronic Billing
Electronic billing eliminates the cost of sending paper claims; provides more accurate submission of claims; and allows quicker processing turnaround time. If you are interested in this service, contact your Provider Relations representative.

Electronic Funds Transfer
Mercy Care Plan offers electronic funds payment directly to your bank account. If you are interested in this service, contact your Provider Relations representative.

Electronic Remittance Advice
Mercy Care Plan offers electronic remittance advice so that you may receive your remit electronically. This will enable you to post payments to accounts quicker. If you are interested in this service, contact your Provider Relations representative.

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

Prior Period Coverage
• Prior Period Coverage refers to the period of time from the effective date of AHCCCS eligibility to the day before the member is enrolled with the program contractor. MCP is retroactively liable for payment of covered services received by the member during Prior Period Coverage.
• AHCCCS is solely responsible for determining if a member is eligible for Prior Period Coverage and also in assigning the Prior Period Coverage eligibility dates.
• MCP is not responsible for payment of non-covered services during the Prior Period Coverage period.
• SNFs should refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310 of the Medical Policy for AHCCCS Covered Services.
CHAPTER 12 - DISCHARGE FROM A SKILLED NURSING FACILITY

MCP Acute
Effective and timely discharge planning and coordination of care are key factors in patient care. Discharges from a SNF must be coordinated with the MCP SNF Concurrent Review Nurse.

MCLTC
- All discharges from a SNF must be coordinated with the MCLTC Case Manager.
- In compliance with the Code of Federal Regulations, Title 42, Section 483.10, Resident Rights, any discharge or transfer of a member must be based on a medical reason, for his or her welfare, for the welfare of other patients, or for nonpayment (except as prohibited by Medicare (Title XVIII) or Medicaid (XIX) of the Social Security Act). Regardless of reason, the member, his representative, and the MCLTC Case Manager must be involved in the discharge planning.

MCA
- The Notice of Medicare Non Covered (NOMNC) Services is required by the Centers for Medicare and Medicaid Services (CMS) for all MCA enrollees and FFS (Original Medicare) members. The notice is time sensitive and must be given by the facility to the member at least 2 full days before the discharge date. The notice must be completed correctly, or it is considered invalid.
- After a determination has been made by MCA that the enrollee no longer meets the criteria and must be discharged, the SNF is responsible for serving the Notice of Medicare Non-Coverage (NOMNC) to the enrollee at least 2 full days in advance of the services ending and retain the NOMNC in their records.
- If an enrollee decides to appeal the discharge, the Quality Improvement Organization (QIO) will contact the plan asking for medical records supporting the discharge decision and MCA is required to provide those records by the end of the day of request.
- If the QIO overturns the appeal, the QIO will notify MCA of the discharge date for the enrollee and MCA is responsible for payment through that date. If QIO concurs with MCA, the enrollee is financially responsible if he/she chooses to remain in the facility beyond the discharge date.
- Discharge notice rules also apply when an MCA enrollee needs to be moved to a lower level of care within the same facility.
- If the MCA enrollee has MCLTC, an authorization for custodial stay will need to be requested from the MCLTC Case Manager.
CHAPTER 13 - INFORMATION AND SERVICES OFFERED BY MERCY CARE FOR SKILLED NURSING FACILITIES

**Contracted Hospitals**
- Mercy Care has an extensive network of contracted hospitals. Should inpatient/outpatient (non-emergent) hospital services be needed for the consignment of care, utilize a Mercy Care contracted hospital facility. For a current list of contracted hospitals, refer to the Mercy Care web site under [Find A Provider](#).
- Any hospital that is not contracted with MCP must have a prior authorization for inpatient admissions or outpatient services, except in an emergency.

**Contracted Labs**
Use contracted labs when MCP, MCLTC or MCA is the payer. Sonora Quest is the contracted lab for all MCP, MCLTC or MCA members.

**Prescriptions/Pharmacies**
- Prescription drugs may be ordered by any authorized prescriber. Prescription medications should be written to allow generic substitution and signatures on prescriptions must be legible in order for the prescription to be dispensed.
  - Please click on the link for the most current version of the MCP’s [Preferred Drug List](#) (PDL).
  - Please click on the link for the most current version of MCA’s [Formulary](#). MCA is a Medicare Part D plan sponsor. The Part D drugs listed on the formulary may require prior authorization, or have step therapy or quantity limitations. Non-formulary drugs may be available through the Formulary Exception process. There is more information regarding this on the MCA website referenced above.
- When MCP is the primary payer, CVS is the contracted pharmacy provider and SNFs must use CVS. Please refer to the [Prescription Drug Benefits](#) webpage for additional information.
- For MCA skilled nursing stays, prescription drugs are included in the RUG payment.

**Patient Trust Accounts**
When a nursing home resident requests a nursing facility to administer his/her personal trust account, the nursing facility must comply with pertinent federal and state regulations. SNFs are required to send patient Trust Account summaries to MCP’s Finance Department on a quarterly basis.

**Transportation**
- Non-Emergency
  - MCP members are eligible to receive medically necessary non-emergency transportation when there is no other means of transportation available.
Transportation services include bus tickets, taxis, stretcher vans or wheelchair vans and non-emergency ambulances.

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

**Provider Relations**

- The role of the Provider Relations Representative is to help contracted providers. They provide general education about working with MCP, MCLTC or MCP, assist with issues, and manage the provider network.
- Each SNF has a Provider Relations Representative assigned to their facility who can assist them with any of the Mercy Care plans (MCP Acute, DD, MCLTC, or MCA).
- SNFs can receive updated information via the web site under [Find Your Provider Representative](#). Additional information will be available through Provider Notifications, quarterly Provider Newsletters, as well as quarterly updates to the Provider Manual.
CHAPTER 14 – MERCY CARE ACUTE/MCLTC APPEALS

Sub-Acute Skilled Stay
- The purpose of concurrent review is to come to agreement between MCP and the SNF at the time the member is in the SNF.
- If the SNF disagrees with level of care or length of stay after the member has been discharged, the SNF must follow appropriate appeal/reconsideration steps based on the primary plan’s process.

Custodial Stay
- If the SNF disagrees with a level of care determination by a MCLTC case manager, the first conversation will be with the MCLTC Case Manager.
- If the issue is not resolved, the SNF should call the MCLTC Case Manager’s Supervisor at MCP and the supervisor may have an alternate team member review the level of care.
CHAPTER 15 - MERCY CARE ADVANTAGE APPEALS

Providers must follow the Notice of Medicare Non Coverage (NOMNC) process and realize that the Quality Improvement Organization (QIO) hears all enrollee discharge appeals. Contracted providers do not have the right to appeal MCA coverage decisions.

- After a determination has been made by MCA that the enrollee no longer meets the criteria and must be discharged, the SNF is responsible for serving the NOMNC to the enrollee at least 2 days in advance of the services ending. They must retain the NOMNC in their records.

- If an enrollee decides to appeal the discharge, the QIO will contact the plan asking for medical records supporting the discharge decision and MCA is required to provide those records by the end of the day of request.

- If the QIO overturns the appeal, the QIO will notify MCA of the discharge date for the enrollee and MCA is responsible for payment through that date. If the QIO concurs with MCA, the enrollee is financially responsible if he/she chooses to remain in the facility beyond the discharge date.