■ St. Louis Region Provider Manual

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Mercy Health Plans Contact Information

Department	**Phone**
Provider Relations (Member Eligibility, Benefits, Claim Status FAX	314-214-8137 800-596-4315 314-810-8350 or 800-466-9854
Prior Authorization Referrals & Prior Authorization/ Pharmacy/Formulary Concerns) FAX	314-214-8282 800-647-2240 314-214-8102 or 800-466-9854
Case Management FAX	866-222 6655 314-214-8102 or 800-466-9854
Member Services	
Commercial	314-214-8196 or 800-327-0763
Mercy Medicare*ADVANTAGE*	314-214-8040 or 800-280-1602
TDD	314-214-8099 or 800-990-7840
Language assistance also available	
Claims Submission	Mercy Health Plans P.O. Box 4568 Springfield, MO 65808-4568
Administrative and Claim Appeals FAX	Mercy Health Plans Attn: Provider Appeals Dept. 14528 S. Outer Forty Road, Suite 300 Chesterfield, MO 63017-5743 314-214-8107 or 800-466-9854
Medical Necessity Written Documentation FAX	Mercy Health Plans Attn: Medical Management 14528 S. Outer Forty Road, Suite 300 Chesterfield, MO 63017-5743 314-214-8102 or 800-466-9854

Mercy Health Plans Contact Information, continued

Clinical Appeals	Mercy Health Plans Attn: Corporate Appeals Department 14528 S. Outer Forty Road, Suite 300 Chesterfield, MO 63017-5743
FAX:	314-214-8233 or 800-466-9854
Compliance Hotline (report activity suspicious of fraud, waste or abuse)	314-214-2300 877-349-5997 siuinvestigations@mercy.net
Provider Demographic Changes (name, TIN, address, phone, W-9 numbers, notice of NPI numbers)	Mercy Health Plans Attn: Provider Information Mgt. 14528 S. Outer Forty Road, Suite 300 Chesterfield, MO 63017-5743
FAX	314-214-8107 or 800-466-9854

Offices are open during the regular business hours of 8 a.m. to 5 p.m., Monday through Friday. MHP is closed for select holidays.

Mercy Health Plans Mission Statement

Rooted in the mission of Jesus and the healing ministry of the Church, and faithful to Catherine McAuley's service tradition marked by justice, excellence, stewardship and respect for the dignity of each person, Mercy Health Plans, a member of the Sisters of Mercy Health System, implements and advocates for innovative health and social services to improve the health and quality of life of the communities served, with particular concern for persons who are economically poor. In doing so, we make a difference by touching the lives of those we serve with compassion and exceptional Mercy service.

As part of the Mercy Health Ministry, we honor our Catholic identity and remain faithful to the Church's moral and religious teachings.

Our Vision

Mercy Health Plans' strategic direction is defined by a vision of:

- An innovative health management company driven by a shared commitment to service, safety and quality.
- A catalyst in supporting enhanced access to health services for all, particularly those in need.
- Collaborating with caregivers by coordinating care across the continuum to assure the right care at the right place and at the right time.
- Enabling members with services that empower them to make healthy choices.
- A leader in excellence and stewardship, delivering measurable value to members, customers, providers and co-workers.

We at Mercy Health Plans thank you for supporting our vision.

Mercy Health Plans Benefits, Services and Strengths

MHP provides healthcare benefits and services with a focus on improving the health and wellness of members. This is achieved through an innovative approach – a provider-sponsored, integrated health plan. As a provider-owned and operated health plan, MHP is committed to innovative approaches to healthcare delivery, information sharing, healthcare financing, and reimbursement. By working with MHP, physicians greatly enhance their patients' access to appropriate medical care at an affordable cost.

The strength of our system lies with our provider partners who, through their strong physician participation and leadership, are continually involved in designing and implementing MHP's care delivery system that maintains quality while improving efficiencies. By bringing together healthcare professionals and providers who have demonstrated their commitment to caring for their local community with the administrative and financial responsibility for that care, MHP brought community-based integrated healthcare to St. Louis and Mid-Missouri.

Another key to MHP's success is our commitment to partnering not only with our providers, but employers and governmental agencies as well, and to address the medical needs of the communities we serve. Goals for improving the effectiveness and efficiency of healthcare include:

- Focusing on health promotion as an effective means of enhancing health status and emphasizing the sanctity of human life as well as controlling health costs;
- Designing quality-focused reimbursement models among primary and specialty care physicians to align incentives and encourage a collegial approach to patient care;
- Promoting active partnerships with employers and employees to recognize shared responsibility for health status;

- Committing to low administrative costs and the return of savings to employers, providers and members while ensuring competitive premiums and affordable member co-payments; and

- Operating in a manner that stewards resources, provides value to the community and treats all individuals with dignity and respect.

  Throughout MHP's history, our commitment to reach out to the less fortunate in the communities we serve has extended beyond our mission to deliver healthcare coverage to our members and to those in need. With our Community Outreach programs, MHP continues to assist charitable efforts in our service regions, furthering the ideals of our founders while strengthening our communities.

Provider Manual Overview

The Provider Manual is considered to be an attachment to all providers' contracts, and may revise or add provisions not contained in the contracts. Since it is an attachment to the provider contract, all policies and procedures in the Provider Manual, as well as published updates, are considered part of the provider contract.

This manual is evaluated and updated at least annually and may be changed by MHP at its sole discretion. In order to furnish all providers and their office staff with the most current information possible, MHP generates newsletters, updates, and ad hoc announcements, which become part of the provider manual at the time of their release. The next publication of the provider manual includes these updates within its formal content.

This manual is designed as a reference source for your office. Specific questions not addressed in this manual may be directed to your dedicated provider relations field representative or the MHP Provider Services Contact Center at 314-214-8137 or toll free, 800-596-4315.

This manual should not be duplicated, as those copies are likely to be out dated and the information incorrect. Please refer to our website at mercyhealthplans.com for the most up-to-date version of the provider manual.

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1. Member Information

1.1. Mercy Health Plans Product Overview

The specific benefits and prior authorization requirements vary between products and benefit plans. For the most current information, refer to our secure access provider website, ***Provider Connection***, at mercyhealthplans.com.

In an effort to serve our mission while meeting the needs of our community, MHP offers several types of health benefit products in MHP's Eastern and Mid-Missouri regions:

Commercial Plans

- PPO (Preferred Provider Organization)
- POS (Point of Service) – Referred Access, Open Access and Option Access
- HMO (Health Maintenance Organization) – Referred Access, Open Access and Option Access
- MyChoice (Group coverage focusing on wellness)
- CDHP (Consumer-Directed Health Plan)
- ASO Administrative Services Only)

Individual Plan

- Mercy*One*

Medicare Advantage

- Mercy Medicare*ADVANTAGE* (HMO) available with Part D Prescription Drug Plan
- Mercy Medicare*ADVANTAGE* (PPO) available with Part D Prescription Drug Plan

MHP maintains eligibility information on all covered members, regardless of plan type.

As advocates for our members, MHP makes every attempt to educate members regarding their roles in the medical delivery partnership through enrollment presentations, benefit booklets, copies of their documents of coverage and member handbooks. When commercial members fail to heed this advice, they may be held responsible for certain costs related to healthcare services.

1.2. Members Rights and Responsibilities

Members are guaranteed the right:

- To be treated with respect and dignity;
- To receive advice or assistance in a prompt, courteous and responsible manner;
- To choose a physician among those contracted with the plan. Members are asked to establish an ongoing relationship with their physicians. Maintaining this relationship is an important part of their healthcare. Members also have the right to change physicians if they so desire;
- To confidentiality. All information concerning their enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing by the member. Members are entitled access to their medical records according to state and federal law; and, with adequate notice, members have the right to review their medical records with their physician;
- To information about their diagnosis, treatments and expected outcomes in terms the member understands. If the provider determines that the information could be detrimental to the member, the information is given to a person the member designates or someone with legal authority;

- To information about the healthcare plan, the network physicians, and other healthcare providers providing their care;
- To discuss healthcare concerns or complaints about MHP with those responsible for the member's care or with MHP;
- To participate in decisions about the kind of care they want or do not want. Members should receive enough information to enable them to make an informed decision before they receive any recommended treatment. The information should include the specific procedure or treatment, medical alternatives, and associated risks;
- To have a guardian, next of kin, or legally authorized person exercise their rights if the members' medical condition makes them incapable of understanding or exercising their rights;
- To receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities;
- To participate with practitioners in decision-making regarding the member's healthcare;
- To a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage;
- To voice complaints or appeals about the managed care organization or the care provided;
- To a copy of their medical records. Members are guaranteed the right to request and receive a copy of their medical records, and to request amendments or corrections; and
- To be free to exercise rights. Members are free to exercise their rights, and that the exercise of those rights does not adversely affect the way the health plan, its providers, or the state agency, treat members.

Members have the responsibility:

- To treat all MHP and provider network personnel and other members with respect and courtesy;
- To provide, to the best of their knowledge, honest and complete information about matters relating to their health. If members do not understand, have questions, or disagree with the treatment plan, they have the responsibility to discuss their concerns with the treatment staff and make certain they understand the explanations and instructions;
- To carry their identification cards at all times and never permit anyone else to use them;
- To provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them;
- To follow the plans and instructions for care that they have agreed upon with their practitioners;
- To be on time for appointments and notify the physician's office promptly if they cannot keep an appointment;
- To pay applicable co-payments and to notify MHP of any additional sources of insurance coverage or reimbursement (e.g., Workers' Compensation and others);
- To notify their employer and MHP of address changes or changes in family status affecting eligibility or enrollment (e.g., marriage, birth, adoption, divorce, death or guardianship); and
- To express their opinions, concerns, or complaints in a constructive manner as outlined in the member handbook to the appropriate people within MHP or the MHP network. Member Services Representatives are available Monday through Friday.

1.3. Advance Directives

All individuals have the right to make their own healthcare decisions, including the right to refuse medical or surgical treatment, to confidentiality of their personal and medical records, to know what treatment they will receive, and to know who will be providing the treatment.

They also have another right: that of self-determination. An Advance Directive enables patients to outline, in advance of a serious illness, what kind of treatment they want or do not want, should they become unable to decide or speak for themselves.

A federal law effective December 1, 1991, requires most hospitals, nursing facilities, hospices, home healthcare programs and health maintenance organizations (HMOs) to give patients 18 years of age and over information about advance directives and their legal choices in making decisions about medical care. The law is intended to increase patients' control over their medical treatment decisions. It is important to remember that state laws differ about the legal choices available to individuals regarding treatment options to be honored by hospitals and other healthcare providers and organizations. In most states, it is not mandatory that patients have an Advance Directive.

Patients are advised to talk to their families, close friends, and physicians before deciding whether they want to complete an Advance Directive.

The two most common forms of Advance Directives are:

- A "Living Will"; (which is also referred to as an Illinois Declaration in the state of Illinois); and
- A "Durable Power of Attorney for Healthcare."

In addition to addressing other future needs, a Living Will generally states the kind of medical care individuals want (or do not want) if they are unable to make their own decisions. It is called a "Living Will" because it takes effect while the individual is still living.

In most states, adults may complete and sign a pre-printed form or draw up their own forms. They may wish to speak to an attorney and/or their physician to be certain they have completed the Living Will in a way that their wishes will be understood and followed.

A Durable Power of Attorney for Healthcare, in many states, is a signed, dated and notarized legal document, naming another person, such as wife, husband, daughter, son or close friend, as the individual's "agent" or "proxy" to make medical decisions for them should they become unable to make such decisions. They can include instructions about any treatment they desire or those they wish to avoid.

Individuals may change their minds or cancel either document at any time in accordance with state laws. Any change or cancellation should be written, signed, and dated in accordance with state law.

If an individual wishes to cancel an Advance Directive while in the hospital, the individual should notify the attending physician, family and others who may need to know.

Primary Care Providers are required to note in the patient's medical record whether an Advance Directive has been executed. It is advised that a copy of the member's Advance Directive be maintained in the medical records, if available.

1.4. Nurse on Call

Nurse on Call is a telephonic 24-hour nurse triage system and general health information resource available to most members, depending on plan type. The program is staffed by specially trained registered nurses.

Nurses have established algorithms to "rate" the severity of the symptoms described by the caller and, based on the responses provided by the patient or the responsible party, recommend that the member do one of the following:

- Self-care with direction (may include a follow-up phone call within 24 hours by the advising nurse); or
- Physician consultation/office visit; or
- Seek urgent or emergent care; or
- Seek emergency care immediately – Call 911.

Nurse on Call addresses diseases/symptoms that can be safely evaluated over the phone. It is available as an added benefit to guide members in their medical decision-making.

The telephone number for Nurse on Call is located on the back of the member's ID card.

NOTE: Depending on benefit products, not all members will have ***Nurse on Call***.

2. Provider Relations

2.1. Provider Relations

MHP is committed to providing timely, efficient, and professional services for participating physicians, other providers of care, and our members.

The manual can be accessed via provider.mercyhealthplans.com. Print copies may be requested at any time, however, the online provider manual is considered the most up-to-date version.

Ongoing communication with participating physicians and other healthcare providers is essential. As policies are developed or refined, or as changes occur that affect MHP physicians and members, newsletters, announcements, email broadcasts and manual updates are communicated to participating offices via USPS, the Internet, fax, or delivery by provider relations field representatives. These informational updates are considered policy addenda and, hence, permanent additions to this manual.

A dedicated provider relations field representative assists each office with educational support regarding MHP policies and procedures, payment resolution, and other issues involving the provider's relationship with MHP.

Via our secure access website, ***Provider Connection***, MHP offers participating providers access to benefit information, member eligibility, claim status, and other tools to expedite and enhance administrative processes.

2.2. Freezing Primary Office Enrollment

PCPs may close their practices to new MHP members if physicians are currently not accepting any new patients, regardless of insurance, or new members from other managed care health plans similar in nature to MHP.

Once office enrollment has been frozen, any exception to this status must be communicated in writing and mailed or faxed to:

Mercy Health Plans Provider Information Management
14528 S. Outer Forty Road, Suite 300
St. Louis, MO 63017-5743
FAX 314-214-8107

Physicians associated with MHP through a network must also notify their network of this decision.

Please allow 30 days from the receipt of the letter for the request to be processed by Provider Relations. The closure shall occur on the first day of the month once the 30 day notification period has elapsed. The panel closure is noted as such in MHP's database and included on the online edition of the provider directory.

Providers may subsequently reopen their office enrollment to all new members by notifying MHP in writing.

2.3. Provider-Member Relationship Termination

If providers determine that their offices and Commercial MHP or Mercy Medicare*ADVANTAGE* members are unable to develop a mutually satisfactory patient-physician relationship, the provider can request that the members choose another provider. The provider then informs the member in writing and sends a copy of the letter to Provider Relations at the address previously listed.

A representative from the Member Services Department will contact the member to facilitate the change. The member's new provider will be effective immediately upon selection, if the member does not appeal removal from the physician's practice. MHP requires that you continue to provide urgent medical care for the member for a maximum of 45 days from the date of the letter. Should the member appeal, MHP's medical director or designee will work with the parties toward a mutually acceptable solution.

2.4. Medical Records

MHP follows nationally recognized standards for the maintenance of medical records within participating practitioner offices that support consistent and complete documentation of each member's medical history and treatment. Appropriate documentation is an essential component of quality care. Protected Health Information (PHI) must be provided only to the extent permitted under state and federal law.

Medical records standards include the following, as applicable:

- Patient name and/or identification (patient name, birth date, address and phone number) documented on each page;
- All entries are dated;
- Documentation by a treating physician of the Advance Directive disclosed by a patient;
- All notes, reports, and records signed by the practitioner;
- Completed problem list;
- Allergies and adverse reactions prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record;
- Medical history easily identified;
- The history and physical examination identified appropriate subjective and objective information pertinent to a patient's presenting complaints;
- Working diagnoses consistent with findings;
- For patients 14 and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances;
- Treatment plans consistent with diagnosis;
- Follow-up care or calls documented and dated;
- Unresolved problems from previous office visits are addressed in subsequent visits;
- Consults, labs, and tests reflect physician review with follow-up if abnormal. The ordering practitioner initials each report filed in the chart;
- There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure; and
- An immunization record is up to date.

Medical records must be made available to MHP for utilization management, quality management, disease management, discharge planning, case/care management, and/or claims payment purposes. The medical records requested will be necessary for the specific case to audit and/or certify medical necessity / appropriateness of an admission or extension of stay, frequency or duration of service. In addition, authorized representatives from the Health Department, the Department of Health and Human Services, and/or CMS are allowed access to medical records of Mercy Medicare*ADVANTAGE* members for specific purposes.

To facilitate the process, all members sign a release of medical information as part of their enrollment process. This release is in effect for the duration of their status as MHP plan members.

Providers may request and receive reimbursement for chart copies according to their provider agreement.

For a minimum of 10 years from the date when the last professional service was provided, the medical record must remain under the care, custody, and control of the practitioner.

Required documentation in the chart includes all services provided directly by the practitioner and, if applicable, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the member was referred by the practitioner (e.g., home health nursing reports, specialty physician reports, and physical therapy reports). A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

Any correction, addition, or change in any patient record made more than 48 hours after the final entry in the record is signed by the practitioner, shall be clearly marked and identified as such. The date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

Upon request by patient changing practitioners, copies of the medical records must be forwarded to the new practitioner in a manner that facilitates continuity of care.

3. Medical and Pharmacy Benefit Management

3.1. Provider Responsibilities

Primary Care Physician (PCP) Responsibilities

As managers of members' care, PCPs and PSPs have accepted the responsibility to provide a wide range of services, including, but not limited to:

- Office and hospital care[1];
- Routine exams;
- Well adult, children, and infant care;
- Immunizations and other preventive care;
- Diagnosis and treatment of disease;
- Counseling/education of members and their families regarding medical care and lifestyle choices;
- Coordination of diagnostic evaluations, specialty consultations and treatments, hospital and home care services;
- Initiation and coordination of case management activities on behalf of members; and
- Participation in quality improvement initiatives.

Within the terms of their participation agreement, PCPs and PSPs agree to maintain the continuity of members' healthcare and coordinate care provided outside of their scope of expertise through the various processes outlined in this chapter.

Non-primary care physicians may coordinate care for members with chronic, disabling or life-threatening illnesses.

Specialist Physician Responsibilities

Participating Specialty Care Physicians work in conjunction with the member's chosen PCP to provide quality, cost-effective medical services. Specialists have agreed to communicate with the PCP on an ongoing basis for the benefit of the member. This open communication process helps to eliminate duplication of effort and promotes a collegial approach to member care. By working together, the PCP, the specialist, the member, and MHP have the greatest opportunity to maximize the benefits of education and alternative care management. While the communication process is important for members covered under all MHP programs, a written plan referral is not required for providers in the St. Louis metropolitan area.

MHP reserves the right to make changes in medical management requirements subject to appropriate notification to practitioners and other providers. The notification will be in the form of newsletters or other updates and should be considered addendums to this manual.

Accessibility Standards

The following appointment access timelines should be adhered to by all participating providers, except certain ancillary service providers*:

Appointments Access Guidelines	
Routine Care Without Symptoms	30 calendar days
Routine Care With Symptoms	5 business days or one week
Prenatal Care	1st Trimester: 7 calendar days 2nd Trimester: 7 calendar days 3rd Trimester: 3 calendar days Emergency Obstetrical Care: 24 Hours per day, 7 days a week
Urgent Care	24 hours
Emergent Medical Services	Must be available immediately 24 hours a day, 7 days a week
Hospital Facility	24 hours, 7 days a week
Behavioral Health Non-Emergent	5 business days or one week
Behavioral Health Urgent Care	24 hours

Accessibility 24-Hours per Day, 7-Days per Week

Participating providers, including mental health therapists, are available to assist/direct members' medical/mental health needs 24-hours per day 7-days per week.

Participating providers or their designated coverage, including mental health therapists, are accessible via telephonic services. This information is provided to members to ensure timely access to the providers.

Preferable after-hours access mechanisms include answering machines or direct linkage to exchange services. Use of an after-hours answering machine is only considered an acceptable means of supporting 24-hour coverage when direction is provided to members regarding methods to access a provider's after-hours pager, exchange, and/or covering provider.

*Providers exempt from these guidelines: Ambulatory Surgery Centers, Chiropractors, Dialysis Facilities, Durable Medical Equipment Providers, Freestanding Radiology, Hearing Aide Providers, Laboratory Draw Sites, Orthotic and Prosthetic Providers, Physical Therapy Providers, Sleep Labs, Urgent Care Facilities.

3.2. Out-of-Network Provider Requests

(Requires Prior Authorization for all members)

Participating physicians help ensure the affordability and success of members' healthcare by referring them to participating specialists, hospitals, and ancillary providers. When participating physicians determine that the appropriate services are not available within MHP's network, they are obligated to contact MHP's Prior Authorization Department for assistance with accessing services.

When alternatives are available within the network, MHP will provide the necessary information for the physician's office. When alternatives are not available, the Prior Authorization staff will assist the physician in arranging out-of-network care. When this approval is arranged in advance for non-emergent services, the member is eligible to receive the standard benefit. Non-emergent services conducted outside of the network, which are not pre-arranged through the Prior Authorization Department, would not qualify for coverage/payment unless the member has Point of Service benefits.

Please call the MHP Prior Authorization Department at 314-214-8282 or 800-647-2240 to initiate the evaluation process, or you may send a letter of medical necessity to the Prior Authorization Department. The chief medical officer, associate medical director, or a physician advisor reviews all requests for non-participating providers.

3.3. Medical Management Services

Prior Authorization – All Plans

Prior Authorization is a process MHP employs to ensure that members receive medically necessary, cost-effective, covered benefits in the most appropriate setting and that members are identified early for home care and other case management needs. At the time of prior authorization, the service is either certified based on the medical information provided or not certified, as there may be alternatives available. Please note that MHP assures that a member's treatment regimen will not be interrupted or delayed, nor will immediately required medically necessary supplies and/or pharmaceuticals be withheld during the Prior Authorization process.

For those services that require Prior Authorization, it is important to know that MHP (and our delegates) conducts these activities with the member's medical needs as a priority. Prior Authorization is not an attempt to deny medical care. Rather, it is a verification process whereby the member is ensured the most appropriate care in the most efficient setting. The process also assists members and providers alike in understanding what services are covered under the member's benefit package and what, if any, financial liability the member may bear by choosing to receive non-covered benefits.

Please remember: It is the responsibility of the treating physician to notify MHP's Prior Authorization Department at 314-214-8282 or 800-647-2240 before rendering any elective service.

Hospitals are required to notify MHP of any direct admissions from the Emergency Room within 48 hours of that event for all members.

Emergency room screenings and/or treatments do not require notification to MHP.

Access mercyhealthplans.com to view CPT codes that require prior authorization. For those codes not available online, please call for prior authorization, 314-214-8282 or 800-647-2240.

MHP uses nationally recognized clinical criteria sets including, but not limited to InterQual, for the screening and evaluation of covered services subject to the benefit determination, prior authorization, concurrent review, and other utilization/benefit management processes. Other clinical resources include, but are not limited to Hayes, Inc. (a technology evaluation resource), CMS Notices of Coverage, and locally developed medical, benefit, and pharmacy policies. All guidelines and criteria sets are based on information published in peer-reviewed literature. The chief medical officer, associate medical director, and/or physician advisors make all Adverse Determinations regarding medical necessity based on this information and the individual's unique healthcare needs.

A checklist for your convenience to prepare before calling for Prior Authorization follows on the next page. ***It is not to be submitted.***

Prior Authorization Checklist

For your information only – Do not submit

_____Member's Name

_____MHP Identification Number

_____Admitting Physician's Name

_____Contact Name in Provider's Office and Phone Number

_____DX (ICD-9) and Procedure Codes

_____Procedures Requested (including CPT-4 codes)

_____Clinical History

_____Inpatient/Outpatient Observation

_____Additional Comments

Call for Prior Authorization

MERCY HEALTH PLANS

MEDICAL MANAGEMENT

314-214-8282 or 800-647-2240

Radiology

A pre-service consultation with Rad*Consult*® is required for all outpatient, non-emergent MRAs, MRIs, CTs, CTAs, PET scans and selected nuclear medicine cardiac procedures.

The consultation process involves:

- Contacting Rad*Consult*® by the ordering physician's office staff member at the following: phone, 866-389-3875; fax, 877-883-5684; or www.healthhelp.com/mercyhealthplans. For maximum efficiency, please have the member's chart available when calling.
- The Rad*Consult*® representative collects relevant clinical information for the recommended procedure (including the member's diagnosis, the test being recommended, the reason for the test, duration of symptoms, prior imaging studies, laboratory studies, medications, and prior treatments).
- The Rad*Consult*® team evaluates this information in conjunction with current evidence-based guidelines.
- When necessary, the Rad*Consult*® physician advisor will initiate a discussion with the ordering physician regarding test appropriateness and member safety.
- Rad*Consult*® provides the ordering physicians or their office staff with a tracking number for the procedure at the end of the interaction. As this is an educational process, a tracking number is provided even if the ordering physician and physician advisor fail to agree.
- Failure to complete the consultation process results in an administrative denial of associated radiology claims (hospital, radiologist, and/or freestanding facility providers). Members are not responsible for denied charges.
- This process is not intended to obstruct or delay member care and as always, MHP continues to recognize that the responsible physician's judgment remains paramount.

Codes for procedures requiring authorizations are available at mercyhealthplans.com

Authorization Requirements When Mercy Health Plans is Secondary Payor

For purposes of this section, "authorization requirements" refers to referrals, prior authorizations, and network limitations of the primary carrier.

If it is verified that MHP is the secondary insurance for a member and the member has met the authorization requirements of the primary insurance carrier (as verified by the information received on the primary carrier's explanation of benefits), MHP's authorization requirements are waived.

Concurrent Review

Once prior authorization is given for a hospital admission, continued stay review, discharge planning, and case management may be conducted. Continued stay review decisions are made in conjunction with national guidelines and the individual member's specific needs and is completed by nurses under the guidance of the chief medical officer, associate medical director, or physician advisor.

Initial reviews are usually completed within 24 hours of the member's admission. Subsequent reviews are completed as needed for each individual patient and the clinical information is evaluated to:

- Verify that continued hospitalization is medically necessary and appropriate;
- Assist the nurses in discharge planning which includes reviewing the member's benefits;
- Identify resources and gauge the member's educational needs prior to discharge; and
- Identify the potential for case management.

Case Management

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs. Case managers work closely to assist physicians with members who have been identified as having chronic, potentially catastrophic diagnoses. Case managers are familiar with the MHP service area, participating providers and facilities, the members' benefits and available educational and other community services that, when combined, may assist members in avoiding an exacerbation of their illness and/or a hospital stay.

MHP's multi-disciplinary team includes physicians, registered nurses, social workers, registered dieticians, and health educators. Case managers provide on-going telephone contact with the member, and can assist physicians and members in coordinating required ancillary services. Case managers assess diagnosis, health history, current needs and the treatment plan in order to determine the level of involvement required. Involvement may include:

- Education about the disease;
- Support member in meeting their personal goals;
- Discharge planning;
- Care coordination;
- Utilization management; and
- Provide community services and resources.

If you have an MHP member who might benefit from case management services please call 866-222-6655.

New Beginnings: OB Case Management

The primary goal of the New Beginnings Program is to improve the health outcomes for our pregnant members through collaboration between each member, their healthcare team, and our case management staff. Members enrolled in the program will receive:

- Access to a registered nurse case manager;
- Educational mailings tailored to each trimester of pregnancy;
- Coordination of care and services, as needed;
- Information on prenatal classes and community resources; and
- Incentives available upon completion of the program.

To refer your pregnant members to the New Beginnings Program please complete the Pregnancy Risk Screening and Notification form. The form can be found at provider.mercyhealthplans.com. The form can be submitted by email to mhpcmrequest@mercy.net or by fax at 314-214-8210.

Prenatal Class Reimbursement

MHP promotes prenatal education as vital to the successful delivery of healthy babies. All Commercial pregnant members are eligible for a $75 reimbursement for prenatal childbirth classes at the participating facility of their choice. Members may obtain additional information through the Member Services Department at 314-214-8196 or 800-327-0763.

Health and Wellness

MHP is committed to providing our membership with tools to assist them in making healthy lifestyle choices. Our Health and Wellness Department is a critical part of our Care Coordination team. Our wellness initiatives include:

- Health Risk Assessments (HRAs);
- Health Coaching (electronic) ;
- Health and Wellness newsletters;
- Support and guidance for employer wellness programs;
- Flu vaccine education and promotion;
- Health literacy; and
- Promotion of health and wellness benefits.

Tobacco Cessation Program

Our commercial members are eligible for a tobacco cessation benefit. MHP offers both educational and/or pharmacological approaches to smoking cessation.

Members with pharmacy benefits through MHP are eligible for coverage of smoking cessation products such as bupropion extended-release (generic Zyban), Chantix or nicotine replacement products such as Nicotrol inhaler, Nicoderm patches, or Nicorette gum. In order to receive coverage for the over-the-counter nicotine replacement products please provide your patient with a prescription. The member may then have it filled at the pharmacy. Pharmacy co-payments will apply for prescriptions, and there is a six month supply limitation. MHP will not reimburse for smoking cessation products that are not processed through the pharmacy benefit.

Transition of Care: Applies to HMO only

Transition of care governs new members under the care of a non-participating physician as well as established members whose specialty provider's contract terminates (for reasons other than cause). All who qualify must complete a Transition of Care/Release of Medical Information form. A case manager reviews the documentation upon either the member's enrollment or notification of the provider's termination and then will assist the member through the transition of care.

Examples of cases requiring transition of care include:

- Women who are in or beyond their 14th week of pregnancy and all high-risk pregnancies shall be allowed to continue through their post-partum period with a non-participating OB/GYN;
- Members with a life expectancy of less than six months;
- Premature infants and/or devastated children (e.g., CP, CF, hemophilia, and endocrine disorders) may continue with a non-par physician up to age six months. A letter of medical necessity is required beyond this time period;
- Members undergoing initial chemotherapy will be allowed to continue with a non-par physician through remission or stability;
- Asthmatics seeing a non-par pulmonologist may continue for 90 days; and
- Diabetics seeing a non-par endocrinologist may continue for 90 days.

Transitioning care necessitates a member assessment by a MHP Case Manager. This assessment includes:

- Review of the treatment plan;
- Current progress toward treatment plan goals;
- Available network options;
- Anticipated length of treatment; and
- Admitting privileges of physician(s).

The chief medical officer, associate medical director and/ or a physician advisor reviews all cases beyond the standard qualifying period described. In the case of a provider's termination, the 90-day transition period as specified in the provider's contract starts the earlier of the date the member receives notice or the date MHP ends its contract with the provider.

Case managers negotiate individual reimbursement agreements, send appropriate documentation, and enter appropriate authorizations. All services remain subject to appropriate benefit limitations and exclusions.

3.4. Requests for Documentation of Medical Necessity and Benefit Determinations

There are occasions when MHP requires additional information regarding the medical necessity of a specific service or procedure. MHP asks that our Prior Authorization Department receive this information in a letter or in copies of the member's medical records.

Examples of such situations include, but are not limited to:

- Procedures that could be potentially considered cosmetic;
- Treatment of vein varicosities;
- Blepharoplasty; and
- Experimental/investigational treatment.

Please note: Proof of medical necessity regarding dermatological and potentially cosmetic procedures may require photographs in addition to the written request.

A Letter of Medical Necessity (LOMN) or Benefit Determination should include:

- Member's MHP Identification Number;
- Member's date of birth;
- Detailed explanation of the requested service or item (e.g. drug, out of network, DME, etc.);
- Reason for the request;
- Place of requested service (if applicable);
- Date of the requested service (if applicable);
- Summary of the member's condition;
- Any conservative treatments tried;
- Labs, other diagnostic tests, and results of same;
- Plan of treatment, if possible and expected outcome;
- All pertinent ICD-9 codes, HCPCS codes, CPT codes ;
- Name and phone number of a contact in the provider's office; and
- The signature of the participating provider on the LOMN.

If the request is for out-of-network services, please include:

- The reason the member needs to go out of network;
- Which in-network providers have been consulted; and
- Medical records from the requesting physician and the consulting physician(s).

Please mail all benefit determinations and responses to requests for medical necessity documentation to:

Mercy Health Plans
Attn: Benefit Determinations
14528 South Outer Forty Road, Suite 300
Chesterfield, MO 63017-5743
If preferred, fax documentation to 314-214-8201 or 800-466-9854.

3.5. Utilization Management Adverse Determination Process

MHP provides a reconsideration (peer-to-peer) and an appeal process for members and providers in the event of an Adverse Determination. An adverse determination is a decision by MHP or its designee, which an admission, availability of care, continued stay or other healthcare service has been reviewed and, based upon the information provided, does not meet MHP's requirements for coverage. These requirements include medical necessity, appropriateness, healthcare setting, and level of care or effectiveness of care. As a result, the coverage for the requested service is subsequently denied or reduced.

MHP adheres to the following timeframes when making a determination:

Pre-service requests for urgent conditions	The medical director will issue a decision within one calendar day of the peer-to-peer opportunity (and receiving complete clinical information to adequately demonstrate the necessity of the treatment/service.)
Pre-service requests for non-urgent conditions	The medical director will issue a decision within three calendar days (72 hours) of the peer-to-peer opportunity (and receiving complete clinical information to adequately demonstrate the necessity of the treatment/service.)
Concurrent requests	The medical director will issue a decision within 24 hours of the peer-to-peer opportunity (and receiving complete clinical information to adequately demonstrate the necessity of the treatment/service.)
Pharmacy requests	See the Pharmacy Section

Adverse determinations made in the course of the review process are communicated verbally to the provider within one day from when the determination was made. This communication is confirmed within three business days by written notice of the determination and any coinciding recommendations. This letter is mailed to the member or responsible party, the physician, and facility (if applicable). The reasons for the adverse determination, available alternatives and the appeal rights and procedures are included in the notices of denial, along with a contact person's name and phone number.

If the reconsideration process does not resolve the difference of opinion, the Adverse Determination may be appealed by the provider (on behalf of the member). The member may also utilize the Grievance/Appeals Processes identified in Chapter 8.

Any member or provider may appeal directly to the appeals coordinator at:

Mercy Health Plans
ATTN: Corporate Appeals
14528 South Outer Forty Road, Suite 300
Chesterfield, MO 63017-5743

3.6. Mental Health and Substance Abuse Services

MHP has contracted with St. John's Mercy Managed Behavioral Health for the provision of mental health services for members of all plan types. To arrange for care, the physician or member must call St. John's Mercy Managed Behavioral Health at 314-364-3600 or 800-413-8008.

Participating providers include:

- Professional Counselors and Psychologists;
- Psychiatrists;
- Psychiatric nurses and social workers; and
- Facilities for inpatient and outpatient care including rehabilitation.

3.7. Pharmacy Benefit Services

Note: Some employers receive their pharmacy benefit from another vendor. If a member's identification card does not have pharmacy benefit information printed in the lower left hand corner, MHP does not provide pharmacy benefits for that member.

Prescription Drug Formulary

MHP maintains Commercial formularies and Medicare Advantage (Part D) formularies for outpatient prescription drugs. The formularies list the medications covered under MHP's prescription drug benefit, including the medication's applicable co-pay tier and any prior authorization, quantity limitations or step therapy requirements. Formularies are developed and maintained by MHP's Formulary Management Committee comprised of practicing physicians and pharmacists.

In order to keep formularies current, the Formulary Management Committee meets regularly to review:

- Medical and clinical literature including clinical trials;
- Relevant patient utilization and experience;
- Current therapeutic guidelines;
- Economic data;
- Provider recommendations; and
- The safest, most effective drugs that will produce the desired goals of therapy at the most reasonable cost to the healthcare system.

Please consider prescribing medications from the applicable Commercial or Medicare Advantage formularies that have the lowest co-pay tiers, such as generics, when clinically appropriate. Lower co-pay tiers are associated with lower member cost-share.

MHP formularies are available at mercyhealthplans.com or through your provider relations representative.

New-To-Market Drug Benefit Coverage

Drugs that are newly made available to the marketplace are not covered under the Commercial pharmacy benefit until they have been reviewed by MHP's Formulary Management Committee for appropriate formulary placement. New-to-market drug reviews occur approximately six months after a drug has entered the marketplace. This time frame allows for the collection of comprehensive clinical and economic data, identification of how the drug is being used in the marketplace along with its efficacy, and identification of any unforeseen adverse events not identified in clinical trials. If you determine that a new-to-market drug is the most clinically appropriate medication for your patient prior to formulary placement, you may request coverage of the drug by contacting MHP's Prior Authorization Department as outlined in the prior authorization section, below.

Generic Drug Policy

MHP's pharmacy benefit design encourages the use of effective, less costly generic medications. Generic medications have a lower member cost-share. Most generics are assigned a Maximum Allowable Cost (MAC) limit of reimbursement. If a physician indicates "Dispense as Written" or if a member chooses to get the brand-name for a medication that is available generically and on the MAC list, the member may incur the generic co-pay plus the cost difference between the brand-name medication and the MAC price.

Self-Administered Injectables

Self-administered injectables are covered under the pharmacy benefit. Many self-administered injectables are high-cost medications used to treat rare, chronic conditions and require special handling. Most are covered at the highest member cost-share, require prior authorization and are subject to quantity limits of up to a 30-day supply per fill.

A small number of employers receive their pharmacy benefit through another vendor. For these groups, self-administered injectables will be covered by the appropriate pharmacy benefit vendor and not by MHP.

Prior Authorization

Formulary drugs with a high potential for misuse, limited therapeutic indications, maximum dosing recommendations based on safety concerns, or those drugs requiring extensive monitoring for side effects may require prior authorization. In addition, prior authorization is used as a means to identify members who may benefit from additional services such as case management or disease management.

Prior authorization criteria are established by MHP's Formulary Management Committee and are based on FDA-approved drug labeling and evidence-based medical standards. Medications requiring prior authorization are designated in the formulary listing by a "PA." A list of medications requiring prior authorization is available at mercyhealthplans.com.

For a member to receive coverage for a medication requiring prior authorization, the physician can call MHP's Prior Authorization Department at 314-214-8282 or 800-647-2240. In addition, requests can be faxed to MHP's Prior Authorization Department at 314-214-8201 or 800-466-9854 on a drug-specific Prior Authorization Request form or on a Medical Exception Request Form. These fax forms can be found under "Forms" in the Provider section of mercyhealthplans.com.

Managed Drug Limitations (Quantity Limits)

Certain medications are subject to quantity limits. Medications with quantity limits are designated in the formulary listing by an "MDL." MHP uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. The quantity limit program includes:

- Dose Efficiency Edits – Examples include limiting coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing and limiting coverage of two capsules/tablets per day when one capsule/tablet of equal strength is clinically equivalent;
- Maximum Daily Dose – Limits coverage of quantities that exceed recommended maximum dosage amounts; and
- Quantity Limits Over Time - Limits coverage of prescriptions to a specific number of units in a defined amount of time.

To request prescription coverage for amounts that are over the allowed quantity, you may request a medical exception by contacting MHP's Prior Authorization Department as outlined in the Prior Authorization section above.

Step Therapy

Certain medications are subject to step therapy. Medications with step therapy requirements are designated in the formulary listing by an "ST." A step-therapy approach to care requires the use of a recognized first-line drug before approval of a second-line drug is given. Step therapies are a safe and effective method to reduce the cost of treatment by ensuring that a proven and cost-effective therapy is tried before progressing to more costly remedies. If you determine that the required therapeutic benefit will not be achieved by use of a first-line drug, the prescriber may request use of a second-line medication by contacting the MHP Prior Authorization Department as outlined above.

Non-Covered Medications

Certain medications are not on the formulary and are considered non-covered. MHP's Formulary Management Committee has deemed them non-covered because they are either categorized as a benefit exclusion or they offer no clinical, safety, or economic advantage over formulary options. Examples of medications that are benefit exclusions include: weight management drugs, drugs that can be obtained over-the-counter (OTC), drugs for cosmetic use, experimental and investigational uses of drugs, drugs classified as medical foods, and drugs for infertility (unless mandated by state regulations or covered under a separate infertility rider). In addition, The Medicare Modernization Act of 1996 specifically prohibits certain medications from being covered under Medicare Part D; therefore, the following types of drugs are specifically excluded from coverage for our Medicare Advantage members:

- Drugs used for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or hair growth;
- Drugs used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Non-prescription (over-the-counter) drugs;
- Inpatient drugs;
- Barbiturates; and
- Benzodiazepines.

For non-covered medications that are NOT categorized as a benefit exclusion, you may request coverage of the non-covered/non-formulary drug by contacting the MHP Prior Authorization Department as outlined in the Prior Authorization section above.

Pharmacy Network

MHP members can obtain their prescriptions from a national network of contracted pharmacy providers. A comprehensive list of pharmacy providers is available through MHP's online provider directory at mercyhealthplans.com.

Drug utilization review and drug use evaluation programs (DUR Programs)

MHP employs several drug utilization programs with a focus on patient safety and appropriate member use of controlled substances. These programs consist of a retrospective review of prescription drug claims to identify opportunities to maximize drug therapy or to address inappropriate use of controlled substances at the member level. Examples of patient safety opportunities include: therapeutic duplication where the member is receiving medications from the same therapeutic class (e.g., ACE-inhibitors) from two different prescribers, drug/disease contraindications, and drug/age safety concerns.

You may receive written notification from us alerting you to drug regimen problems identified in our DUR programs. The notification includes a summary of the potential problem identified along with a patient prescription history that lists all medications prescribed for the patient by all prescribers. We hope you find this information helpful in optimizing your patients' drug regimens.

Notification of formulary changes

When we make formulary changes that result in a drug moving to a higher co-pay tier or no longer being covered, you will receive notification from us at least 30 days in advance if you have any impacted patients. In addition, we notify impacted members encouraging them to proactively speak to their physician about the coverage change and the possibility of switching to a covered formulary alternative, if appropriate. This does not apply to drugs removed from the market by the FDA or due to a drug recall.

Clinical Trials

MHP covers routine patient care costs associated with cancer clinical trials. It does not cover the costs of the experimental/investigational drug(s). If you have a patient that you intend to participate in a clinical trial, please notify MHP's Prior Authorization Department for approval prior to enrolling the member in the trial or providing services related to the clinical trial. The Prior Authorization Department can be notified by calling MHP's Prior Authorization line at 314-214-8282 or 800-647-2240 and choosing the option to speak to a medication specialist. In addition, requests can be faxed to MHP's Prior Authorization Department at 314-214-8201 or 800-466-9854 on a Medical Exception Request Form found under "Forms" in the Provider section of mercyhealthplans.com.

Pharmacy Management Adverse Determination Process

MHP provides a reconsideration (peer-to-peer) and an appeal process for members and providers in the event of an Adverse Determination. An adverse determination is a decision by MHP or its designee, whereby a request for coverage of a non-covered medication or a medication subject to prior authorization, quantity limits, or step therapy requirements has been reviewed and, based upon the information provided, does not meet MHP's requirements for coverage. As a result, the coverage for the requested service is subsequently denied.

MHP adheres to the following timeframes when making a determination:

Requests for urgent conditions	The medical director will issue a decision within one calendar day of the peer-to-peer opportunity (and receiving complete clinical information to adequately demonstrate the necessity of the treatment.)
Requests for non-urgent conditions	The medical director will issue a decision within three calendar days (72 hours) of the peer-to-peer opportunity (and receiving complete clinical information to adequately demonstrate the necessity of the treatment.)

Adverse determinations made in the course of the review process are communicated verbally to the provider within one day from when the determination was made. This communication is confirmed within three business days by written notice of the determination and any coinciding recommendations. This letter is mailed to the member or responsible party and the physician. The reasons for the adverse determination, available alternatives and the appeal rights and procedures are included in the notices of denial, along with a contact person's name and phone number.

If the reconsideration process does not resolve the difference of opinion, the Adverse Determination may be appealed by the provider (on behalf of the member). The member may also utilize the Grievance/Appeals Processes identified in Chapter 8. Any member or provider may appeal directly to the MHP's Appeals Coordinator at:

Mercy Health Plans
ATTN: Corporate Appeals
14528 South Outer Forty Road, Suite 300
Chesterfield, MO 63017-5743

4. Quality Improvement

Commitment to quality care is one of MHP's founding principles. MHP actively partners with its providers to consistently evaluate member care and service through systematic monitoring of:

Access and availability of care and adequacy of the provider network;

Continuity of care and service; and

Clinical outcomes of disease prevention and management of chronic conditions.

MHP supports and adopts the standards developed by government regulators, nationally recognized professional organizations, and accreditation bodies. MHP's Quality Improvement (QI) program incorporates these standards into the structure and evaluation of its internal operations.

Active physician participation in the Plans' Quality Improvement Committee is integral to the success of MHP's QI Program. The committee acts as a decision-making body and regularly reviews, develops, implements, and monitors the quality improvement activities, performance of its core operations, clinical practice guidelines, and disease management initiatives.

5. Credentialing

MHP has established standard credentialing and re-credentialing policies and procedures for practitioner and facility participation throughout all regions. Providers are required to participate in and comply with credentialing and re-credentialing procedures. Failure to do so is grounds for termination from MHP.

MHP may delegate credentialing authority to participating PHOs, networks, or other provider groups after their credentialing program has been audited for compliance with MHP's credentialing guidelines.

Each practitioner applicant and/or re-applicant must have an independent relationship with MHP, complete an application for participation, and meet the following minimum requirements:

- Completed, signed, and dated application;
- Attestation of history of loss of license and/or clinical privileges, disciplinary actions, and felony convictions;
- Attestation to lack of current substance and/or alcohol abuse;
- Attestation to mental and physical competence to perform the essential duties of the profession;
- Attestation to the correctness/completeness of the application;
- Signed and dated release of information form;
- Execution of a current Participating Provider Agreement;
- Current unrestricted license in the state where practice is located (absent of current restriction and/or sanctions);
- Current liability insurance in compliance with minimum limits set by Plan's provider agreement; however, in no case will this amount be below state mandated requirements by provider type;
- Board certification. If not board certified, proof of graduation from highest level of training and three letters of recommendations are required for validation purposes;
- Acceptable Credentialing Committee (CC) findings determinations of risk in regards to professional liability claims history for the immediate past five years for new applicants and recent three-year period for re-applicants;
- Current federal Drug Enforcement Agency (DEA) certificate and State Bureau of Narcotics and Dangerous Drugs (BNDD) Controlled Substance License (as applicable);
- Complete work history, with fully explained gaps for periods greater than thirty (30) days, for the immediate past ten (10) years for new applicants and recent three-year period for re-applicants;
- Current unrestricted Medicare (if applicable to product) participation;
- No history of Medicare or Medicaid sanctions or limitations; and
- Current privileges in good standing at an in-network admitting facility, including privileges to perform all procedures the provider is qualified to provide at that facility (or acceptable coverage arrangements).

Re-credentialing occurs every three years, verifying a practitioner's credentials and evaluating his/her performance through analysis of:

- Member satisfaction;
- Quality reviews;
- Claims and encounter data;
- Member complaints; and
- Medical record reviews.

A reminder letter is sent to the practitioner at least four months before the re-credentialing due date. The practitioner is asked to update application information on Council for Affordable Healthcare (CAQH) website or submit an application directly to MHP. If a practitioner does not respond to requests for re-credentialing information after two written requests termination activities are initiated.

The Credentialing Committee reviews the re-credentialing information and makes recommendations for or against the physician's continued participation with MHP. MHP's chief medical officer reviews and establishes a corrective action plan where necessary. Their determinations are considered final unless the practitioner appeals the decision. Appeal rights will be detailed in a letter sent to the practitioner. All appeals must include additional supporting documentation in favor of the practitioner's reconsideration for initial or continued participation with MHP.

Practitioners are required to hold members harmless and support continuity of care for up to 90 days after a termination from MHP participation or until the member(s) can be safely transitioned to an in-network practitioner, whichever is less.

6. Clinical Adverse Events Investigations

Clinical Adverse Event Investigations promote member safety and provide opportunities to detect, identify and potentially reduce risks in the delivery of care to our members. MHP and its provider partners share in the responsibility to identify irregularities in member care and service.

The investigations, conducted within the Quality Management Department (QM), help facilitate the understanding of root cause and reduce the future occurrence of these events by promoting changes to systems and/or processes. Detection of the clinical adverse events relies upon reports from the medical management operations within MHP. The process also relies upon utilization reports that identify excessive or unnecessary services that could potentially have been avoided. Investigations are scored according to risk and documented for any trends analysis.

Peer review of a potential adverse event may occur within the Credentialing/ Peer Review Committee to ensure appropriate clinical risk decision making. Service providers involved in the case may be required to provide additional clinical information and be involved in a corrective action plan to ameliorate future risk.

7. Fraud, Waste and Abuse

As a faith-based provider of access to healthcare services, MHP believes in the integrity and ethical conduct of our employees and others who deliver services to our members.

MHP is committed to maintaining a comprehensive program to prevent and detect fraud, waste and abuse in MHP's operations and services provided to members pursuant to both statutory and regulatory authorities. If you or one of your patients has a concern that you would like to bring to our attention, you may anonymously report these concerns to MHP's Compliance Hotline at 314-214-2300 or 877-349-5997 or send a detailed e-mail to SIUInvestigations@mercy.net.

MHP's Compliance Program is available at mercyhealthplans.com under "About MHP," Fraud and Abuse.

8. Complaint, Grievance & Appeal Processes

8.1. Provider Complaint, Grievance, and Appeal Process

MHP supports our providers' right to grieve or appeal any adverse decisions or coverage issues made by MHP in a timely, fair, and consistent manner. MHP manages these processes as follows:

Provider Contact Center: 800-596-4315.

This department processes claim payment issues that involve fee schedules and contractual issues. The representatives are responsible for correcting claim payment errors and researching benefit plans.

Corporate Appeals Department: 800-830-1918, extension 2394.

The Corporate Appeals Department manages provider appeals that involve medical necessity decision-making and prior authorization issues. To facilitate timely decision-making, medical records should be included with the appeal letter. You will receive written communication about the appeal decision.

8.2. Member Complaint, Grievance, and Appeal Process

MHP supports our members' right to grieve or appeal any adverse decisions or coverage issues made by MHP in a timely, fair, and consistent manner.

The Corporate Appeals Department manages the appeal process according to the member's benefit plan and government regulations.

When members believe their needs may have not been met they, or anyone on their behalf, have the right to file a complaint or appeal regarding access, availability, and/or the provision of care, cultural insensitivity, quality and/or appropriateness of services rendered.

Members may also, at any time during the complaint, grievance, and appeal process, take their concerns to the Department of Insurance, CMS, or to the employer, as applicable. When members appeal for provider payment the provider is copied on the resolution decision to assure communication between both parties.

All members are notified of their rights to file a complaint, grievance, or appeal upon enrolling with MHP.

Grievance

A grievance is a complaint of dissatisfaction by a member or authorized representative about co-payments or premiums in general, the quality of care or services provided, enrollment and disenrollment issues, treatment by a provider, or failure to respect a member's rights. Grievances may be filed in writing, or orally then followed up in writing.

Appeal

An appeal is a request to change a denial, reduction, or termination of benefits. Pertaining to Medicare Advantage members, a "standard appeal" may be filed by either members or their physician. The appeal could include complaints concerning payment for services, denial of services that include an unpaid bill, a partially unpaid bill, non-approval, or denial of care that the member feels should still be covered, or the cessation of care that, in the member's opinion, is still necessary.

9. Billing Guidelines

9.1. Claims Submission

The electronic submission of claims to MHP is the single most important action providers may take to ensure accurate and timely payment of claims. MHP encourages all providers to submit claims electronically.

Participating EDI Vendors

Below is a list of Electronic Data Interchange (EDI) vendors that participate with MHP. Their website address and toll-free numbers are included, as well as the MHP payor ID for each vendor. If you require assistance to set up electronic billing in your office, please contact your provider relations field representative.

Vendor	Website	Phone	Payor ID
Availity	www.availity.com	800-282-4548	43166 (Phy) MER11 (Fac)
Gateway EDI	www.gatewayedi.com	800-556-2231	00365 & (Phy) 00360 (Fac)
The SSI Group	www.thessigroup.com	800-881-2739	99999-0387
Emdeon	http://transact.webmd.com/	877-363-3666	43166
Relay Health	www.relayhealth.com	800-778-6711	7550 & (Phy) 2746 (Fac)

Please see the MHP website at mercyhealthplans.com for our latest 835 companion guide.

EDI Billing Guidelines

- When submitting claims electronically, EDI acceptance of electronic files is enhanced by submitting:
- The patient's member identification number and name as it appears on their MHP ID card, as well as the patient's date of birth and group account number;
- Current diagnoses (ICD-9) codes to the highest level of specificity as well as current year procedure codes (CPT, HCPCS) including modifiers where applicable;
- Supporting documentation with non-specific CPT and HCPCS codes (these claims may be submitted manually with a copy of supporting medical records);
- Complete dates of service including beginning and end dates;
- Separate claims for each calendar year;
- Rendering (type 1) and billing (type 2) NPIs (if applicable) with tax identification number (TIN);
- Appropriate prior authorization numbers as required;
- Claims in the ANSI 837 format with all Medicare required fields including modifiers; and
- Claims within MHP's timely filing limit.

Paper Billing Forms

Paper billing forms may be utilized by MHP providers. Please consult your participation agreement for any specific requirements.

Please mail all claims to:

Mercy Health Plans
P.O. Box 4568
Springfield MO 65808-4568

9.2. Maintaining Accurate Provider Information

In the same manner that MHP asks that our providers submit accurate and valid information in their medical claims, MHP must maintain accurate and valid provider information in its provider database and claims system. The matching of provider submitted claims data to the provider information in MHP's claims system is a critical component of quickly and correctly processing a provider's claims.

It is critical that MHP has your current and accurate provider and billing information loaded in its claims system. Please confirm with your Provider Relations Representative that the following information is current in our system:

- Provider Name (as noted on current W9 form);
- National Provider Identifier —Type I, Individual NPI);
- National Provider Identifier —Type 2, Group NPI) as applicable;
- Physical address;
- Billing name and address; and
- Tax Identification Number (TIN).

MHP rejects claims if billing information submitted does not match the information currently in our system. A rejected claim results in delayed processing and is not considered a "clean claim" for purposes of timely filing requirements.

A clean claim is a claim that is coded correctly and ready for adjudication without any additional information or documentation needed by Plan to process to completion.

MHP expects to be notified in advance of changes pertaining to billing information.

Maintaining an up-to-date W-9 form for MHP's records complies with IRS regulations and ensures the correct delivery of your 1099 Form at year's end.

W-9 forms are available on our website, mercyhealthplans.com. Please return the completed form to Provider Information Management at the following address:

Mercy Health Plans Provider Information Management
14528 S. Outer Forty Road, Suite 300
Chesterfield, MO 63017-5743

Providers may also fax updated forms to 314-214-8107 or 800-466-9854.

9.3. Billing Guidelines for All Services

Coding

Submit professional claims with current and valid CPT and/or HCPCS codes. Submit institutional claims with four-digit type of bill, valid four-digit revenue codes and CPT or HCPCS codes and ICD-9 codes and DRG codes (when applicable).

Providers improve the efficiency of their reimbursement through proper coding of a member's diagnosis. MHP requires the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fifth digit when indicated by the coding requirements in the ICD-9 manual. (Note: not all codes require a fifth digit.) Please consult your ICD-9 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity may result in a denial of the claim and a consequent delay in payment.

Additionally, written descriptions, itemized statements and invoices may be required for any services billed using non-specific codes.

Authorization Numbers

Providers must submit applicable prior authorization numbers on all claims.

National Provider Identifier (NPI)

MHP requires the submission of National Provider Identifiers (NPIs) on all claims. For physician claims, the rendering (Type 1) NPI must be submitted in Box 24j of the CMS 1500 form. The billing (Type 2) NPI must be submitted in Box 33a, if applicable. Please refer to CMS website for guidelines on whether your provider type requires a Type 2 NPI. If a Type 2 NPI is not required, please submit your Type 1 NPI in Box 33a.

MHP requires that the referring provider's NPI number be present on all claims submitted on a CMS 1500. This number must be in the referring physician field 17b.

MHP also requires each provider's tax identification number (TIN) in field 25. MHP will reject all claims that are missing NPIs and/or TINs. Claims rejected for missing this information must be resubmitted as new claims to be considered for payment.

For facility claims billed on UB04 claim forms, MHP requires that the facility (Type 1) NPI is entered in field 56 in addition to the TIN in field 5 on all claims submitted on a UB-04. The attending physician's NPI is required in field 76. The operating physician's NPI, if applicable, is required in field 77.

Also, please be aware that MHP can only accommodate one address per billing (Type 2) NPI. If a provider has multiple offices and only one billing (Type 2) NPI then all payments must be directed to one address. Providers may have payments sent to multiple addresses by acquiring additional billing (Type 2) NPIs.

Rendering Provider Name

The name and NPI of the provider who rendered services must be indicated in field 31 of the CMS 1500. In situations where a provider is billing under a corporate or clinic name, the corporate or clinic name must be submitted in field 33. This rendering name must match that appearing on the physician's W-9 form on file with MHP.

Timely Filing

MHP enforces a timely filing limit based upon your provider participation agreement. Generally, clean claims* must be received within ninety (90) days from the date of service or discharge. In cases of coordination of benefits (COB) when MHP is the secondary carrier, the time limit is extended to 120 days from the date of the primary carrier's Explanation of Benefits. Corrected claims must be received within 90 days from the original claim's processing date.

Members cannot be billed for services denied as not meeting the timely filing requirements.

* A clean claim is a claim that is coded correctly and ready for adjudication without any additional information or documentation needed from provider/member to process to completion. A rejected claim is not considered a 'clean claim' for purposes of timely filing requirements.

Delayed Interest Payments

In accordance with state and federal regulations governing the payment of interest on delayed claims, interest may be due.

Interest applies only to claims submitted electronically, as directed by the Health Insurance Portability and Accountability Act (HIPAA). Paper claims do not qualify for delayed interest payment.

Corrected Claims

MHP cannot accept hand-written resubmissions of claims. All necessary modifications for the purpose of correction must be submitted as follows:

- Institutional Claims – For corrections to a UB-04, change the fourth digit of the bill type to indicate a corrected claim.
- Professional Claims – Must be marked as a "Corrected Claim," in Field 19
- Electronic Claims – MHP accepts corrected claims electronically when submitted per clearinghouse and MHP guidelines

See Timely Filing guidelines above for additional requirements.

Returned/Reissued Checks and Requests for Refunds

MHP appreciates the timely return of incorrectly paid funds. The return of funds may either be physician/healthcare provider-initiated or plan-initiated (request for refund). In an effort to streamline the process and increase communication, MHP provides a form for providers to complete and attach to any refund checks. The "Payment Refund Notification" form is found at the end of this chapter or on our website, mercyhealthplans.com on the provider page under "Forms." Use of this form allows MHP to properly reconcile your refund. Please attach a copy of the pertinent page of the remittance advice that accompanied the initial payment or the refund request. This will ensure the adjustment is made on the proper member and for the appropriate date of service.

In instances of overpayment and in accordance with your provider agreement, MHP may offset the overpayment against future claims payments to recoup identified overpayments.

In instances of overpayment and in accordance with your provider agreement, MHP may generate a written request for refund. If the provider does not remit the required amount within 45 business days from the date of the letter, MHP will offset the amount against future claims payments. If MHP receives your refund after the amount has been offset against future payments, MHP will return your refund. Therefore, it is in your best interest to refund the payment as quickly as possible.

Please note that if a check is received for payments on multiple accounts, and only a few of the accounts were processed incorrectly, please do not return the entire check to MHP. Instead, notify the Provider Relations Department of the specific issue(s) (e.g., insufficient payment, no record of member, etc.), and MHP will initiate individual action accordingly. Returning the entire check only results in delayed postings to those accounts paid correctly.

Balance Billing Members – Hold Harmless Obligations

Missouri Law (Section 354.606.5, RSMo) states, "In no event shall a participating provider collect or attempt to collect from an enrollee any money owed to the provider by the health carrier nor shall a participating provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles." As a matter of professional courtesy, members should not be billed for claims in process. The member should be held harmless during this time period.

Members can only be billed for co-payments, deductibles, coinsurance, or for actual charges for non-covered services.

Re-bundled Charges

All billed charges are subject to ClaimCheck edits during the adjudication process. This may result in a re-bundling of inappropriately unbundled services. Any services or amounts not covered due to ClaimCheck edits are not billable to members.

Compensation

Payment for reimbursable services rendered by providers will be in accordance with the provider's participation agreement.

Audits and Recovery

MHP maintains the right to audit billings from and payments to providers at any time. MHP may also recover payments to providers for services that are determined not to be medically necessary or not covered at the time the service was rendered and/or overpayments.

9.4. Billing Guidelines for Professional Services

Coding

Physicians should use CPT or HCPCS codes for all services. In the case of non-specific CPT or HCPCS codes, please include a description of the service. For drugs, non-specific HCPCS codes should be accompanied by the applicable National Drug Classification (NDC) number.

Billing for Covering Physicians

If a participating provider is unable to provide services due to temporary circumstances (e.g., vacation, illness, etc.), a covering physician may evaluate and/or treat the member. To avoid a potential delay in payment, please indicate "Covering for (provider's name)" including the first and last name of the physician for whom your physician is covering in Field 19 of the CMS 1500 form if billing on a paper claim. If billing electronically, please indicate this same information in the Notes field.

Billing for Physician Extenders

Physician Extenders include, but are not limited to Nurse Practitioners and Physician Assistants, acting within the scope of their licensure.

Services rendered by credentialed physician extenders should be billed using the physician extender's own individual (type 1) NPI, as well as group (Type 2) NPI.

CRNA services must be billed on a separate claim with the appropriate modifier.

Medical Supplies – In-office

Generally, supplies and materials provided in the physician's office (e.g., syringes, gauze, tubing, etc.) are included in the payment for the office visit or in-office procedure.

MHP reimburses physicians for surgical trays when used in support of a Medicare qualifying procedure (see Medicare guidelines for a comprehensive listing).

Injection/Infusion Services

The following guidelines affect billing for all drugs (e.g., injectables, infusables, pharmaceuticals, chemotherapy agents, blood, and blood products).

Providers must bill with the applicable CPT/HCPCS code (e.g., "J" codes). For the administration of multiple drugs, the applicable HCPCS code for each drug must be listed. If billing on a UB-04, the applicable Revenue Code must also be noted.

Please include the "units" administered and *the unit measurement in field 24g (CMS 1500) or field 46 (UB-04) as it correlates to that which is specified by the particular HCPCS code used* (e.g., J9000 Doxorubicin HCI, 1 unit equals 10 mg; or J7100 dextran 40 infusion, 1 unit equals 500 ml).

A miscellaneous or non-specific HCPCS or CPT code should *only* be utilized for drugs that do not have an applicable code. When a miscellaneous or non-specific code is used, include *the NDC number and enter the product quantity in the Units field.*

Multiple Infusion Therapies

When a member receives multiple home IV infusion therapies, please use the modifier "-SH" (second concurrently administered infusion therapy) and, when applicable, modifier "-SJ" (third or more concurrently administered infusion therapy). For example, if a member has two infusions (e.g., antibiotic and enteral) and are billing supplies (e.g., A4222) for the infusion pumps, please bill the second supply/nursing visit, etc., with an "-SH" modifier.

Use of Non-Participating Vendors

If a physician utilizes a non-participating vendor for services in connection with office services, he/she should reimburse the third party vendor before billing MHP for the services under his/her own name. MHP will not directly reimburse those vendors, as MHP does not have a participation agreement with them.

Chiropractic Care (for members covered by this benefit)

Billing guidelines for chiropractic care follow standard procedures found in the CPT coding manual. MHP reimburses for an Evaluation and Management code for the initial visit only. Successive visits must be billed using standard chiropractic manipulative treatment (CMT) codes 98940 – 98943. MHP denies any additional evaluation and management code submitted on the same claim since CMT codes, by their definition, include pre-manipulation patient assessments. These denied codes should not be billed to the member unless the denial is due to the member exceeding their benefit limit.

9.5. Anesthesia Billing Guidelines – All Plans

Anesthesia Billing and Payment Parameters

According to the American Society of Anesthesiologists' (ASA) guidelines, anesthesia payments are comprised of three components. These components are as follows:

- Basic Value — This element represents the cost of the anesthetic management of the procedure. It includes the cost of all anesthesia services provided, except the actual time spent rendering the anesthesia and/or any payment for complex patient conditions present during the procedure. Examples of services included in this component include pre-operative and post-operative visits, administration of fluids and/or blood products related to the anesthesia care, and interpretation of non-invasive tests. Basic value is stated in terms of anesthesia units;
- Modifying Units — Physical status modifiers are used to indicate the patient's condition at the time of the surgical procedure. These modifiers may increase the provider's reimbursement by adding additional anesthesia units to the basic value. Additional payment is determined by the complexity of the patient's medical condition. Regardless of whether or not an increased payment is warranted, a physical status modifier is required on all anesthesia claims. There are other anesthesia modifiers besides those relating to physical status, such as modifiers that qualify whether or not CRNA administered anesthesia was under the direction of a physician. When appropriate, anesthesia providers bill these modifiers in addition to the applicable physical status modifier; and
- Time Units — This element represents the specific amount of time required to perform the surgical procedure. Time units are added to the basic value and applicable modifying units to complete the anesthesia payment. Time units are reported as is customary in the provider's geographic region.

While ASA guidelines do not specify the manner in which time should be indicated, MHP guidelines stipulate the following:

- Paper submission: The number of ***minutes*** required to complete a surgical procedure must be indicated in field 24g. Time in ***units*** is not accepted; and
- Electronic submission: The appropriate unit of measure indicator must be submitted. If the time submitted is units, indicator UN is required. If the time submitted is minutes, indicator MJ is required.

Failure to submit claims in the manner indicated above may result in incorrect reimbursement.

Submit claims with the appropriate ASA code for the procedure performed as indicated in the ASA Relative Value Guide, as well as at least one anesthesia modifier. Anesthesia modifiers are limited to the following codes: 23, AA, AD, G8, G9, P1-P6, QK, QS, QX, QY or QZ. (See below for specific information related to modifiers QK, QX, QY and QZ.) **In addition, time must always be indicated specifically in total minutes**. Time should never be indicated in anesthesia units. For example: if a procedure required an hour and a half of anesthesia time, "90" should be indicated in field 24g of the CMS1500 form.

Payment for anesthesia services is made according to contracted rates and based on the "base + time" units as indicated in the ASA Relative Value Guide. Fifteen minutes equals one unit of time. MHP rounds fractional units up or down to the nearest whole unit.

Teaching Anesthesiologists

- The teaching anesthesiologist should use AA and GC modifiers.
- The teaching anesthesiologist should report AA and GC modifiers if involved in training of residents in a single anesthesia case.
- The teaching anesthesiologist should also report AA and GC modifiers if involved in two concurrent resident cases.
- The teaching anesthesiologist should report AA and GC modifiers if involved in one resident case concurrent to another case paid under the CMS medical direction payment policy.
- The GC modifier is reported by the teaching physician to indicate that he/she rendered the service in compliance with the teaching physician requirements.

CRNA Charges

Charges for anesthesiologists and CRNAs should be billed separately using the appropriate ASA code and modifiers. Charges filed on behalf of the anesthesiologist must include the HCPCS modifier "QK" which is defined as "medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals" (i.e. CRNAs). If the anesthesiologist is medically directing only one anesthesia procedure performed by a CRNA, the modifier "QY" should be used. Concurrently, the claim for the CRNA should include the modifier "QX" which is defined as "CRNA service with medical direction by a physician." If a CRNA must perform anesthesiology services in the absence of an anesthesiologist, only the CRNA's charges should be submitted and should include the modifier "QZ."

Pre- and Post-Anesthesia Consultations (All Plans)

Pre- and post-anesthesia consultations or evaluations are part of the global anesthesia reimbursement.

"Qualifying circumstances" (e.g. frail health status, patients under the age of one or over the age of seventy, cancelled surgery) must be billed with the appropriate anesthesia procedure codes (i.e. 99100, 99116, 99135, or 99140).

Authorization Requirements (All Plans)

Anesthesia services are covered under the authorization for the surgery obtained by the physician performing the procedure. No separate authorization is required.

Pain Management Services

For members of all plans, authorization is required for pain management services performed on an outpatient basis at a participating facility. Post-operative pain management services billed for the same date of service as the surgery must include supporting documentation.

Anesthesia Administered by Surgeons

Claims for anesthesia services submitted by the provider who performs the surgical procedure are denied as included in the global rate for the procedure. The member is not responsible for these charges. This does not pertain to oral surgeons or dentists (services are covered for accidental dental only).

9.6. Surgical Billing Guidelines

The Centers for Medicare and Medicaid Services (CMS) assigns each surgical procedure code indicators. The indicator designates the following, but not limited to:

- Multiple surgery;
- Bilateral surgery; and
- Assistant at surgery.

The indicator is used in the reimbursement determination.

Surgical procedures that are components of or incidental to a primary procedure are not separately reimbursable.

Multiple Surgery-Modifiers -51

Multiple surgeries are defined as separate procedures performed by the same physician during the same operative session.

Primary vs. secondary surgical procedure reimbursement is determined based on The Centers of Medicare and Medicaid (CMS) Resource Based Relative Value System (RBRVS) Relative Value Units (RVU). The procedure with the highest RVU is determined to be the primary surgical procedure and is reimbursed at 100% of the fee schedule allowable. Remaining surgical procedures are determined to be the secondary surgical procedure and reimbursed at 50% of the fee schedule allowable.

Bilateral Surgery-Modifier -50

Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session. Bilateral procedures are reported on a single line of the claim with a unit of 1 and reimbursement for a bilateral procedure will be 150% of the fee schedule allowable.

Bilateral procedures may also be subject to multiple surgery reduction if billed in conjunction with other surgical procedures. Bilateral reimbursement is calculated prior to any applicable reduction that may apply.

Procedures that indicate “bilateral” or “unilateral” in the definition is not subject to bilateral pricing. Reimbursement would be subject to fee schedule allowable.

Procedures that are not considered bilateral are those related to organs that are considered midline (e.g., bladder, esophagus).

Assistant at Surgery-Modifier -80, -81, -82

From time to time, surgical procedures may require more than one surgeon, a primary surgeon and an assistant surgeon. The indicator designated for the surgical code will indicate if it is never acceptable, always acceptable or sometimes acceptable. If assistant at surgery is “sometimes” acceptable, documentation is required to accompany the claims for review and payment determination. Reimbursement for an assistant at surgery will be 16% of the fee schedule allowable.

Billing for Assistant Surgeons

MHP follows the medical criteria established by Medicare in determining reimbursement for assistant surgeons. If a procedure warrants the services of an Assistant Surgeon and is reimbursable by Medicare, it is also reimbursable by MHP. Conversely, any Assistant Surgeon service that is not covered by Medicare is not covered by MHP. Any expenses not considered appropriate are not billable to the member.

If Medicare requires the submission of medical records in order to determine the appropriateness of the charges, MHP requires records as well.

Microscopic Assistance During Surgery

MHP covers and reimburses for microscopic assistance during surgery (e.g., a craniotomy or an extensive spinal surgery). Please bill with CPT code 69990.

9.7. Obstetrical Billing Guidelines

Commercial Plans

When your office has provided *global maternity care for a member who has been effective with MHP for nine months or longer*, please bill with the appropriate global maternity code:

- 59400 Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care; or
- 59510 Routine obstetrical care including antepartum care, cesarean delivery, and postpartum care.

These codes include reimbursement for the following services:

- Prenatal care (office visits by physician or one or more partners);
- Lab work related to pregnancy – venipunctures and urinalysis only;
- Delivery (vaginal or cesarean);
- Post-partum hospital visits; and
- Post-partum office visits (anytime during the 6 weeks following delivery).

These codes do not include reimbursement for physician hospital visits made when a member is hospitalized for preterm labor. Separate payment is remitted for those services.

When the member has been *effective less than nine months and your office has provided maternity services in the prenatal through the postpartum periods*, please submit your claims in the following manner:

- Ten visits or more: Global Maternity code with the number “1” in the “Units” field of the CMS 1500;
- Less than 10 visits:
- 1-3 Visits: Appropriate E&M code with your usual charge noted for each service;
- 4-6 Visits: 59425 with a start date and an end date and your usual charge for the service; or
- 7 or More: 59426 with a start date and an end date, and your usual charge for the service, and a separate line with charges for delivery 59409 or 59410 (vaginal); or 59514 or 59515 (cesarean.)

When your office has provided prenatal/antepartum care only, please bill using 59426 with the appropriate start and end dates and your usual charge for the service provided.

When your office has provided delivery only or delivery and postpartum care, please bill using 59409, 59410, 59514 or 59515 and your usual charge for these specific services.

9.8. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Payment is subject to Prior Authorization requirements and is based either on Medicare’s definitions of DMEPOS categories or the MHP DMEPOS Fee Schedule.

Prior Authorizations are required for:

- Items with a purchase price of $1,000 or more or a rental price of $100 or more. Purchased items are HCPCS codes either without a modifier or have a “NU” modifier;
- Customized DMEPOS;
- Oxygen;
- Back-up Equipment;

Rental of Equipment

- A few items, those classified by CMS as "FS" or "Items Requiring Frequent and Substantial Servicing," rent as long as there is Medical Necessity for the item. These items remain owned by the providing DME company. Continuous rental is paid and Maintenance is not allowed;
- Other rented items are reimbursed until the purchase price is met. All payments for rental are applied towards the purchase price should an item be converted to purchase prior to the purchase price being met by sequential rental payments; and
- Some rental items may begin as rental for a specified period prior to purchase or continued rental pending proof of patient compliance or an improvement in health status. Examples include CPAPs and TENS units.

Purchase of Equipment

- Most DMEPOS are purchased. Those HCPCS codes either have no modifier or a "NU" modifier.
- Items that are deemed "purchase only" that are billed with a "RR" modifier, indicating "Rental" should be denied and re-billed for purchase of the item.

Oxygen Supplies and Equipment

- Oxygen equipment rents for 36 months and then rental payments cease. The equipment ownership is maintained by the DME company and payments for maintenance are authorized.
- When a stationary oxygen system is being rented, the monthly allowance includes payment for all required contents.
- If the member uses an oxygen stationary system that has reached rental cap, other than an oxygen concentrator or uses a portable system only, payment may be made for contents.
- If the member uses a stationary system and a portable system, the portable content fee is never payable in addition to the regular content fee.
- Additional or reduced payments for contents are payable based on the "QF" modifier for 150% of the payable amount and the "QE" modifier for 50% of the payable amount.

Delivery and Set-up

- DME delivery, set up and/or dispensing services (e.g., A9901) will not be reimbursed separately to the provider and shall be included as part of the DME charge. If the fees are submitted separately to MHP, they will be denied and may not be balanced billed to the Member.

Maintenance

- Routine periodic servicing, such as testing, cleaning, regulating, and checking of the member's equipment, is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a member owns.

9.9. General Institutional Billing Guidelines

Institutions should bill using the standardized ANSI 837I electronic transaction or on a standardized UB-04 form using four-digit type of bill, four-digit revenue codes and applicable CPT and/or HCPCS codes. All applicable fields on the UB-04 should be completed in compliance with Medicare guidelines. For accurate payment, please include both admitting/presenting AND discharge diagnoses.

Submit claims for hospital-based inpatient and outpatient services, associated durable medical equipment, and home health services via the ANSI 837I or on a UB-04. In addition, written descriptions, itemized statements, and invoices may be required for specific types of claims.

Incomplete claims may result in rejection, delayed payment or may be returned to the provider for additional information.

Diagnostic Services Prior to Admission/Ambulatory Surgery

Any charges for required diagnostic services rendered to a member within 72 hours of an inpatient admission and/or ambulatory surgery are included in the case rate paid for that admission/surgery. No additional compensation will be paid with the exception of charges for CT scans and MRIs. (Note: This does not pertain to those facilities paid on a per diem basis).

Identification of Attending Physician

The name and NPI of the attending physician must be indicated in the appropriate 837I field or field 82 of the UB-04. Claims that lack this information cannot be processed.

Identification of Operating Physician

The name and NPI of the operating physician must appear in field 83 of the UB-04 when the following conditions are met:

- If the Bill Type is “011x or 012x” and a principal procedure code is indicated in field 4 & 80 of the UB-04; or
- If the Bill Type is “013x or 083x”, a surgery code of 10040-69979 in indicated in field 44 AND Revenue Code(s) 036x, 049x, or 075x is/are indicated in field 42 of the UB-04 (Exception: This information is NOT required if the ICD9 code is V64.1-V64.3).

Inpatient Claims

Claims for inpatient hospital stays should be submitted with an appropriate Diagnostic Related Grouping (DRG) in addition to pertinent Revenue Codes and CPT codes. Please indicate the authorization number in field 63.

Hospitals must also include the proper Value Code in fields 39 indicating private versus semi-private room availability. Hospitals with semi-private rooms available should use a Value Code of “01” with the semi-private room rate indicated. Hospitals with only private rooms available (e.g. labor/delivery/post-partum suites) should use a Value Code of “02.” These Value Codes ensure that the claim is processed correctly and the member is not held inadvertently responsible for a private room rate when there is no other option available.

Private rooms for infectious disease reasons must be requested at the time of initial authorization of the stay or at the time of decision during an approved stay currently in process.

Interim Claims

Charges for on-going services may be submitted in 30-day increments on interim claims. Charges for services that are reimbursed as a one-time case rate, (e.g., inpatient admissions reimbursed based on DRG rates) must be submitted on one claim, at the end of treatment.

Billing for Transfers

When billing for patients who have transferred to another facility, please be sure to indicate the appropriate disposition code. This allows MHP to correctly price the claim. MHP employs Medicare transfer payment guidelines unless otherwise outlined in the provider’s contract.

Readmissions

Readmissions to a hospital within the timeframes specified by Medicare’s DRG methodology will be considered an extension of the original admission.

Outpatient Surgeries

Claims must be submitted with both the appropriate CPT code in field 44 of the UB-04 and the ICD9 procedure code(s) in field 67 for the surgery performed. Indicate the name of the operating physician in fields 82 and 83. Please indicate the authorization number, if applicable, in field 63.

Emergency Room Care

Claims must be submitted with both a revenue code and CPT emergency room evaluation and management code based on the level of treatment provided. It is imperative that both the presenting and discharge diagnoses are indicated on the claim. When transition is made from the Emergency Room, prior authorization requirements apply.

Variances between Levels of Service

If the hospital renders a service at a higher level of care than was authorized, MHP will deny the claim.

Facility/Clinic Fees

MHP does not reimburse claims for clinic fees separately unless indicated in the contract. Providers may not bill members for these charges.

"Stat" lab Charges

MHP does not reimburse additionally for "stat" lab fees. Payment is made for the actual lab test performed ONLY.

Education Services Performed at a Facility – Revenue Code 0942

While not all forms of educational services are covered benefits, MHP does recognize the health benefits of certain programs sponsored by participating hospitals and associations.

Please use the following minimum coding parameters in addition to standard Medicare requirements:

- Revenue Code 0942
- Type of Bill 0131
- One of the following CPT codes based on the nature of the session:
- 99404 – Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 60 minutes
- 99412 - Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure) approximately 60 minutes

When billing for *Nutritional Counseling*: Use specific the ICD9 code for the reason for nutritional counseling.

When billing for *Smoking Cessation Programs*: Use ICD9 diagnosis code of 305.1. Commercial members have a one-time co-payment.

When billing for *Natural Family Planning* (when a covered benefit): Use ICD9 diagnosis code of either V25.09 or V26.4. Claims should be submitted for the initial evaluation, supplies and on-going sessions at the time the member enrolls in the program. Claims should be billed under the female unless she is not a covered member. In the latter instance, the claim may be submitted under the male. The covered member is responsible for a one-time co-payment payable at the time of enrollment. There should be no more than one claim associated with each member accessing this benefit. This benefit is limited to once per lifetime.

When billing for *Prenatal Classes for Pregnant Women*: Use ICD9 diagnosis code V22.1. Members may have a limited benefit. There is no applicable CPT code. Indicate "Lamaze classes – 8 weeks" in Field 43 of the UB-04.

9.10. Correct Coding Software

Correct coding software has been developed to assist health plans in expediting claims processes and evaluates submissions for medical billing information and coding accuracy. MHP with the support and guidance of its medical directors has implemented consistent and objective correct coding software. MHP utilizes this software for professional and certain outpatient institutional claim submissions. The software is reviewed as periodic updates are released.

Claims adjudication procedures are reviewed regularly and modified as necessary to ensure claim processing accuracy. The software applies code auditing to medicine, anesthesiology, laboratory, pathology, radiology and surgery. The auditing rules applied, include but are not limited to: age conflicts, Correct Coding Initiative (CCI), duplicates, gender conflicts, improper use of modifiers, pre/post operative auditing, Intensity of Service (IOS) and bundling.

If the audit result is not as expected, providers may appeal the decision with the appropriate documentation for medical review and final payment determination.

The claims review software does not make determinations of medical necessity.

9.11. Coordination of Benefits (COB)

Commercial Plans

Helpful hints in determining primary payors:

- The benefits of a healthcare plan that does not have a coordination of benefits provision or non-duplication provision shall in all cases be the primary payor;
- If the member is covered under more than one plan, the plan that covers the member as a subscriber will be considered primary. The plan that covers the member as a dependent will be considered secondary; and
- If the member is covered under two plans as the subscriber, then the group health plan that covered the member the longest would be considered primary.

When MHP and another group health insurance plan cover the same child as a dependent of married parents, the birthday rule is used to decide the order of benefits determination:

- The benefits of the plan of the parent whose date of birth comes first in the year (month and day only) are determined first, followed by the benefits of the plan of the parent whose date of birth is later in the year; or
- If both parents have the same date of birth, the benefits of the health plan of the parent that covered the child the longest are considered as primary.

When MHP and another group health insurance plan cover the same child as a dependent of both parents who are separated or divorced, benefits are determined in the following manner:

- First, if the child is covered by a separation or divorce decree which outlines financial responsibility for the medical, dental and other healthcare expenses of the child, the benefits of that parent's health plan will be determined as primary;
- In the absence of a decree outlining financial responsibility, the health plan of the custodial parent is considered primary;
- If there is joint custody and both parents carry the dependent on their plan, MHP follows the "birthday rule."
- If both parents have the same date of birth, the benefits of the health plan of the parent that covered the child the longest are considered as primary;
- Second, the benefit of the health plan of the parent with custody of the child;
- Then, the benefit of the health plan of the spouse of the parent with custody;

- Then, the benefits of the health plan of the parent without custody of the child; or
- If there is joint custody and both parents carry the dependent on their plan, then MHP follows the "birthday rule".

MHP does not coordinate benefits or services provided to a member pursuant to any worker's compensation laws, no-fault automobile insurance, any federal, state, or local government or community program providing medical benefits or reimbursements of medical costs, or any type of employer's liability insurance.

At the time of enrollment, each MHP member is requested to complete the coordination of benefits information on the enrollment form. MHP will request that this information is updated from time-to-time. Should a request to the member be outstanding, claims may be held until the information is received.

COB Involving Medicare

Medicare's COB rules depend on the size of the group, and the reason the member is eligible for Medicare coverage. If this information is unknown, please contact Provider Service Department 314-214-8137 or 800-596-4315 for assistance.

When a member is covered by both Medicare and MHP, the following rules apply:

Employers with ***less than 20*** employees:

- **Active, Retired, or COBRA/State Continuation Members**: If the member has Medicare coverage because he or she is over age 65, Medicare is primary; and
- **Active, Retired, or COBRA/State Continuation Members**: If the member has Medicare due to a disability, Medicare is primary.

Employers with ***20-100*** employees:

- **Active Members**: If the member has Medicare coverage because he or she is over age 65, MHP is primary;
- **Retired or COBRA/State Continuation Members**: If the member has Medicare coverage because he or she is over age 65, Medicare is primary; and
- **Active, Retired, or COBRA/State Continuation Members:** If the member has Medicare coverage due to a disability, Medicare is primary.

Employers with ***more than 100*** employees:

- **Active Members**: If the member has Medicare coverage because he or she is over age 65, MHP is primary;
- **Retired or COBRA/State Continuation Members:** If the member has Medicare coverage because he or she is over age 65, Medicare is primary;
- **Active Members:** If the member has Medicare coverage due to a disability, MHP is primary: and
- **Retired or COBRA/State Continuation Members:** If the member has Medicare coverage due to a disability, Medicare is primary.

Note: All members not covered as "Retirees" or on a "COBRA/State Continuation" plan are considered "Active."

Medicare and End Stage Renal Disease

When a member who is not eligible for Medicare for any reason other than End Stage Renal Disease, MHP is the primary carrier for all treatment received by the member, including kidney transplant services, for the first 33 months after the initiation of dialysis treatment. This time period is calculated beginning the first of the month during which dialysis began.

After this time has elapsed, Medicare becomes the primary carrier. Medicare remains the primary carrier until the earlier of the following events occur:

- Twelve months after the month the member no longer requires dialysis treatment or,
- Thirty-six months after a kidney transplant.

If the member has resumed receiving dialysis services at the end of the 36 month period, Medicare will remain primary for as long as the member continues to receive treatment.

If the member has not resumed dialysis treatment, MHP becomes primary again.

(Note: If the member receives a second transplant before the 36 month recovery period has elapsed, a new 36 month recovery period is initiated.)

If the member must begin receiving dialysis treatment after MHP has reverted to the primary carrier, another coordination period will begin (MHP will again be the primary carrier for the first 30 months following the initiation of dialysis treatment).

When a member is eligible for Medicare for reasons other than End Stage Renal Disease and MHP was the primary carrier before the initiation of dialysis, the above-referenced guidelines apply. If MHP was the secondary carrier before the initiation of dialysis, MHP remains the secondary carrier throughout the duration of the member's treatment for End Stage Renal Disease.

Medicaid

All group coverage plans are primary to Medicaid coverage. Such third party liability is defined as any individual, entity or program that is or may be liable to pay all or part of the healthcare expenses of the individual and can therefore be considered as a funding resource. State regulations require that providers take all reasonable measures to identify legally liable third parties and to submit evidence of other insurance coverage to the State of Missouri on an Insurance Resource Report.

Authorization Requirements When Mercy Health Plans is Secondary Payor

For purposes of this section, "authorization requirements" refers to referrals, prior authorizations, and network limitations of the primary carrier.

When MHP is the secondary insurance for members, and members have met the authorization requirements of the primary insurance carrier (as verified by the information received on the primary carrier's explanation of benefits), MHP's authorization requirements are then waived. MHP will pay up to its allowable for the service.

If members did not meet the authorization requirements of their primary carrier, but have met MHP authorization requirements, MHP processes the claim in the normal manner, accounting for payment, if any, from the primary carrier.

If members did not comply with the authorization requirements, MHP reduces or denies the claim, as appropriate.

PAYMENT REFUND NOTIFICATION

This refund notification pertains to the following:

Patient Name: ____

Patient ID number: ____

Date of Service: ________________________________

Claim Number: _________________________________

Check Number: ________________________________

Amount: ______________________________________

Reason for refund (please check all that apply):

_______ Duplicate payment due to:

______ Other insurance paid as primary (attach primary carrier's EOB)

______ Claim previously paid on ____________ (Date paid)

______ Other:____

_______ Not our patient

_______ Service not performed

_______ Service billed in error

_______ Other:____

PLEASE SEND THIS COMPLETED FORM WITH COPY
OF THE ORIGINAL REMITTANCE ADVICE TO:
Mercy Health Plans
ATTN: Adjustment Unit
PO Box 4568
Springfield, MO 65808-4568

10. Physician and Member Satisfaction Surveys

10.1. Physician Satisfaction Survey

Every year MHP conducts a survey of a sample of participating physicians utilizing a third party vendor. The objectives of this survey are to measure the physicians' overall satisfaction with MHP and ForeSee Health; to evaluate progress of the corrective action plans developed from last year's results; to conduct trending and comparisons to national averages (where applicable); and to identify where significant differences in performance exist.

The results of this survey are posted on the MHP website and are available for your viewing at mercyhealthplans.com.

10.2. Member Satisfaction Surveys

Member satisfaction surveys are conducted annually according to regulatory requirements utilizing a third party vendor. These Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are standardized by the National Committee for Quality Assurance (NCQA). The surveys include questions regarding the members' satisfaction with physicians and their office operations, communication about treatment options and the care they received, and their role in healthcare decision making. The survey results are posted at mercyhealthplans.com.

11. Benefits and Limitations – Commercial Products

11.1. Eligibility

MHP maintains eligibility information on all covered members, regardless of plan type.

Eligibility and benefit information may also be accessed through our secure access self-service tool, ***Provider Connection***, at mercyhealthplans.com.

Providers may also obtain the most up-to-date eligibility information by calling MHP Provider Relations at 314-214-8137 or 800-596-4315, Monday through Friday from 8 a.m. to 5 p.m.

Commercial membership is effective for the period of time premium is paid by the member's and/or the member's employer.

11.2. Benefits

The member is provided the appropriate document describing his/her healthcare benefits upon enrollment. These documents outline all terms, conditions, exclusions, and limitations of coverage.

To be considered medically necessary, the service must not be for care that is provided primarily for the convenience of the MHP member of healthcare provider.

To be considered medically necessary, the service must not be for care that is provided primarily for the convenience of the MHP member or healthcare provider.

Benefits may be subject to co-payments or co-insurance as selected by the member or the member's employer. Co-payments may be a flat dollar amount paid at the time of service for office visits or a flat fee per diem/per admission for hospital-based services. Co-insurance is a percentage of the payment rate negotiated between MHP and participating physicians, hospitals, health professionals or other providers for certain services.

Co-payments for many services are indicated on the member's identification card.

Emergency services rendered by participating/ or non-participating providers.

MHP covers the costs for medically necessary emergency care rendered by participating/ and non-participating providers to a member.

11.3. Limitations and Exclusions

The members' plan benefit document describes their healthcare benefits. All coverage is subject to the terms, conditions, exclusions, and limitations outlined in the benefit document.

To be considered medically necessary, the service must not be for care that is provided primarily for the convenience of the MHP member or healthcare provider.

For HMO members, services and supplies not provided by or under the direction of a participating provider, except in cases of an emergency or through the request for non-participating provider process, are not considered covered benefits.

PPO members may seek care from out of network providers, in accordance with their benefit documents.

11.4. Point of Service (POS) Information

MHP offers our clients a Point of Service (POS) option. When the POS option is selected, the member has the option of receiving most types of care from non-network providers. Referred Access POS members need not obtain referrals for services sought outside of the network.

When electing to use this option, the member will be responsible for the payment of a deductible, co-insurance, and any amounts over Usual and Customary (U&C) for the service regardless of whether his/her "base" plan is Referred or Open Access. The same financial exposure results when Referred Access POS members seek care from an in-network specialist without having obtained a prior referral from their primary care physician.

The member is responsible for assuring prior authorization is obtained, or the benefit will be decreased by the amount of the non-compliance penalty. The non-compliance penalties range from 50–100% depending on the type of service obtained. Non-compliance penalties do not apply to deductibles or yearly or lifetime maximums and are subtracted before any application of deductible or coinsurance.

While members may receive most care from non-network providers, the following services are considered covered benefits when received from in-network providers only (Missouri groups):

- Preventive care services including well woman exams;
- Mental health and substance abuse services;
- Transplant services;
- Mammography;
- Dialysis services;
- Orthotic equipment;
- Chiropractic care;
- Infertility service; and
- Sterilization.

12. Mercy Medicare*ADVANTAGE* Benefits and Limitations

12.1. Mercy Medicare*ADVANTAGE* Eligibility Criteria

Mercy Medicare*ADVANTAGE* offers Medicare recipients an excellent alternative in the marketplace with a comprehensive benefit package that covers more than traditional Medicare. MHP's Medicare Advantage products are Mercy Medicare*ADVANTAGE* HMO and PPO.

Members may select HMO or PPO benefits plans. All plans are easy to use and affordable. Each is offered with the Part D prescription drug benefit.

There are no pre-existing condition clauses. Mercy Medicare*ADVANTAGE* accepts all members regardless of their medical condition. MHP maintains eligibility information on all covered members, regardless of plan type.

For Mercy Medicare*ADVANTAGE*, providers may obtain the most up-to-date eligibility information by calling MHP Provider Relations at 314-214-8137 or 800-596-4315, Monday through Friday from 8 a.m. - 5 p.m. Providers may also access eligibility information through MHP's provider portal, ***Provider Connection***, 24 hours a day, seven days a week, once a provider key has been obtained from Provider Relations.

Mercy Medicare*ADVANTAGE* membership is effective for as long as the member meets the eligibility requirements or elects another Medicare Advantage plan or original Medicare.

12.2. Benefits

Subject to all the terms of the Medicare contract between MHP and the Centers for Medicare and Medicaid Services (CMS), all Mercy Medicare*ADVANTAGE* members are entitled to the medical care, services, supplies and other medically necessary benefits covered under original Medicare (except hospice) and set forth in the member's schedule of benefits and limitations.

These services and benefits are only available if they are:

- Medically necessary; and
- When indicated, prior authorization from MHP has been received.

Members are generally responsible for a nominal flat fee co-payment per physician office visit or coinsurance if accessing an out of network provider under the Mercy Medicare*ADVANTAGE* PPO plan. Preventive services are covered at either a nominal or zero dollar co-payments. Members, based on benefit package selection, may be responsible for deductibles, co-insurance, and/or co-payments for other services.

Specific benefits are available in the member's Evidence of Coverage, by calling Provider Relations at 314-214-8137 or 800-596-4315, or by accessing the Member's Benefits through the ***Provider Connection***, the secure provider portal at mercyhealthplans.com.

12.3. Transition of Care Form

There may be instances in which a newly enrolled member may have a chronic medical condition or have an active referral from a previous health carrier. For a smooth transition of care and to assist the member's physician in meeting the member's needs, Mercy Medicare*ADVANTAGE* has members complete a "Transition of Care" form.

The form inquires about:

- Referrals in place from a previous health carrier;
- Previously scheduled outpatient or inpatient hospitalizations which would occur after the member's effective date;
- Existence of a chronic medical condition such as cancer, kidney failure, or COPD; and
- Active home health or DME care.

The form also includes an "Authorization for Release of Information" which is solely for continuity of care purposes to assist any physicians not currently involved in the member's care. It is not intended for screening on the basis of the member's health.

After completion by the member, the form is reviewed by Mercy Medicare*ADVANTAGE* for services that may require follow-up and/or case management intervention and the member's physician is notified if necessary.

12.4. Medicare Reporting Form

Medicare prohibits any potential enrollees diagnosed with End Stage Renal Disease (ESRD) from joining Mercy Medicare*ADVANTAGE* unless the potential enrollee is currently an MHP commercial plan member. If a current Mercy Medicare*ADVANTAGE* member develops ESRD, becomes enrolled in hospice or is institutionalized, the member cannot be automatically disenrolled from the plan.

In addition to reporting the presence of ESRD, attending physicians must notify MHP when members elect hospice, become institutionalized or are discharged from an institution.

The completed form must be forwarded to:
Mercy Medicare*ADVANTAGE* Member Services Department
14528 S. Outer Forty Road, Suite 300
Chesterfield, MO 63017-5743
FAX 314-214-2463

The "Medicare Reporting Form" can also be used to notify Mercy Medicare*ADVANTAGE* of the expiration of a covered member.

Copies of the form can be obtained either through Mercy Medicare*ADVANTAGE* HMO Member Services 314-214-8040 or 800-280-1602, Mercy Medicare*ADVANTAGE* PPO Member Services 314-810-8300 or 800-919-6459, or Provider Relations at 314-214-8137 or 800-596-4315.

12.5. Medicare Risk Adjustment Program

Medicare Risk Adjustment

- Medicare Risk Adjustment is the payment methodology mandated by the Balanced Budget Act of 1997 and used by the Centers for Medicare & Medicaid Services (CMS) to improve payment accuracy to Medicare Advantage organizations such as MHP;
- CMS determines the risk for each member based on the ICD-9 diagnostic codes from a provider's medical record;
- Payments to MHP are adjusted (i.e. Risk Adjustment) and designed to more accurately cover a given member's anticipated medical expenditures based on the health status of beneficiaries;
- Diagnosis information is collected from provider-submitted encounter data sent to MHP in claim transactions;
- Encounter data with *all* diagnosis codes are submitted by MHP to CMS, i.e. unlimited number of codes; and

- MHP's Medicare patients should be contacted to arrange an appointment early each calendar year for a comprehensive medical examination to resubstantiate *all* medical conditions and to support CMS' validation requirements. This is the opportunity to record *all* known health conditions for the patient. MHP depends on the proper submission of encounters and claim transactions.

Diagnosis Coding

- CMS relies on complete and accurate ICD-9-CM diagnostic codes, not the actual CPT codes;
- All codes should be submitted at the highest level of specificity and include all appropriate secondary codes;
- Claim submissions must be backed up by accurately maintained and documented medical records;
- Medical records are subject to CMS validation and review at any time;
- CMS requires a patient's diagnosis codes to be re-substantiated every year; all codes are wiped out at the end of each year, even for chronic health conditions;
- Increased accuracy of coding helps MHP identify your patients who may benefit from disease management and other medical support programs;
- The claim transaction to MHP should be evaluated to determine whether ALL diagnosis codes are included for the encounter;
- Providers should refer to their billing system to determine whether they limit the claim to reflect only four codes when the record contains more than four diagnoses;
- MHP and CMS require complete diagnosis coding to appropriately reflect a patient's complete medical history;
- Medical records should be made available to MHP's Risk Adjustment Department for periodic review;
- CMS and other web sources provide additional medical coding assistance;
- Electronic medical records (EMR) systems assist in coding accuracy of claims; and
- More accurate medical status information can be used to match healthcare needs with appropriate level of care.

CMS outlines the responsibilities of physicians and other healthcare providers to include:

- Accurately report ICD-9-CM diagnostic codes, including secondary diagnoses, to the highest level of specificity;
- Maintain accurate and complete medical record documentation (ICD-9-CM codes submitted must be justified with proper documentation); and
- Report claims and encounter data in a timely manner, generally within 30 days of the date of service or discharge from a hospital's inpatient facilities.

Several resources are available for additional information regarding CMS Medicare Risk Adjustment. Contact your MHP Provider Relations Field Representative; visit provider.mercyhealthplans.com; visit CMS at http://www.csscoperations.com/new/usergroup/2008raps/2008-raps-participant-colorslides.pdf; contact MHP at 314-214-8405 or email MHP at mhpmedicarerisk@mercy.net.

13. Standards for Medical Record Keeping

Appropriate documentation is an essential component of quality care. MHP adopts nationally recognized standards for the maintenance of medical records within participating practitioner offices that support consistent and complete documentation of each member's medical history and treatment.

13.1. Confidentiality of Medical Records

- Records are stored securely;
- Only authorized personnel have access to records;
- Staff receive periodic training in member information confidentiality; and
- Each physician office shall have policies and procedures in place regarding confidentiality.

13.2. Medical Record Release to the MHP Member

- Medical record release procedures are compliant with HIPPA regulations (signed release); and
- Upon request by patient changing practitioners, copies of the medical records must be forwarded to the new practitioner in a manner that facilitates continuity of care.

13.3. Medical Record Release to Mercy Health Plans

- Protected health information (PHI) must be provided only to the extent permitted under state and federal law;
- All members sign a release of medical information upon enrollment which remains in effect for the duration of their enrollment;
- By virtue of the enrollment agreements signed by MHP members, providers are obligated to disclose requested medical records of MHP members as outlined above;
- Participating physicians are required to participate in MHP's QI activities as stated in the provider/practitioner contract;
- Medical records will be provided to MHP within the time frame specified in the request; and
- Providers may request and receive reimbursement for chart copies according to their provider agreement (Contracted fees supersede industry standard).

13.4. Medical Record(s) Maintenance

Medical record maintenance shall adhere to the following:

- Forms and methodology for filing within a chart is consistent and secure within the chart;
- Electronic record-keeping format must be printable;
- Medical records shall be maintained for a minimum of ten (10) years from the date when the last professional service was provided;
- Upon request by a member changing primary care providers, the medical records or copies of the medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of the request or prior to the next scheduled appointment to the new primary care physician to ensure continuity of care; and
- Required documentation in the chart includes all services provided directly by the practitioner and, if applicable, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the member was referred by the practitioner (e.g., home health nursing reports, specialty physician reports, and physical therapy reports).

13.5. Documentation Standards

An adequate and complete patient record shall include the following as applicable:

Personal biographical data:

- Patient name and/or identification, birth date, address, primary or secondary phone number, parent/guardian; and;
- Patient name and date of birth on each sheet in the chart.

Each separate encounter/phone contact/entry/report/record shall:

- Be noted as such (i.e. phone contact…);
- Be dated; and
- Be signed or initialed by the practitioner.

Problem list:

- Shall identify and contain significant illnesses and medical conditions past and present;
- Shall be updated and reviewed annually; and
- Shall be dated and signed annually.

Allergies and adverse reactions:

- Must be listed; and
- If the patient has no known allergies or history of adverse reactions, this shall be appropriately noted in the record and easily identified.

History and physicals shall identify and contain:

- Past medical history which includes serious accidents, procedures/surgeries, illnesses, medications;
- Chief complaint;
- Present illness;
- Review of symptoms;
- Pertinent past family and social history;
- Physical examination containing appropriate subjective and objective information pertinent to a patient's presenting complaints;
- Proposed treatment plan; and
- Working diagnoses consistent with findings.

Medications:

- Dated written provider documentation of current medications with dosages (includes over-the-counter, herbals, vitamin/mineral/dietary supplements) as verified with the patient or authorized representative.

Preventive services/risk screening:

- An immunization record shall be initiated and up to date for each pediatric patient;
- Shall include a growth chart for each pediatric patient; and
- Patients age 14 and over: notations shall exist concerning the use of cigarettes, alcohol and substance abuse.

Orders/referrals:

Progress notes shall include:

- A separate entry for each date of service;
- Chief complaint;
- Treatment plans consistent with diagnosis;
- Unresolved problems;
- Results of pertinent lab/test findings;
- Preventive/wellness issues addressed;

- Health education;
- Plan of care and treatment including but not limited to consultations, medications; (prescribed, dispensed, or administered) and/or diagnostic testing; and
- Any informed consent for office procedures.

Test results:

- Consults, labs, and tests shall reflect physician review; and
- Follow-up care, if indicated, shall be duly noted and signed.

Calls and content of phone calls shall be documented.

Records from prior treating or consulting physicians shall be documented.

Advance Directives:

- Shall include documentation by a treating physician of the Advance Directive disclosed by the patient.

Consultative report:

- Shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician.

Corrections, additions or changes in any patient record made more than forty-eight hours after the final entry in the record:

- Shall be signed by the practitioner;
- Shall be clearly marked and identified as such; and
- Shall include the date, time and name of the person making the correction, addition or change.

13.6. Medical Record Review/Audit

All MHP providers are required to participate in MHP's QI activities as stated in the provider/practitioner contract, which includes medical record audits/reviews. Medical record audits/reviews will be conducted in compliance with regulatory and internal reporting requirements, which include but are not limited to:

- HEDIS;
- Adverse Event Investigations;
- Fraud, Waste & Abuse;
- Corporate Appeals;
- Benefit Determination,
- Benefit Exceptions, Claims Processing;
- Health and Wellness Initiatives;
- Case Management;
- Disease Management;
- Quality Improvement Projects and Quality Incentive Projects;
- Medicare Operations; and
- Evaluation of provider practice and adherence to documentation standards.

Reviews/Audits may be performed annually and/or on an as-needed basis.

Review of Medical Records may be conducted onsite or requested for an offsite review. Audits will be conducted utilizing specific abstraction tools following an established procedure for provider notification and scheduling.

Protected health information (PHI) will be utilized and shared only to the extent required for job duties and as permitted under state and federal law. All employees, committee members, board members and participating providers will preserve

the confidentiality of PHI consistent with state and federal law. All medical records obtained by MHP will be maintained in a secure location as specified for action/department conducting the review/audit.

Medical records are confidential documents. All MHP representatives shall maintain member and provider confidentiality when reviewing and/or handling medical records.

14528 South Outer Forty
Suite 300
Chesterfield, MO 63017
(314) 214-8100
(800) 830-1918

mercyhealthplans.com

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